Prarambh Life

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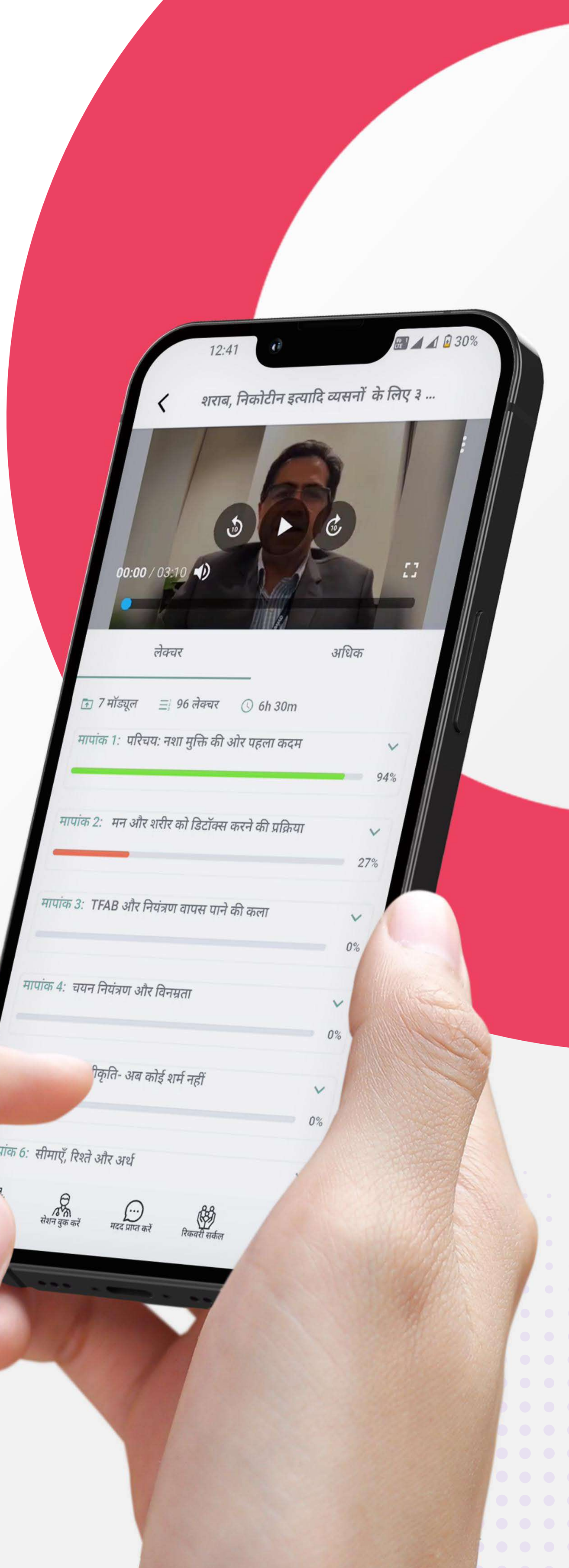
Evidence Base for Prarambh Life

Grounded in Peer-Reviewed Research and Real-World Outcomes



1. Introduction

Prarambh Life is a structured digital de-addiction programme built on the Life Recovery Program (LRP), developed by Paul Radkowski, an internationally awarded psychotherapist, crisis counsellor, and trauma specialist based in Canada. The LRP has been peer-reviewed, cited in one of the most widely used addiction counselling textbooks in North America, and recognised twice at the professional level for its innovation in digital addiction recovery.

In 2010, researchers at the University of Western Ontario conducted a qualitative content analysis of participants moving through the programme: the Dunlop and Campbell outcome study, the anchor evidence base for this document. This report summarises that study, crossreferences its findings against wider peer-reviewed literature on digital cognitive behavioural therapy (CBT) and online peer support, and explains how Prarambh Life has adapted the core LRP framework for the Indian recovery context.

Three questions frame the sections that follow: what the underlying evidence shows, how those findings hold up against independent research, and how Prarambh Life has translated that evidence for Indian users, given realities around stigma, language, family structure, and access to professional support that a Canadian programme does not address by default.

2. Methodology of the Validation Study

The dataset

The Dunlop and Campbell study analysed a cohort of 37 participants who engaged with the LRP over a four-month period. Most had entered with a primary concern involving alcohol, followed by drugs and nicotine, and many also presented with co-occurring anxiety or mood challenges, an overlap typical of real-world recovery populations.

Rather than self-report surveys, which are prone to social desirability bias, the researchers used participants' own posts on the programme's peer support forum as the primary data source: written to peers in real time, often during or just after a craving, without a clinician on the other end. Across the four-month window, more than 350 posts spanning 44 pages of forum content were reviewed and coded.

Content analysis approach

The analysis followed a standard qualitative content-analysis methodology: repeated reading of the posts, open coding to identify emerging themes, axial coding to group related themes, and selective coding to identify the dominant patterns.

Four themes emerged consistently across the dataset:

Peer support and accountability:

Certain techniques were referenced frequently in participants' own words, particularly the TFAB (Thought-Feeling-Attitude-Behaviour) framework, 5x5 breathing exercises, journalling, and positive affirmations. The frequency of these organic mentions is a strong indicator that participants were actually using the techniques rather than simply completing a module.

Adoption of specific coping techniques:

By volume and emotional depth, this was the single most dominant theme. Participants held each other accountable to programme completion, counselling attendance, and sobriety milestones, and they described the forum itself as a place where they could be honest without being judged.

Cognitive shifts in self-perception:

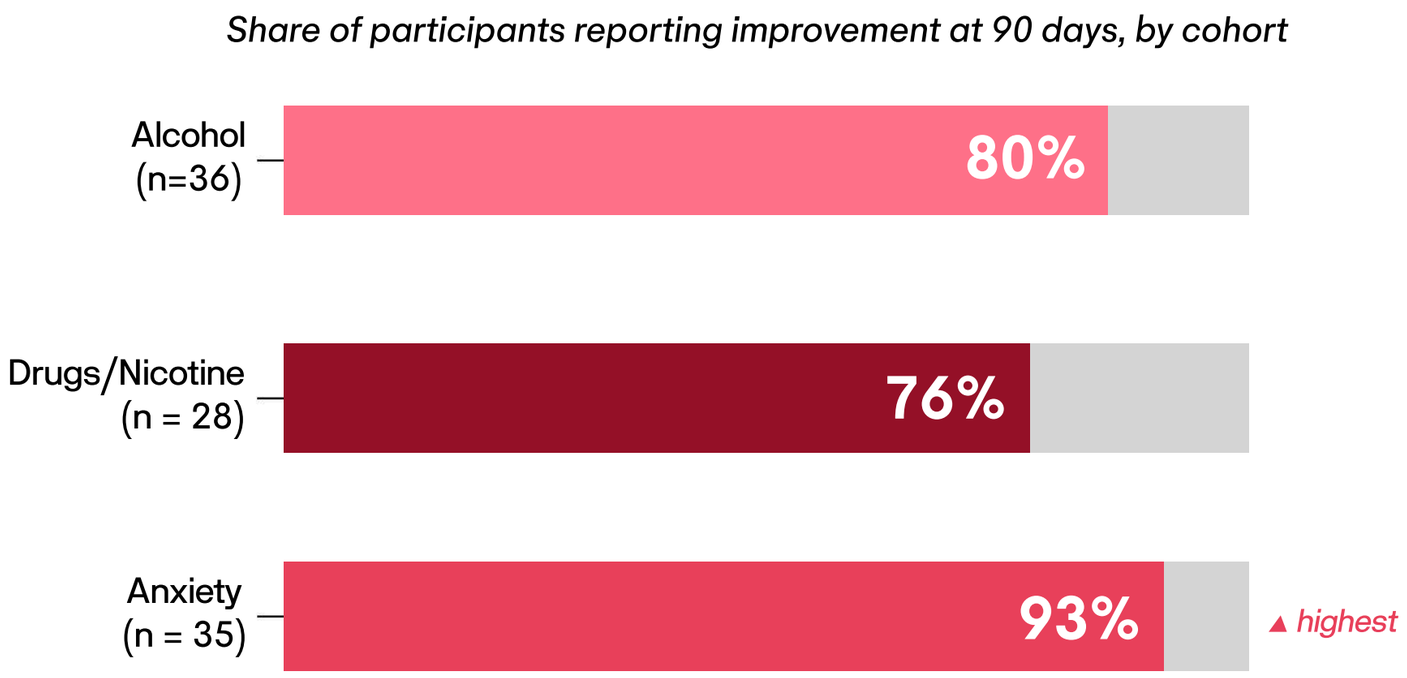
Participants described re-examining earlier assumptions about themselves, often noting that they had once believed change was impossible and had come to see it as achievable..

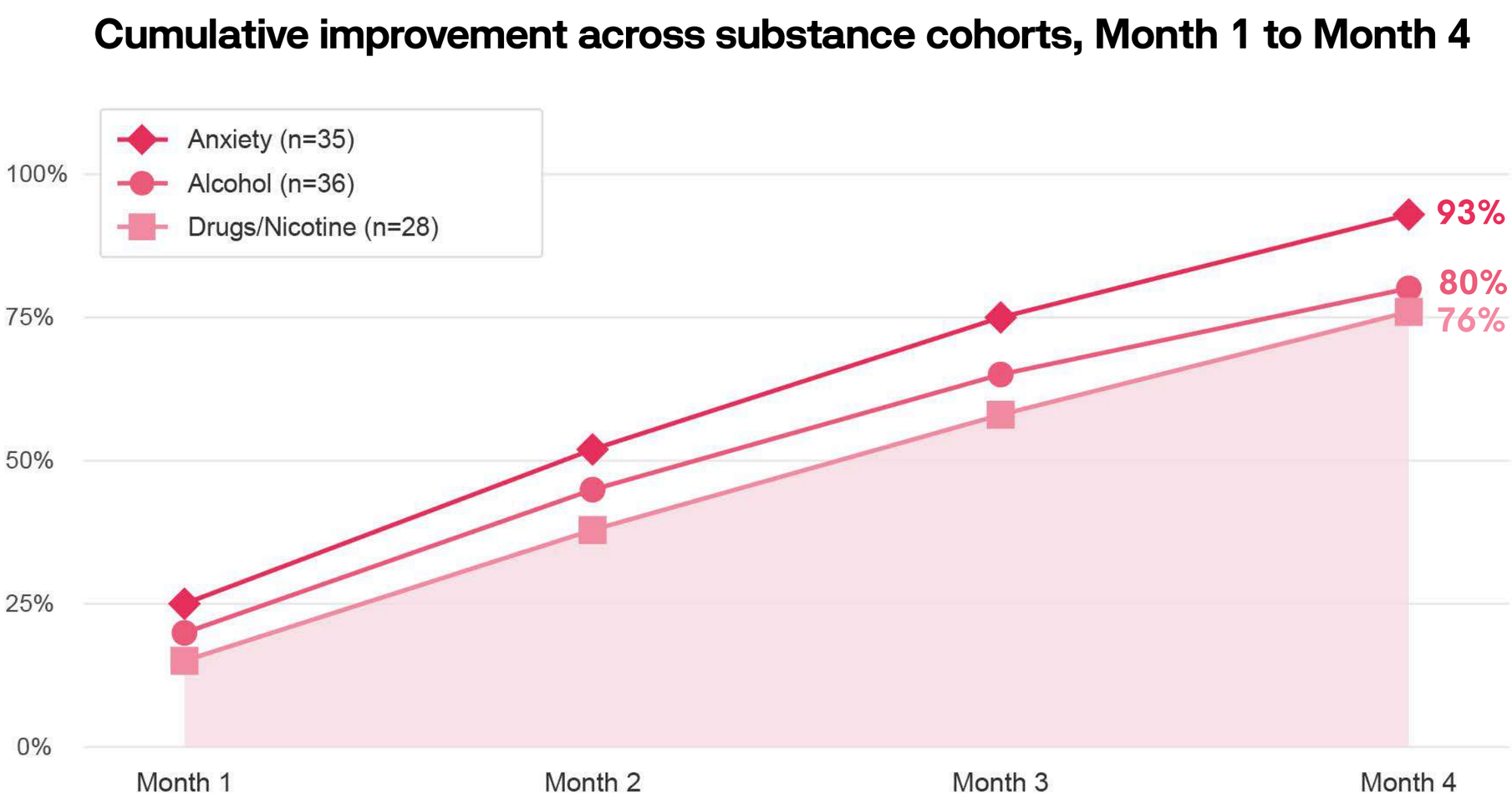
Behavioural changes reported in real time:

Rather than reporting outcomes only at study end, participants documented incremental changes throughout the four months: a first sober weekend, a difficult social event navigated without drinking, a craving that passed without acting on it.

Summary of substance-use outcomes

The headline outcomes from the content analysis, measured at the 90-day mark, were:





These figures should be read alongside the trajectory over time. Improvement was notconcentrated at the end of the four-month window; participants reported gains progressively across the observation period, with the steepest gains typically visible between Month 2 and Month 3.

Voices from the study

A small sample of participant posts illustrates the outcomes in practice, representative of the toneand content that recurred across the dataset:

- *“This is a place where I don't feel judged even when I feel awful. That's why I keep posting.”*
- *“My sobriety means too much for me. When I get an urge, I post about it and the craving passes.”*
- *“Day 7 of my sobriety is going well. In the past, this used to be the hardest day to get through as my body detoxes from alcohol. I did have that one extreme craving the other night. I let myself get too tired, so I'm learning new tools - the first of which is to become more aware of how I'm feeling and take care of it before it becomes an urge.”*
- *“I never realised how much of my day was organised around drinking. Now that I've taken it out, I have all this time. I don't know what to do with it yet but I'll figure it out.”*

Two patterns stand out: participants describe the forum as a safe space rather than a therapeutic one, and they describe skills like TFAB as applied in real moments rather than remembered as module content

3. Research Papers Supporting the Framework

The LRP is one of several programmes that have tested digital CBT and online peer-support interventions. The following papers are cited within the Dunlop and Campbell study and within the *Fundamentals of Addiction* chapter that features the LRP. Each is a peer-reviewed publication and each addresses a specific concern that Prarambh Life inherits.

Reger and colleagues (2009) conducted a meta-analysis across nine studies of internet-based CBT for anxiety disorders. Their finding was that internet-delivered CBT produced outcomes equivalent to therapist-delivered CBT and superior to waitlist or placebo conditions. The clinical implication is that CBT delivered through a screen is not a diluted or less effective version of face-to-face therapy: it is functionally equivalent for the anxiety conditions that so often co-occur with substance use.

Andrews and colleagues (2010) replicated this comparison with a broader set of five direct comparative studies of computerised CBT versus face-to-face CBT. The two modalities produced equally beneficial outcomes across the studied samples.

Rooke and Thorsteinsson (2010) looked specifically at alcohol and tobacco interventions delivered through digital or minimal-contact formats. Their conclusion was that these interventions represent a cost-effective and accessible treatment pathway, particularly valuable in populations where face-to-face treatment carries stigma or is logistically difficult to access.

Carey and colleagues (2009) examined computer-delivered interventions for alcohol use specifically. They found significant reductions in both drinking quantity and drinking frequency, with outcomes equivalent to alternative in-person interventions. This matters because the LRP's own 80% alcohol outcome is corroborated by an independent literature base.

Cunningham and Wild (2010) synthesised 75 research trials of computer-based health behaviour interventions. The overall pattern was of significant, consistent efficacy across trials, not just for substance use but for a range of behaviour change targets.

Herie and Skinner (Editors, 2013), in Fundamentals of Addiction: A Practical Guide for Counsellors (4th edition, Centre for Addiction and Mental Health), feature the LRP as an evidence-informed, holistic programme integrating biological, spiritual, and psychosocial approaches to recovery. This is one of the most widely used addiction counselling textbooks in Canada, and its inclusion of the LRP is itself a form of peer validation, since the programme has been reviewed and accepted by clinical editors as suitable for professional training.

Taken together, these papers make two points relevant to Prarambh Life. First, the delivery format is not the limiting factor in whether the intervention works. Digital CBT produces equivalent outcomes to face-to-face CBT in the conditions where both have been tested. Second, the LRP's own outcomes fall within the range that independent research would predict for a welldesigned digital intervention - they are not anomalous.

4. Key Findings

Bringing the study and the wider literature together, five findings stand out as directly relevant to the design of Prarambh Life

Finding 1: Digital delivery is not the constraint. The evidence base is clear that CBT-based interventions delivered digitally produce outcomes equivalent to those delivered face-to-face. This holds across anxiety, alcohol, and tobacco cohorts. The remaining question is not whether digital works, but how to design it well.

Finding 2: Peer support is the differentiating mechanism. In the content analysis, peer support was the single most dominant theme by post volume and emotional depth. It outweighed both feedback about the programme and discussion of specific techniques. Two behavioural patterns explain why:

Accountability formation: a core group of active contributors held themselves and each other accountable to programme completion, counselling attendance, and sobriety milestones. This mutual accountability appears to function as an external commitment device that participants cannot easily construct alone.

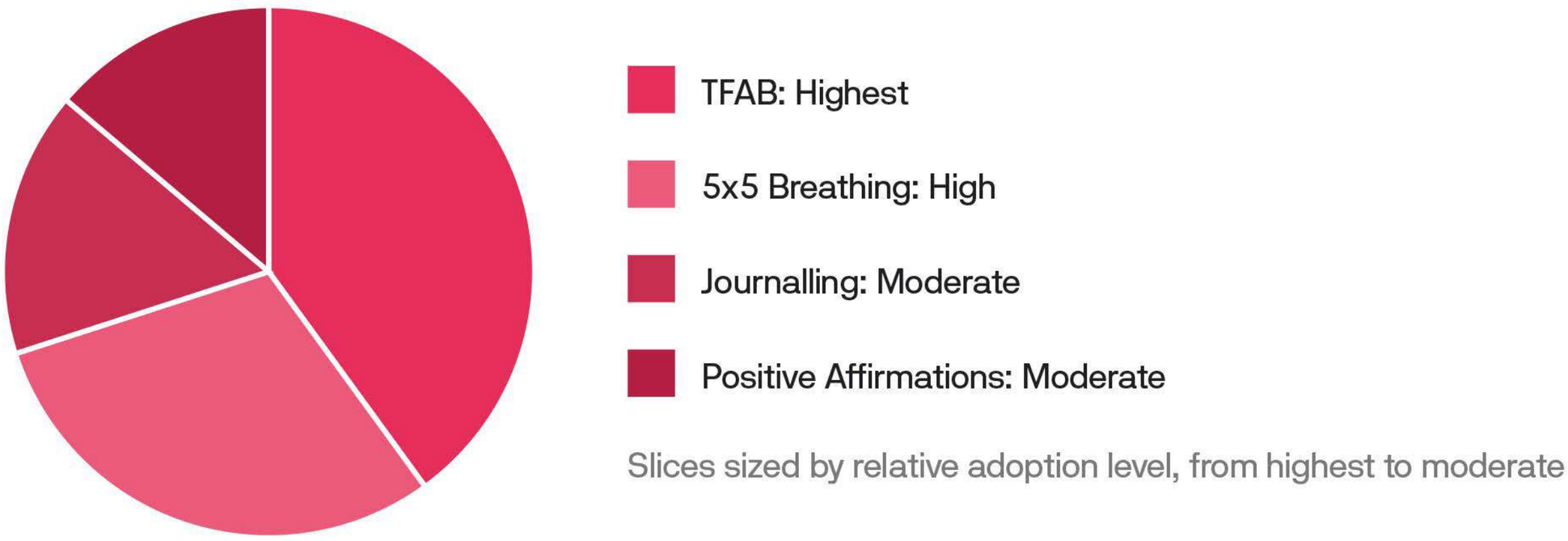
Real-time skill modelling: participants demonstrated techniques like TFAB and breathing exercises publicly, in the moment, giving less active members live examples to observe rather than abstract instructions to read.

Finding 3: Certain techniques transfer to real use; others do not. Not every module in a programme is used equally. Content analysis of what participants organically referenced in their own posts, the most reliable proxy for skill transfer, showed a clear hierarchy:

What Participants Actually Used: Technique Adoption

Content analysis of 350+ forum posts identifies which skills participants referenced organically - the most reliable proxy for real-world skill transfer:

Technique	Level	How participants used it
TFAB (Thought-Feeling-Attitude-Behaviour)	**Highest**	Journalled daily, used during cravings, shared as peer modelling
5x5 Breathing	**High**	Applied during stress, cravings, and pre-counselling sessions
Journalling	**Moderate**	Complement to TFAB for tracking thoughts and self-compassion
Positive Affirmations	**Moderate**	Counter negative self-talk; law-of-attraction framing applied naturally



TFAB (Thought-Feeling-Attitude-Behaviour) was the most frequently referenced technique. Participants used it during cravings, journalled with it daily, and shared their completed TFABs publicly as a form of peer modelling.

5x5 Breathing was used during work stress, cravings, and before counselling sessions. It was often the first technique participants reached for in an acute moment.

Journalling functioned as a complement to TFAB, used for tracking thoughts over time and building self-compassion.

Positive Affirmations were used to counter negative self-talk, sometimes framed by participants in law-of-attraction terms.

Techniques that appeared less frequently in participant posts were still valuable but had lower adoption. This is a useful design signal: building more of a programme around the techniques that participants actually adopt is likely more effective than adding more content across a wider surface area.

Finding 4: Co-occurrence is the norm. Most participants presented with overlapping dependencies, most commonly alcohol alongside anxiety. This mirrors the population that any real recovery platform will serve. A programme designed around a single, clean substance-use profile will underserve the majority of users. Prarambh Life's architecture reflects this - its assessment layer and content pathways are built to handle co-occurrence rather than treat it as an edge case.

Finding 5: Progress is incremental and non-linear. The recovery trajectory in the study was not a straight line. Participants had setbacks, discouraged posts, and periods where they described feeling like they were going backwards. What predicted eventual improvement was not the absence of setbacks but the presence of continued engagement: posting through the setback, reviewing modules again, and re-committing to counselling attendance.

This finding shapes how Prarambh Life talks about difficulty. Rather than framing a slip as a “relapse” and a failure of the programme, the platform frames it as “old habits returning” - a normal part of the trajectory that other participants have moved through.

5. Adaptation to the Indian Market

The LRP was developed and studied in a Canadian context. Prarambh Life is not a translation of the LRP; it is a re-implementation designed for the realities of the Indian recovery context. The adaptations fall into five areas.

Language and cultural translation

The Indian market is multilingual, and English-only content excludes a large portion of the population that Prarambh Life is designed to reach. All programme content is available in Hindi in addition to English, with careful attention to transliteration conventions rather than direct translation. Technical terms like TFAB, craving, and cognitive restructuring are transliterated into Devanagari (टीएफएबी, क्रेविंग, कॉग्निटिव रिस्ट्रक्चरिंग) rather than translated into equivalent Hindi phrases, because participants using the programme alongside a counsellor or Englishspeaking clinician need to be able to reference the same concept in both languages.

Certain words are deliberately avoided. The Hindi word “नशा” (”ntoxication” or, in slang, “addiction”) is not used in participant-facing materials because it carries stigma and moral judgement that undermine the platform's non-judgmental framing. Instead, concrete examples such as cigarette, drink, or the specific substance are used.

Features designed for Indian recovery patterns

Several structural features have been added or modified relative to the LRP:

The **Urge Pause** button is available at all times in the app, giving users a one-tap intervention during acute cravings. It surfaces the participant's own pre-recorded voice or video message from onboarding, a technique that reduces the cognitive load of deciding what to do in the moment.

A **buddy system**, where the user chooses their own buddy rather than being assigned one, is built into onboarding. This reflects the reality that recovery in India is often supported by family members or close friends rather than by strangers in a peer support forum, and it works around the concern many users have about disclosing their recovery status to unknown peers.

A **30-day active programme followed by an 8-week maintenance phase** adapts the LRP's more open-ended structure. This gives Indian users a defined commitment window, a design choice that matches research on Indian digital product engagement, where finite programmes with clear endpoints show higher completion rates than open-ended subscriptions.

Counsellor guidance and clinical integration

Prarambh Life is designed to work alongside a counsellor, not replace one. Counsellor-facing materials, including session notes templates, first-session intake questionnaires, and progress tracking dashboards, are built into the platform architecture. These reflect the reality that most Indian users who engage seriously with recovery will do so with some form of clinical support, whether from a psychiatrist, psychologist, or counsellor.

Substance-specific and personalised pathways

The LRP's original design was substance-generic: the same content served alcohol, drugs, and other users. Prarambh Life takes a more differentiated approach

Separate programmes are built for alcohol, nicotine, cannabis, other drugs, and behavioural dependencies (screen use, work). Within each programme, the specific triggers, coping techniques, and progress metrics are calibrated to the substance. A nicotine user tracks vape puffs and cigarettes with a specific nicotine-equivalent conversion; an alcohol user tracks drinks with reference to standard drink sizes; a cannabis user works with different social and emotional triggers than a nicotine user.

Ethical considerations

Recovery data is among the most sensitive personal data anyone will share with a digital platform. Prarambh Life's ethical framework addresses three dimensions.

Privacy. All user data is stored with encryption at rest and in transit. Data is not shared with third parties for marketing purposes. Where anonymised, aggregated data is used to improve the platform, users are informed at onboarding and consent is explicit rather than implicit. Counsellor access to a user's data requires the user's explicit opt-in.

Accessibility. The platform is built for a wide range of device capabilities, not only high-end smartphones. The user can use the program at their own time and in their own space.

Anonymity. Users can engage with the platform under a chosen name rather than their legal identity. The buddy system allows a user to be a buddy without disclosing their own recovery status if they choose. Peer community features, where present, are moderated to prevent identification and to enforce the “no judgement” norm that the LRP research showed to be the differentiating factor.

The evidence base underneath Prarambh Life is not marketing text. It is a peer-reviewed programme, tested in a formal outcome study, cited in a major addiction counselling textbook, and grounded in a wider literature on digital CBT that has been developing for two decades. What Prarambh Life adds is the translation of that evidence into an Indian context, delivered in Indian languages, with the ethical guardrails and clinical integration that Indian users actually need.

The results in the original study (80% of alcohol users reporting reduced urges or stopped drinking, 76% of drugs and nicotine users reporting decreases in use, 93% of participants with co-occurring anxiety reporting reduced symptoms) are the benchmark. Prarambh Life is built to meet that benchmark in a market where the need is larger and the barriers to access are higher.

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