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Teaching Health Versus Treating Illness: The Efficacy of Three Principles Correctional Counseling with People in an English Prison

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Abstract

Three principles correctional counseling (3PCC) posits that people in prison have inner mental health they have obscured to varying degrees with their own thinking. 3PCC further posits that people in prison can rekindle and sustain this inner health via understanding how three psychospiritual principles—Universal Mind, consciousness, and thought—coalesce to form people's psychological experience. We review the three principles and explain how exposure to these principles can lead to improved mental health and improved behavior. Then, we describe 3PCC and distinguish it from prevailing correctional counseling methods. Finally, we present a preliminary study that examines the efficacy of 3PCC for improving the mental health and behavior of people in an English prison. Our findings show that participants exposed to 3PCC showed a significant improvement in mental well-being and purpose in life, significant reductions in anxiety and anger, and improved behavior in the prison community.

Keywords

correctional counseling, the three principles, Universal Mind, consciousness, thought, innate mental health, thought recognition

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Three principles correctional counseling (heretofore 3PCC; Kelley 2008, 2011) is derived from the insights of theosopher, Sydney Banks (1998, 2001), and an intervention based on Banks's insights by Mills (1995) and Pransky (1998). 3PCC is grounded in the following propositions: (a) people's psychological experience (e.g., perceptions, feelings, states of mind), behavior (from deviant to conforming), and behavior change can be explained by the interaction of three psychospiritual principles—Universal Mind, consciousness, and thought; (b) people have all the mental health they need already inside them; and (c) people can realize and sustain this inner health regardless of past traumas, present circumstances, and without techniques via understanding how the principles of Universal Mind, consciousness, and thought coalesce to create people's psychological lives.

The authors have provided detailed explanations of the three principles elsewhere (for a review, see Kelley, Pransky, & Lambert, 2014, 2015a, 2016a, 2016b; Kelly, Alexander & Pransky, 2017). Here, we review the three principles and explain how they appear to combine to form people's psychological lives. Next, we summarize the components of our proposed process from exposure to the three principles to improved mental health and improved behavior. Then, we explain 3PCC and attempt to distinguish it from prevailing correctional counseling methods; particularly cognitive-behavioral therapy (CBT) with which it is often confused. Finally, we present a preliminary study that tests the efficacy of 3PCC for improving the mental health and behavior of people in an English prison.

The Three Principles

Origin

In 1973, Sydney Banks, an iron worker in Salt Spring Island, British Columbia, experienced what preventive mental health pioneer, Donald Klein (1988), referred to as "spontaneous spiritual transformation" (p. 311). During this experience Banks claimed to "see" how three psychospiritual principles—Universal Mind, consciousness, and thought—interact to construct people's psychological experience. Banks referred to Mind, consciousness, and thought as principles because he "saw" them as fundamental truths operating in everyone, at every moment, and affecting all behavior.

The Principle of Universal Mind

Banks referred to Universal Mind (or Mind) as the purest life force; the formless energy within and behind all of life; the essence of everything in the universe, including human beings; and the creative intelligence behind all of life that fuels people's psychological functioning. Also, Banks viewed Mind as the source of innate health/resilience always available to people no matter what circumstances, stressors, or traumatic events they encounter over time. This life energy is continually manifested in and flows through "personal mind," the individual mind of every person. Banks (1998) stated,

> The Universal Mind, or the impersonal mind, is constant and unchangeable. The personal mind is in a perpetual state of change. All humans have the inner ability to synchronize their personal mind with impersonal Mind to bring harmony into their lives . . . Universal Mind and personal mind are not two minds thinking differently, but two ways of using the same mind. (pp. 31-34)

Universal Mind powers the other two principles— consciousness and thought—that all people "use" to construct psychological experience.[1]

The Principle of Consciousness

Banks referred to consciousness as the Mind-powered agency that converts people's thinking into their psychological experience through their physical senses. As people use the power of thought to construct mental images, these images appear real to them as they merge with consciousness and register as sensory experience. Put another way, consciousness uses thought to inform people's senses, direct people's attention and awareness, and construct people's psychological lives from the "inside-out," so to speak. Furthermore, consciousness allows people to recognize they are using the agency of thought to construct their psychological lives—to realize they (and everyone else) live in a separate, continually changing thought plus consciousness "reality."

The Principle of Thought

Banks referred to thought as the Mind-powered agency that all people use to construct psychological experience. Thought, as a principle, refers to people's *ability to think*, or "that people think," and does not refer to thought content, or "what people think." It is the ability to think that is constant from person to person and this is what the principle of thought refers to.

In sum, this understanding posits that people's psychological lives are formed from the "inside-out" via thought enlivened via consciousness, and powered up by Universal Mind. It further proposes that people's behavior is perfectly aligned with how their use of the principles of Mind, consciousness, and thought makes their lives appear to them.[2] In other words, people's moment-to-moment behavior—deviant to conforming—unfolds in perfect synchronization with their continually changing personal realities constructed from the "inside-out" via the three principles.[3]

A Proposed Process from Three Principles Exposure to Improved Mental Health

The Kelley, Pransky, & Lambert (2015a) proposed a process from exposure to the principles of Mind, consciousness, and thought to improved mental health and improved behavior. 3PCC is grounded in the components of this process that follows.

Three Principles Exposure

To varying degrees, most people attribute the source of their psychological experience to external events and circumstances. Also, most people tend to believe that their perceptions are "reality," and that they must act on the "realities" they see (Maruna, 2001). With exposure to the three principles, people have an opportunity to recognize that their psychological lives are constructed from the "inside-out" via their own thinking no matter what occurs "out there," and that while the "realities" they experience appear to be "the truth" they are in fact—thought plus consciousness apparitions.

Three Principles Understanding

Because people are exposed to the three principles does not ensure they will understand how the principles work within everyone. By understanding, we mean the knowledge of how these principles actually work in every person psychologically to create their own experience of life, not only an intellectual understanding but actually seeing them in operation in their own and others' lives. Without an insightful understanding, exposure to the principles would likely have little or no effect on people's mental health and behavior. However, while three principles understanding is essential, it is not sufficient for people to realize and sustain improved mental health and improved behavior. People who understand the principles must also experience new insights regarding at least one of the following—*thought recognition* (TR), and *innate health via a clear mind* (IH/CM).

TR

TR refers to the realization that thought in interaction with consciousness is the only reality that people can ever experience and is the source of people's perceptions, feelings, and states of mind. People who grasp TR "see" that what looks real is only one's own usually inadvertent creation—a momentary illusion brought to life by consciousness. People who gain TR are able to recognize such thinking occurring in the moment, creating a changed "reality" with each new thought, and yielding resultant feelings, perceptions, and states of mind, or they recognize it later as a self-correcting function. TR shifts the way people relate to and use the agency of thought. With TR, people look before thought content or "what people think" to the manner in which thoughts are created and then experienced (i.e., the ability of thought or "that people think"). Sedgeman (2005) stated, "Once people understand the thought-experience connection and realize how to reaccess a healthy state of mind, they can sustain day-to-day peace of mind, wisdom, and well-being regardless of circumstances" (p. 48).

IH/CM

The other major realm of understanding is about realizing that people have all the mental health they need already inside them, that the only thing that can obscure this

health is people's personal thinking, and that people have direct access to this health whenever the personal mind quiets or clears. 3PCC posits that when the personal mind clear, generic, free-flowing, mindful thought immediately fills the void and forms the experience of mental well-being. In sum, according to 3PCC, regardless of their current circumstances, mental status, or prior socialization, all people (including prison in prison) have the same built-in predisposition for optimal mental health and will exhibit its attributes to the degree their minds quiet or clear allowing generic, free-flowing thought to surface. Mustakova-Possardt (2002) stated,

> Mental health is the innate capacity of every person to return into alignment with Mind from a clear mind, and manifest fresh understanding and creative responsiveness in the moment . . . In every moment, when individual mind is spontaneously or intentionally aligned with Mind, and focused away from its intensely personal memory-based world, innate mental health bubbles up, and is characterized by a natural and effortless flow of thought . . . as the experience of peace, contentment, larger perspective on immediate reality, detachment and a generous, loving, and deeply moral view of life. (p. 11)

Improved Mental Health/Improved Behavior

When people understand the three principles, and in turn grasp insights regarding TR and/or IH/CM, they will experience improved mental health. Although there are many definitions of "mental health," all appear to have "wellbeing" in common (American Heritage Dictionary, 2009; World Health Organization, 2004). This understanding has a two-pronged view of well-being: (a) well-being created by natural thought that surfaces spontaneously whenever the personal mind clears; and (b) well-being during stressful/painful/insecure states of mind via understanding the temporary and illusory nature of negative moods, and getting back on track, so to speak, by allowing the personal mind to clear. Furthermore, as the quality of people's behavior reflects the quality of their mental health/well-being, improved well-being is typically accompanied by more civil, responsive behavior. Mills (1995) stated,

> When people recognize how the three principles work, they gain tremendous freedom and clarity . . . the ability to live life at its highest potential. As people begin to see how reality is created, moment-by-moment, through the inter-weaving of these principles, they realize their innate creative power and resilience, their own wisdom and beauty, and their genuine potential for a gratifying life. (pp. 21-22)

Supportive Empirical Evidence

Preliminary evidence exists that appears to support this process from three principles understanding to improved mental health and improved behavior. For example, Kelley (2011) exposed adults on probation to the three principles, and reported a significant positive association between participant's understanding of the principles and their mental wellbeing, and experience of mindfulness. Kelley, Pransky,

and Lambert (2015a) reported that insights regarding TR and IH/CM gained by people exposed to the three principles showed a significant positive relationship with nonattachment, regulating negative emotions, and a significant inverse relationship with rumination, depression and anxiety. Kelley, Pransky, and Lambert (2015b) concluded that as participant's understanding of the three principles, TR, and IH/CM increased, their dependence on techniques to experience mindfulness decreased, and their ability to maintain wellbeing during unpleasant moods increased. Kelley, Pransky, and Lambert (2016a) reported that participants exposed to the three principles reported significant increases in TR and IH/CM, and in turn significant improvements in hedonic wellbeing, eudiamonic wellbeing, social wellbeing, and flourishing mental health. Kelley, Pransky, and Lambert (2016b) reported that participants exposed to the three principles reported significant improvements in TR and IH/CM, and in turn significant improvements in mindful attention, mindful acceptance, flow experience, and mental wellbeing. Finally, Kelley, Alexander, and Pransky (2017) reported that compared to a waitlist control group, children and adolescents exposed to the three principles showed a significant increase in resilience. Also, "high-risk" participants reported a significantly greater improvement in overall resilience than moderate and low-risk participants, as well as a significant decrease in risky behavior. Participants related their improved resilience to heightened TR and/or IH/CM.

3PCC

The three principles intervention has been applied in several areas including prevention (e.g., Pransky, 2003), community revitalization (e.g., Pransky, 2011), trauma treatment (e.g., Kelley, Pransky, & Sedgeman, 2014; Halcon, Robertson & Monsen, 2010), school violence prevention (Kelley, Mills, & Shuford, 2005; Evans and Pevalin (2017), anger management (e.g., Kelley & Lambert, 2012), chemical dependency treatment (e.g., Bannergee, Howard, and Mansheim (2010) mental health counseling (e.g., Kelley, Pransky, & Lambert, 2015a, 2015b, 2016a, 2016b; Sedgeman & Sarwari, 2006), and intimate partner violence prevention (Kelley & Pransky, In Press). [4] When used with people under criminal justice supervision, three principles intervention is typically referred to as 3PCC (Kelley, 2008). Because 3PCC is often confused with other correctional counseling methods—particularly cognitive-behavioral therapy or CBT, Kelley (2008) highlighted the following critical distinctions between 3PCC and other interventions.

Awareness Versus Understanding

Many prevailing correctional counseling methods (e.g., CBT) attempt to increase clients' awareness of the content of their thinking (e.g., "criminogenic" beliefs). For these methods, *awareness* refers to clients' recognition of particular (e.g., "antisocial") thoughts and beliefs, perhaps how they developed historically, and various techniques to challenge, and recondition these schemas.

3PCC practitioners, on the contrary, help clients understand that everyone continually uses the power of thought to create psychological experience. They strive to deepen clients' understanding of thought as an ability used to generate thoughts that consciousness enlivens and gives the appearance of "reality." Thus, *understanding* in 3PCC is not about thought content or "what people think." Rather, understanding refers to TR, grasping how thought works from within to create people's psychological lives, and how what people call "reality" is really only their own self-generated creation.

Memory Work Versus Memory Recognition

Consider a client diagnosed with posttraumatic stress disorder. A CBT counselor would attempt to help this person address the traumatic event. This counselor would view the traumatic event as a major focus of treatment, the client's fearful reaction to the event as a signal of proper therapeutic direction, and the client's posttraumatic symptoms as facts about which he or she must learn to think more rationally. This counselor would then focus on the client's memories and beliefs regarding the traumatic event, as if these thoughts had power independent of the client thinking they do. Then the counselor would attempt to recondition the client's thinking as though it were a fixed experience, with little or no acknowledgment of the subtle variations in her or his thinking that coincide with an ever-changing state of mind (e.g., Ehlers & Clark, 2000; Foa, Keane, Friedman, & Cohen, 2008).

A 3PCC practitioner, on the contrary, would view the client's "traumatic" memories as stored thoughts regarding the past enlivened by consciousness and made to look real in the present. This practitioner would view the traumatic event in and of itself as having no special importance to the therapy process. Rather than focusing on the client's painful memories and teaching her or him techniques to recondition these memories, the 3PCC counselor would teach TR—that memories are simply thoughts brought forward from the past with present thinking, and the client can recognize these unproductive thoughts, allow them to pass through, and, by so doing, these thoughts and the painful feelings they spawn will be healed naturally with minimal life interference (Kelley & Pranksy, 2013; Kelley, Pranksy & Sedgeman, 2014).

Coping with Feelings Versus Understanding Feelings

Many prevailing correctional counseling methods (e.g., CBT, social learning) focus directly on clients' painful feelings as if they had a life and influence of their own. Then, these methods attempt to teach people in prison ways to deal with these feelings using techniques such as cognitive restructuring, conflict resolution, problem solving, meditation, and anger management. In contrast, 3PCC practitioners recognize that if clients engage in techniques to overcome negative feelings, these feelings are still acting on them because they still appear to be real and to demand attention rather than merely dismissible thoughts. Thus, 3PCC practitioners help clients understand that painful feelings are products of their own thinking, merely thoughts that have no

power over them unless they think they do, and they can relate to these thoughts as they would an unwanted memory, nightmare, or daydream.

Change via Techniques Versus Change via Insight

Most prevailing correctional counseling methods (e.g., CBT, mindfulness-based) teach clients various techniques to help them recondition their dysfunctional beliefs and better cope with the negative feelings they spawn. In contrast, 3PCC strives for more natural and sustained change which it posits will emerge from insights regarding TR and IH/CM gained through understanding the three principles. For example, clients who tend to react violently who learn techniques to better manage anger would be seen by 3PCC practitioners as preferable to no positive improvement. However, these practitioners would view this result as temporary and treatment as incomplete until these people realize how anger is caused by their own thinking, minimize the significance of the angry thoughts that made violence appear desirable, are living typically in a more healthy state of mind, and are able to distinguish and correct for less healthy states of mind. In sum, 3PCC practitioners would consider violence prone individuals able to function in society in a healthy way only when they have grasped TR and IH/CM at a level that minimizes the significance of angry thought-feelings that previously spawned their violent behavior.[5]

Treating Illness Versus Teaching Health

Most prevailing correctional counseling methods (e.g., CBT) strive to treat *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; *DSM-5*; American Psychiatric Association, 2013) diagnosed illnesses. These methods assume that clients are restored to their "normal" level of health or highest previous global level of functioning when their presenting symptoms and problems appear to be relieved or resolved. In contrast, the primary goal of 3PCC is to facilitate permanent, positive change in clients' overall mental health. 3PCC views clients' presenting symptoms as evidence of their innocent misunderstanding and misuse of the power of thought, and their ignorance regarding their own inner mental health and how to access and sustain this health. While clients' presenting symptoms are viewed compassionately by 3PCC practitioners, these symptoms are seen as irrelevant to effective intervention because these practitioners trust that as clients allow their thinking to operate in an increasingly healthy way, their symptoms will naturally resolve across the board.

In sum, 3PCC differs markedly from CBT and other prevailing correctional counseling methods that attempt to *put health into* people by reconditioning their beliefs or schemas, teaching them mind-quieting techniques, improving their communication, problem solving and coping skills, and inculcating positive virtues and character strengths. Rather, 3PCC attempts to rekindle and the inner health that it posits exists undamaged within all people.

The primary purpose of the study that follows is to test the efficacy of 3PCC for improving the mental health and behavior of people in an English prison. It is expected

that exposing these people to the three principles will direct them toward new insights regarding TR and/or IH/CM. In turn, it is expected that insights gained by these people regarding TR and/or IH/CM will result in improved mental health and improved behavior. Thus, the hypotheses for this study are as follows:

Hypothesis 1: Compared with the control group, inmates exposed to 3PCC will show a significant increase in TR.
Hypothesis 2: Compared with the control group, inmates exposed to 3PCC will show a significant increase in IH/CM.
Hypothesis 3: Compared with the control group, inmates exposed to 3PCC will show a significant increase in mental well-being.
Hypothesis 4: Compared with the control group, inmates exposed to 3PCC will show a significant increase in purpose in life.
Hypothesis 5: Compared with the control group, inmates exposed to 3PCC will show a significant decrease in depression.
Hypothesis 6: Compared with the control group, inmates exposed to 3PCC will show a significant decrease in anxiety.
Hypothesis 7: Compared with the control group, inmates exposed to 3PCC will show a significant decrease in anger.
Hypothesis 8: Compared with the control group, inmates exposed to 3PCC will show greater improvement in behavior in the prison community.

The Present Study

Location

The location of this study is HM Prison Onley in Willoughby, Warwickshire, United Kingdom, and operated by Her Majesty's Prison Service. The prison houses up to 750 adult males in mostly single cells. Prison treatment services are provided exclusively by Phoenix Futures (PF), an external provider. Upon reception at the prison, PF devises a treatment plan for each resident, which includes several mandatory classes grounded in CBT. Also, PF offers prison residents voluntary substance misuse services grounded in CBT.

In early 2015, Beyond Recovery (BC), a Community of Interest Company located in Birmingham, United Kingdom, asked PF to offer 3PCC to their residents. PF agreed to allow BC to provide 12 of their staff a 3-day intensive 3PCC training to raise their awareness of 3PCC and how it differs from CBT. Following this training, PF allowed BC to offer 3PCC to residents as an elective 3-hr weekly class spanning 10 consecutive weeks.

The 3PCC Intervention

The 3PCC classes were facilitated by five BC practitioners each with between 4 and 6 years of experience teaching the three principles to a variety of client types. Each

3PCC class met weekly for 10 consecutive weeks, and each session was approximately 3 hr in length. The 3PCC classes included the following modules: building rapport, exploration of "reality," separate realities, exploration of thought and insight, consciousness—where does it come from?, exploring feelings/moods/behavior, exploring innate health/natural intelligence, what is Mind?, exploring infinite potential, exploring mental clarity versus a busy mind, stepping into the unknown, implications of the principles for life in prison, and living outside of prison.

The program format, however, was not rigid and allowed flexibility for the facilitators to trust their own wisdom to guide each session. Each session was designed to be conversational, exploratory, and reflective rather than traditional lecturing/teaching. Conversations were often based on what participants brought in to the room, and facilitators continually looked for opportunities to teach TR and IH/CM, and highlight the innate health and common sense of each participant.[6]

Experimental Groups

Between June 2015 and May 2016, 179 prison residents were referred to the 3PCC intervention either by PF staff or self-referred. Of these referrals, 65 residents decided not to enroll. Thus, the response rate for the study is approximately 65%. During this same time period, BC conducted six 10-week 3PCC classes. Each class began with between 12 and 15 residents. Some residents did not complete their selected 3PCC class for the following reasons: (a) they failed to show up at Week 1; (b) before the class ended, they were transferred to another prison; (c) before the class ended, they were released from prison; and (d) they violated prison unit rules. In sum, of 75 residents initially enrolled in these six 3PCC classes, 53 completed the 10-week intervention and formed the study's treatment group. Treatment participants completed the study's measures at pretest during their first 3PCC session and at posttest at the end of their final session at Week 10.

A waitlist control group was also formed. This group was composed of 39 residents who enrolled in a 3PCC class but for various reasons (e.g., course space limitations, scheduling conflicts related to their job duties, and/or mandatory CBT-based classes) were unable to attend their desired class. Each control participant completed the study's measures at pretest and at posttest (10 weeks later) at either their work site or cell.

Method

Participants

In total, 92 residents participated in the study. All participants were male. In terms of age, 34% of the participants were between the ages of 18 and 29 years, 64% were between 20 and 49 years, and one inmate was over age 50. Regarding ethnicity, 38% were White, 10% Asian, 9% Black, 1% Hispanic, and 42% selected "Other" ethnicity.[7] All but one participant indicated their residence as the United Kingdom. Regarding

education level, 32% of participants reported some senior school, 20% reported completing senior school, 44% reported some college with no degree, 1% reported an associate's degree, and 2.5% reported a bachelor's degree. Finally, regarding marital status, 59% of the participants indicated they were single.

The offenses committed by study participants included drug dealing, burglary, robbery, assault, receiving stolen property, fraud, and vehicular homicide. Many participants sentenced for drug dealing and robbery, and were also sentenced for possessing a weapon such as firearm or knife. Several of those sentenced for burglary had committed multiple burglaries. Several sentences also included driving offenses (i.e., death by dangerous driving, drunk driving, dangerous driving, and vehicle theft). Finally, over half of the participants were abusers of Class A drugs (e.g., heroin, methamphetamine, cocaine) and/or alcohol. Length of sentence ranged from 1 year to life with most participants serving between 2 and 10 years.

Measures

Three Principles Inventory (3PI). The 3PI contains 15 items with five items measuring three principles understanding (e.g., reverse scored—"Techniques such as positive thinking and meditation are important for people to maintain their mental health"; Kelly, 2011), five items measuring TR (e.g., "The only feelings I can have are created by my thinking," and "The only way people can experience stress is as a result of their thinking"), and five items measuring IH/CM (e.g., "No matter what my circumstances, wisdom is always available to me," and—reverse scored—"My self-esteem can be affected by what happens to me in life"). Each item is scored on a 6-point Likert-type scale ranging from 1 (*strongly disagree*) to 6 (*strongly agree*). Item responses are summed to obtain a total 3PI score. The internal consistency reliability coefficient was .74 for the pretest total 3PI index and .74 for the posttest total 3PI index.[8]

Warwick–Edinburgh Mental Well-Being Scale–Short Form (WEMWBS-SF). The WEMWBS-SF was developed at the Universities of Warwick and Edinburgh and comprises seven items that relate to an individual's state of mental well-being (thoughts and feelings) in the previous 2 weeks (Tennant et al., 2007). The WEMWBS has good psychometric properties (Stewart-Brown et al., 2009). In the validation of WEMWBS, Tennant et al. (2007) examined the relationships between other measures of positive mental health (e.g., WHO-5 Well-Being Index, Scale of Psychological Well-Being [SPWB], Positive and Negative Affect Scale [PANAS]) and mental ill health (General Health Questionnaire [GHQ-12], PANAS), and reported relatively high correlations with the other positive well-being measures (correlations ≥ .7) and moderate, negative correlations with the GHQ-12 ($r = –.53$) measure of mental ill health. Each item is worded positively and together they cover most, but not all, attributes of mental well-being, including both hedonic and eudemonic perspectives. Responses are made on a 5-point Likert-type scale ranging from 1 (*none of the time*) to 5 (*all of the time*). Item responses are summed to obtain a total WEMWBS-SF score. The

internal consistency reliability coefficient was .83 for the pretest and .83 for the posttest WEMWBS-SF index.

Purpose in Life Test (PILT). The PILT is a 20-item self-report attitude scale, which measures the extent to which people perceive their lives to be purposeful and meaningful (Crumbaugh & Maholick, 1964). As for psychometric properties, internal consistency and split-half reliability coefficients for the PILT typically range from the high .70s to the low .90s (e.g., Melton & Schulenberg, 2007, 2008). With regard to validity, PILT scores are positively associated with constructs such as life satisfaction, happiness, self-acceptance, and emotional stability, and are negatively correlated with depression and anxiety (e.g., Crumbaugh & Henrion, 1988; Robak & Griffin, 2000). Each item is rated on a 7-point Likert-type scale ranging from 1 (*low purpose*) to 7 (*high purpose*). Items are summed to obtain a total PILT score which can range from 20 (*low purpose*) to 140 (*high purpose*). Item scores are summed to obtain a total PILT score. The internal consistency reliability coefficient was .81 for the pretest PILT index and .90 for the posttest PILT index.

National Institute of Health Patient-Reported Outcomes Measurement Information System (NIH PROMIS) measures (PROMIS Health Organization). Many legacy instruments measuring mental health components (e.g., depression, anxiety, anger) suffer from shortcomings in sensitivity at the low and/or high ends of the scale, thus providing limited accuracy for the healthiest and the most affected respondents (Pilkonis et al., 2014). PROMIS items, however, have undergone rigorous testing for evidence of differences by respondent characteristic (e.g., sex, age, education). The PROMIS initiative has extended this work with a focus on validation studies across several disease groups and settings. Results to date demonstrate that the PROMIS measures function as well as or better than legacy measures, as demonstrated by improved reliability and evidence of increased sensitivity to clinical change (Broderick, DeWitt, Rothrock, Crane, & Forrest, 2013).

PROMIS Depression–Short Form (PR-Dep; PROMIS Health Organization). The PR-Dep contains eight items, which measure depression based on *DSM-5* symptomatology. Respondents report the degree to which they have been bothered by each symptom during the past 7 days (e.g., "I felt worthless"). We used five PR-Dep items each scored using a 5-point Likert-type scale ranging from 1 (*never*) to 5 (*always*). Item responses are summed to obtain a total score. The internal consistency reliability coefficient was .83 for the pretest PR-Dep index and .82 for the posttest PR-Dep index.

PROMIS Anxiety–Short Form (PR-Anx; PROMIS Health Organization). The PR-Anx contains seven items, which measure anxiety based on *DSM-5* symptomatology. Respondents report the degree to which they have been bothered by each symptom during the past 7 days (e.g., "I felt fearful"). We used six PR-Anx items each scored using a 5-point Likert-type scale ranging from 1 (*never*) to 5 (*always*). Item scores are summed to obtain a total score. The internal consistency reliability coefficient was .77 for the pretest PR-Anx index and was .86 for the posttest PR-Anx index.

PROMIS Anger–Short Form (PR-Ang; PROMIS Health Organization). The PR-Ang contains five items, which measure anger based on *DSM-5* symptomatology. Respondents reported the degree to which they have been bothered by each symptom during the past 7 days (e.g., "I felt angry"). We used all five items scored using a 5-point Likert-type scale ranging from 1 (*never*) to 5 (*always*). Item scores are summed to obtain a total score. The internal consistency reliability coefficient for the pretest PR-Ang index was .88 and for the posttest PR-Ang was .88.

Improved behavior. HR Prison Onley uses three regime levels for residents (i.e., basic, standard, and enhanced). All residents begin serving their sentence at the basic regime. Based on the quality of their behavior in the prison community, residents can move from basic to standard regime, and from standard to enhanced regime. Regime elevations offer fewer restrictions and more privileges. The maximum reward for improved behavior is transfer to the Prison's L-Wing, which provides the most comfortable living quarters and maximum privileges. Improved behavior is measured by the number of treatment and control participants who achieve regime elevations, and L-Wing transfers during the 10-week duration of the 3PCC intervention.

Results

This study was approved by the following internal review boards: the Northamptonshire County Council, Public Health and Wellbeing Committee, the HM Prison Onley Drug Strategy Committee, and Phoenix Futures Substance Misuse Services Board. Among the 92 participants, 53 composed the experimental group and 39 composed the control group. Based on the chi-square tests, there were no statistically significant differences between the control and experimental groups on the demographic variables of age ($\chi^2 = 1.64$, $p = .44$), race ($\chi^2 = 4.92$, $p = .30$), residence ($\chi^2 = 0.71$, $p = .40$), education level $\chi^2 = 2.11$, $p = .72$), or marital status ($\chi^2 = 5.08$, $p = .28$). Also, there were no differences of note between the treatment and control participants on offense type and sentence length.

The descriptive statistics for the outcome measures of 3PI, WEMWBS, PILT, PR-Dep, PR-Anx, and PR-Ang are presented in Table 1. There was a significant variation in the six outcome measures (i.e., none were constants). In addition, the Cronbach's alpha values, a measure of internal reliability for the index outcome variables, were higher than .70, which is viewed as good.

Independent *t* tests were computed between the control and experimental groups on the seven pretest outcome variables and the seven posttest outcome variables. The results are presented in Table 2. In addition, the descriptive statistics (means and standard deviations) on the outcome variables for the two groups are also presented in Table 2. The Cronbach's alpha value for each outcome variable was similar for the two groups (see *Note* section of Table 1). There were no statistically significant between-group differences on the pretest measures of 3PI, WEMWBS, PR-Dep, PR-Anx, and PR-Ang. There was a significant pretest difference ($p \leq .05$) between the two experimental groups on the PILT index; the control group was higher on this measure than

Table 1. Descriptive Statistics for Pre- and Posttest Outcome Measures for All Study Participants.

Variable	Description	*M*	*SD*	Median	Minimum	Maximum
Pretest						
3PI	Three Principles Inventory, 15-item additive index, α = .74	50.35	6.80	51	30	82
WEMWBS	Warwick–Edinburgh Mental Well-Being Scale, seven-item additive index, α = .83	23.77	5.19	24	10	35
PILT	Purpose in Life Test, 20-item additive index, α = .81	73.92	13.03	75	37	105
PR-Dep	PROMIS Depression–Short Form, five-item additive index, α = .83	10.32	4.48	9.5	8	25
PR-Anx	PROMIS Anxiety–Short Form, six-item additive index, α = .77	11.88	4.82	11	7	27
PR-Ang	PROMIS Anger–Short Form, five-item additive index, α = .88	10.52	4.99	10	5	25
Posttest						
3PI	Three Principles Inventory, 15-item additive index, α = .74	55.70	10.22	55	22	82
WEMWBS	Warwick–Edinburgh Mental Well-Being Scale, seven-item additive index, α = .83	27.38	4.53	28	11	35
PILT	Purpose in Life Test, 20-item additive index, α = .90	84.06	12.02	85	49	105
PR-Dep	PROMIS Depression–Short Form, five-item additive index, α = .82	8.59	3.88	7	8	25
PR-Anx	PROMIS Anxiety–Short Form, six-item additive index, α = .86	10.10	4.55	9	7	26
PR-Ang	PROMIS Anger–Short Form, five-item additive index, α = .88	8.53	4.25	7	5	23

Note. The total number of participants was 92, with 39 in the control group and 53 in the experimental group. While not reported in the above table, the Cronbach's alpha values for the control and experimental groups were similar to one another and are available upon request. The descriptive statistics of the outcome measures for the control group participants and the descriptive statistics of the outcome measures for the experimental group participants are presented in Table 2. α = Cronbach's alpha (a measure for internal reliability).

the experimental group. For the posttests, there was a significant difference between the two groups on the 3PI, WEMWBS, PR-Anx, and PR-Ang variables. For the 3PI and WEMWBS measures, the experimental group was higher than the control group.

Table 2. Independent *t* Test Results for Pretest and Posttest Outcome Measures.

	Control group		Experimental group		
Variable	*M*	*SD*	*M*	*SD*	*t* value
Pretest					
3PI	50.64	5.69	50.13	7.58	−0.35
WEMWBS	24.85	4.42	22.98	5.60	−1.72
PILT	77.03	11.85	71.56	13.50	−1.98*
PR-Dep	9.97	4.54	10.57	4.46	0.62
PR-Anx	11.63	4.99	12.06	4.72	0.41
PR-Ang	10.72	5.55	10.36	4.57	−0.33
Posttest					
3PI	50.23	8.39	59.81	9.58	4.98**
WEMWBS	25.71	4.67	28.58	4.06	3.13**
PILT	81.55	11.13	85.87	12.42	1.71
PR-Dep	9.74	4.67	7.74	2.94	−0.89
PR-Anx	10.59	5.17	9.74	4.03	−2.48*
PR-Ang	9.77	5.19	7.60	3.11	−2.53**

Note. The number of participants in the control group was 39 and the number of participants in the experimental group was 53. 3PI = Three Principles Inventory; WEMWBS = Warwick–Edinburgh Mental Well-Being Scale; PILT = Purpose in Life Test; PR-Dep = PROMIS Depression–Short Form; PR-Anx = PROMIS Anxiety–Short Form; PR-Ang = PROMIS Anger–Short Form.
*$p \leq .05$. **$p \leq .01$.

Conversely, for the PR-Anx and PR-Ang measures, the control group was higher than the experimental group. There was no significant difference between the two groups on the posttest measures of PILT and PR-Dep.

Next, paired *t* tests were used to determine whether each group showed a significant change on any of the six outcome variable from the pretest to the posttest, where only the experimental group was exposed to 3PCC. The results are presented in Table 3. For the control group, there was no significant change from pretest to posttest for the variables of 3PI, WEMWBS, PR-Dep, PR-Anx, and PR-Ang. There was a significant increase for the control group from the pretest to the posttest on the PILT variable. For the experimental group, there was a significant change from the pretest measurement to the posttest measurement on all seven outcome variables. Specifically, after their exposure to 3PCC, these participants showed a significant increase in 3PI, WEMWBS, and PILT. Conversely, after their exposure to 3PCC, these participants showed a significant decrease in PR-Dep, PR-Anx, and PR-Ang.

Finally, analysis of covariance (ANCOVA) was conducted to see whether the differences between the control and experimental groups continued once the pretest scores were taken into account, and the results are reported in Table 4. For the outcome variables of 3PI, WEMWBS, PILT, PR-Anx, and PR-Ang, there was a significant difference between the control and experimental groups. There was no significant difference between the two groups on the PR-Dep variable.

Table 3. Paired *t* Test Results for the Control and Experimental Groups on the Outcome Variables.

Variable	*M*	*SD*	*M*	*SD*	*t* value
Control group					
3PI	50.64	5.69	50.23	8.39	0.36
WEMWBS	24.68	4.35	25.71	4.67	−1.19
PILT	77.03	11.85	81.55	11.13	2.32*
PR-Dep	9.97	4.54	9.74	4.67	0.34
PR-Anx	11.63	4.99	10.66	5.23	1.41
PR-Ang	10.72	5.55	9.77	5.19	1.79
Experimental group					
3PI	50.14	7.66	59.72	9.65	−5.57**
WEMWBS	22.98	5.60	28.58	4.06	−7.82**
PILT	71.56	13.50	85.78	12.75	−8.12**
PR-Dep	10.57	4.46	7.74	2.94	4.30**
PR-Anx	12.06	4.72	9.74	4.03	3.70**
PR-Ang	10.24	4.51	7.47	3.01	5.30**

Note. A negative *t* value means that there was an increase from the pretest to the posttest, and a positive *t* value means that there was a decrease from the pretest to the posttest. The number of participants in the control group was 39 and the number of participants in the experimental group was 53. 3PI = Three Principles Inventory; WEMWBS = Warwick–Edinburgh Mental Well-Being Scale; PILT = Purpose in Life Test; PR-Dep = PROMIS Depression–Short Form; PR-Anx = PROMIS Anxiety–Short Form; PR-Ang = PROMIS Anger–Short Form.
*$p \leq .05$. **$p \leq .01$.

Based on all three statistical tests, of which the results are presented in Tables 2 to 4, it is concluded that Hypotheses 1 (TR),[9] 2 (IH/CM; see Note 9), 3 (WEMWBS), 4 (PILT), 6 (PR-Anx), and 7 (PR-Ang) are supported. Based on the statistical analysis, Hypothesis 5 (PR-Dep) was not supported. Finally, regarding improved behavior, during the 10-week duration of 3PCC intervention, 13 treatment inmates were elevated by prison staff from either the basic regime to the standard regime or from the standard regime to the enhanced regime. Also, three treatment inmates were transferred to the Prison's L wing. For control group, two inmates received regime elevation and none were transferred to the Prison's L wing. As such, it is concluded that Hypothesis 8 was supported.

Discussion

The purpose of this study was to test the efficacy of 3PCC for improving the mental health and behavior of people in an English prison. It was expected that exposing these people to the logic of the principles behind 3PCC would direct them toward new insights regarding TR and/or IH/CM. In turn, it was expected that if insights regarding TR and/or IH/CM were grasped by these people, their mental health and behavior would improve. The results appear to support seven of the study's eight hypotheses.

Table 4. ANCOVA for the Outcome Variables Controlling for Pretest Scores.

Outcome variable	SS	MS	*F* value	R^2
3PI				.24
Intercept	2,995.08	2,995.01	36.68**	
Pretest	229.47	229.47	2.81	
Group	2,039.52	2,039.52	24.98	
Corrected total	9,325.38			
WEMWBS				.24
Intercept	1,467.83	1,467.83	91.39**	
Pretest	251.34	251.34	15.65**	
Group	253.87	253.87	15.81**	
Corrected total	1,847.54			
PILT				.29
Intercept	5,575.80	5,575.80	51.67**	
Pretest	3,371.62	3,371.62	31.25**	
Group	982.52	982.52	9.10**	
Corrected total	12,929.82			
PR-Dep				.22
Intercept	404.70	404.70	33.58**	
Pretest	205.12	205.12	17.02**	
Group	28.97	28.97	1.99	
Corrected total	1,368.30			
PR-Anx				.32
Intercept	201.31	201.31	13.81**	
Pretest	574.39	574.39	39.41**	
Group	108.91	108.91	9.04**	
Corrected total	1,875.67			
PR-Ang				.54
Intercept	101.43	101.43	12.11**	
Pretest	748.71	748.71	89.36**	
Group	89.65	89.65	10.70**	
Corrected total	1,594.40			

Note. The number of participants in the control group was 39 and the number of participants in the experimental group was 53. SS = sum of squares; MS = mean squares; 3PI = Three Principles Inventory; WEMWBS = Warwick–Edinburgh Mental Well-Being Scale; PILT = Purpose in Life Test; PR-Dep = PROMIS Depression–Short Form; PR-Anx = PROMIS Anxiety–Short Form; PR-Ang = PROMIS Anger–Short Form.
*$p \leq .05$. **$p \leq .01$.

Hypotheses 1 and 2 were supported. Following exposure to 3PCC, participants showed a significant increase in TR, understanding that thought enlivened by consciousness is the only reality that people can experience, that they (and everyone else) are the sole creators of their own psychological experience with their own thinking, and that thought is a continual dynamic process always bringing people new realities. Also, following exposure to 3PCC, participants showed a significant increase in IH/CM,

understanding that they (and everyone else) have innate mental health that is accessed via a clear mind.

Via grasping these new insights, people in prison realize that they—not external circumstances or how other people treat them—create their feelings and perceptions via their use of the power of thought. Also, they "see" that their behavior is always perfectly aligned with how their thinking makes their lives appear to them. These insights turn the power of experience over to people in prison, not to life events. Sedgeman (2005) stated,

> When people realize the one-to-one connection between thought and experience, they gain perspective on life. Changes in their experience of reality no longer look as though they were randomly caused by outside events or forces. Fear, hopelessness, and alienation begin looking like thought-events, rather than horrible life circumstances. Seeing the emergence of experience from thought . . . appears to bring people peace of mind, no matter what they are thinking. Understanding principles gives the power of experience to the person, not to life events. (p. 3)

Mental Well-Being

Hypothesis 3 was supported. Compared with the control group, participants exposed to 3PCC showed a significant improvement in well-being. This result was expected because when people grasp TR and/or IH/CM through understanding the principles behind 3PCC, their relationship with their thinking shifts. They become less likely to identify with the thoughts they think, less likely to view their thoughts as "reality" or "the truth," and less likely to become gripped by their thoughts. In other words, they become the observer rather than the prisoner of their thoughts. They realize that thoughts have no power over them unless they think they do. They "see" that they have free will to choose which thoughts to honor and entertain, and which thoughts to allow to pass through. With these insights, people in prison spend more time experiencing well-being, and less time entertaining and acting on less healthy thoughts that happen to mind.

Purpose in Life

Hypothesis 4 was supported. Compared with the control group, participants exposed to 3PCC showed a significant increase in purpose in life. This finding is important because considerable research (e.g., Martin, MacKinnon, Johnson, & Rohsenow, 2011) supports a strong association between poor purpose and meaning in life and addiction problems and deviant behavior. Also, purpose in life has become a core component of positive psychology (e.g., Schulenberg, Hutzell, Nassif, & Rogina, 2008), and is positively associated with hope, faith, love, health, and happiness, and negatively associated with depression, anxiety, drug/alcohol use, and boredom proneness (e.g., Melton & Schulenberg, 2007; Ryff & Keyes, 1995).

Depression, Anxiety, and Anger

Hypotheses 5 was not supported. While the experimental group showed a significant decrease in depression from pretest to posttest, once pretest scores were taken into account, the between-group difference regarding depression was not significant. Hypotheses 6 and 7, however, were supported. Compared with the control group, participants exposed to 3PCC showed significant decreases in anxiety and anger. These findings were expected because when people grasp TR and/or IH/CM, they realize that negative feelings are caused and sustained via their own thinking, not external events and circumstances. They "see" that by taking these feelings and the thoughts that spawn them to heart, they are only hurting themselves and preventing their "psychological immune system" from ushering in healthier thoughts and feelings. The realize negative emotions such as depression, anxiety, and anger signal less healthy thinking and the need to lighten up, and allow the mind to clear.

Singleton, Meltzer, and Gatward (1998) reported that 45% of prisoners in England and Wales experience depression or anxiety disorders compared with only 13.8% for the general population. To the extent that people in prison understand they are continually thinking, and the thoughts they think are continually translated into apparent reality via consciousness, they see that every so-called reality is merely a fleeting, ephemeral product of their own minds at work. With this realization, anxiety, anger, depression, and other negative feelings (e.g., boredom) show up as thought events rather than negative life circumstances. Thus, it seems reasonable to expect that the significant reductions in anxiety and anger for these people in prison combined with their significant increases in well-being, and purpose in life may have a cumulative reciprocal effect on prison culture that can help reverse the process leading to alienation, violence, drug use, manipulation, and other health-damaging behaviors in the prison community.

The significant reduction in anger appears to have particular significance for these people, many of whom are incarcerated for acts of violence. Unless these people are helped to call into question what they would swear is a "reality" they must act on, they will have no choice but to follow their thinking or be forced to continually fight against it. Through understanding the three principles, however, these people realize that feelings serve as a reliable, moment-to-moment barometer of the quality of people's thinking. They "see" that anger signals less healthy thinking, and the need to lighten up, so the personal mind can clear and realign with Mind. Mills (1995) underscored two elements of this understanding that help people prone to violence relax and psychologically take charge of their lives:

> The first is knowing how their reality is determined in the moment. When people understand how their view of life, their perceptions, are a product of ongoing continuous thought . . . they start to experience more self-efficacy, along with the ability to better manage their moods and behavior. The second is knowing that responsive, functional thought . . . is always available . . . helps people relax, and feel less of a need to rely on their conditioned thinking habits to project artificial images and to look for answers. (p. 206)

Improved Behavior

Hypothesis 8 was supported. Compared with the control group, participants exposed to 3PCC demonstrated greater improvement in behavior in the prison community. During their 10 weeks of exposure to 3PCC, 13 prison residents were reassigned by prison staff from either basic to standard regime or from standard to enhanced regime. Furthermore, three treatment group participants were transferred to the Prison's L wing. During the same time frame, only two control participants received regime elevations and none were transferred to the Prison's L wing. This result was expected because the consensus of considerable research is that improved mental health is typically accompanied by more civil, prosocial behavior.

Implications for Correctional Counseling

In sum, it appears that the logic of the three principles behind 3PCC can redirect correctional counseling's inquiry regarding the mental health and psychological functioning of people in prison. The logic of these principles suggests that it is not fruitful to focus on multiple outside factors to understand mental health or mental dysfunction. The logic of these principles appears to turn cause and affect inside-out. This understanding posits that independent variables commonly associated with deviant behavior, such as antisocial values, criminal peers, low self-control, substance abuse, and so on, are effects, not putative causes. It also posits that independent variables commonly associated with well-being, such as supportive friendships, challenging work, religious faith, intimate relationships, and so on, are also effects, not supposed causes. It further suggests that well-being associated with mindfulness techniques, activities that induce flow, and myriad other techniques and/or interventions (e.g., hypnosis, progressive relaxation, guided imagery) used by correctional counselors is the product of natural, free-flowing, insight-based thought realized via a clear mind.

What appears evident from this study is that insights regarding TR and/or IH/CM gained via understanding the three principles behind 3PCC can assist the field of correctional counseling to better understand mental health and illuminate a path to improved mental health for people in prison—without techniques (see Note 5). These principles posit that there is only one source of people's experience—the use of thought enlivened via consciousness. Thus, it is possible that this understanding can move correctional counseling to a deeper, more precise understanding of the psychological functioning of people in prison (and others under criminal justice supervision) turning attention away from external causal factors, and toward the people's ability to create thought and psychological experience from the "inside-out."

Limitations

Like most studies, the current study has limitations. Our findings should be considered preliminary, as the sample size is small. A larger number of participants would have increased the power of analysis, allowing for smaller effects to be demonstrated. In

addition, because of the sample size, it was not possible to explore whether the effects of the intervention differed by different subgroups, such as younger and older prison residents, White and non-White residents, or married and unmarried residents. A larger sample size would allow for more detailed analyses. Also, all of the analyses in this study were bivariate and therefore can be misleading. Also, participant's responses to the 3PI may have reflected their intellectual knowledge of the terminology and general awareness of 3PCC rather than an insightful understanding of the three principles, TR, and IH/CM.

Another limitation is that the study participants were not randomly assigned to the control and experimental groups. Future studies should randomly assign the participants to the control and treatment groups. Random assignment would help ensure that the control and experimental groups are equivalent to one another and address the issue of selection bias. Also, this study did not determine whether there were differences of note between the 53 people who completed the 3PCC intervention and the 22 who did not ensure to there was no selection bias. In addition, the current study did not control for motivation to change among the study participants. Motivation to change could have influenced the results. New research in this area should test for the level of desire to change and control for it in the analyses. While a rigorous design was instituted and followed, there is always the question of the fidelity of the intervention. Future research should use actual behavioral measures at different points of time after the conclusion of the intervention to see whether the psychological results reported actually occurred and for how long after the treatment.

Furthermore, residents at other prisons, including those in other nations, need to be studied. It could be that the effects of the intervention are situational and contextual. Furthermore, research is needed to determine whether this intervention could be successful among people on community supervision (e.g., probation or parole). It could be that the unique nation of prison aided (e.g., less distractions or temptations than found in the community) or detracted (fear of victimization while in prison or negative pressure from fellow residents not in the treatment program) from the effects of 3PCC. In addition, future studies should examine how long the effects of 3PCC last on prison residents. It could be that aftercare interventions to reinforce three principles understanding are needed. It is also possible that treatment studies with people in prison need to include outcome measures that evaluate other dimensions of functioning such as self-control. Furthermore, as yet there has been no follow-up for these participants which would have enabled a better test of treatment efficacy. Another limitation of this study was that only self-report outcome measures were used (i.e., absence of posttreatment diagnostic interviews). Finally, future studies are needed to see whether 3PCC has other positive effects such as reducing prison misconduct or future recidivism. In sum, it is clear that more research is needed.

Conclusion

The findings of this preliminary study appear to support our proposed process from three principles exposure to improved mental health and improved behavior. On

average, participants exposed to 3PCC appeared to grasp new insights regarding TR and IH/CM. In turn, these participants, on average, showed significant improvements in mental well-being and purpose in life, significant reductions in anxiety and anger, and improved behavior in the prison community.

Most prevailing correctional counseling methods operate from an "outside-in" paradigm attempting to put mental health "into" people in prison using various strategies and techniques. Thus, developments in correctional counseling over the past several decades have mainly been improvements in techniques based on the prevailing assumption that people's "deviant" thoughts and "antisocial" schemas must be "dealt with," and that people must grasp various tools, techniques, and coping strategies to sidestep mental distress and improve their behavior. 3PCC is grounded in a different paradigm—*that all people (including people in prison) have innate mental health and only innocently think themselves away from this health*. When people in prison recognize how to move through life allowing their minds to *quiet naturally* so new, fresh thoughts can come to mind in a better feeling state, they lead mentally healthier lives. Also, they are less likely to respond to negative thoughts and feelings with deviant and other health-damaging behavior. Banks (1998) stated, ". . . a lost thinker experiences isolation, fear, and confusion . . . The misled thoughts of humanity, alienated from their inner wisdom, cause all violence, cruelty, and savagery in the world" (p. 83).

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Notes

1. Author (2015) stated, "Universal Mind or similar constructs are evident in virtually all spiritual teachings (Pransky & Kelley, 2014)." For example, Sri Arobindo (1990) saw Mind as the power behind thought and consciousness, and stated, "Our physical organism no more causes or explains thought and consciousness than the construction of an engine explains the motive-power of steam or electricity. The force is anterior, not the physical instrument" (p. 234). Nisargadatta Maharaj asserted that everything is One. Buddhism teaches Master Mind. Vipassana meditation teaches that Mind is everywhere. Hart (1987) stated, "The whole body contains the mind" (p. 29). Walsch (1995) pointed to Mind, stating, "That which you call life . . . is pure energy . . . vibrating constantly, always . . . while objects are different and discrete, the energy, which produces them, is exactly the same" (p. 178). William James (1981) referred to the "spiritual self" as "Absolute Mind" (p. 268).
2. When we posit that people "use" the three principles, we are not suggesting that people must "do something"—that tools, techniques, or strategies are necessary. Rather, we posit that everyone uses the three principles to have psychological experience the same way everyone uses gravity to stay anchored to Earth. However, it appears that the deeper people

understand how these principles interact to form people's psychological lives, the better they use the principles to realize and sustain mental well-being.

3. While considerable literature exists that describes the three principles, their spiritual basis, and the intervention grounded in them, little scientific evidence has been offered that might corroborate what Banks professed to understand through his realization. To help fill this gap, Kelly, Alexander & Pransky, 2017 proposed a process by which formless energy comes into physical form within human beings via Universal Mind powering consciousness and thought to create people's psychological lives, and offered a scientific basis for what appear to be the steps or phases in this process.
4. The three principles understanding has previously been known in the literature as "health realization" and is referred to as such in some of the papers cited in this section.
5. We do not mean to suggest that techniques such as thought reconditioning and meditation are not useful and should not be practiced. We are simply positing an alternative view of what makes techniques work for some which might lead to a deeper understanding.
6. Considerable concern for the fidelity of the intervention was taken in the study. For example, we clearly describe the content and dose of the intervention and the use of a waitlist comparison group. We also describe in detail the number, length, and frequency of intervention sessions. Also, we attempt to clearly articulate the underlying theoretical framework or clinical guidelines that provided the foundation for the intervention. We also planned for potential setbacks (e.g., backup providers were available in case of "provider dropout"). Also, to ensure fidelity, each provider administered the same intervention, focusing on the steps of the proposed process from exposure to the three principles to improved mental health and improved behavior described in detail in the article. Also, attendance was tracked at each session, and pre- and post intervention assessments were taken to measure knowledge gained regarding three principles understanding, thought recognition (TR), and innate health via a clear mind (IH/CM), and the impact of this knowledge on participant's mental health and behavior.
7. In general, British people do not like to divulge their ethnicity. This preference tends to be amplified in prisons. Many of the participants in this study did not prefer to reveal their ethnicity, and several complained about being asked to do so. However, most of the participants that selected "Other" for ethnicity are likely Jamaican, West Indian, African, Somalian, and a few Ghanaian.
8. The Three Principles Inventory (3PI) is the only validated instrument available that attempts to measure three principles understanding, TR, and IH/CM. Validation of the 3PI involved 30 teachers of the three principles understanding, each with a minimum of 20 years of teaching experience. These teachers evaluated an initial group of 60 items and divided these items into three groups: three principles understanding, TR, and IH/CM. Items in each group that obtained agreement from all 30 raters were resubmitted to these raters for scoring. The final items selected for the 3PI were those in each group scored either "agree completely, no exceptions" or "disagree completely, no exceptions" by all 30 three principles teachers. Subsequently, the predictive validity of the 3PI was tested in each study described in the "Supportive Empirical Evidence" section of this article.
9. The 3PI measures TR and IH/CM. Thus, significantly higher pretest to posttest scores on the 3PI indicate significant increases in TR and IH/CM.

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