Emotionally Focused Group Therapy in Aiding Substance Abuse Recovery for Incarcerated Women: A Pilot Program

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A Clinical Research Project presented to the faculty of the Hawai'i School of Professional Psychology at Argosy University, Hawai'i in partial fulfillment of the requirements for the degree of Doctor of Psychology in Clinical Psychology.

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This Clinical Research Project by (Name of Student), directed and approved by the candidate's Clinical Research Project Committee, was approved by the faculty of the Hawai'i School of Professional Psychology at Argosy University, Hawai'i in partial fulfillment of the requirements of the degree of Doctor of Psychology in Clinical Psychology.

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ABSTRACT

A significant gender-based risk factor for female prisoners in the criminal justice system is a history of early trauma and victimization (Keyser-Marcus et al., 2015). Incarcerated women are far more likely than their male counterparts, to report being raised in a substance using household, were childhood victims of sexual or physical abuse, and as adults were pulled into substance use by their partner, and were subjected to intimate partner violence (Ashley, Marsden, & Brady, 2003; James & Glaze, 2006; Lynch, DeHart, Belknap, & Green, 2012). Prison-based substance abuse treatment often does not adequately address the need for corrective emotional experiences for female inmates who report having been abused physically and sexually as children as the prevailing substance abuse treatment is behavioral or cognitive in nature (Fletcher et al., 2015; Glaze & Maruschak, 2009; Huang et al., 2012; NIDA, 2018). Within this group of judicial detainees who are seeking substance abuse treatment a significant number of female inmates have suffered attachment-based injuries as roughly thirty percent of their perpetrators were members of their own family (Ashley, 2003; U.S. Department of Justice, 2014a; 2014b).Attachment theory serves to inform and link the application of Emotionally Focused Therapy, adapted for groups, in treating incarcerated women in a therapeutic community substance abuse treatment program (Bowlby 1969; Johnson 2019). EFT for couples and families

has been found to simultaneously focus on the integration of the self and the system to which the self belongs (Johnson, 2019). The corrective process of EFT's couples and family therapy provides new experiential ways to connect emotionally with partners and family (Johnson, 2019). A pilot program has been developed to integrate EFT therapy, adapted for groups, as part of substance abuse counseling offered in women's prison-based therapeutic communities, with the goal of not only aiding women in their quest for sobriety but the reparation of damaged self-concept, reconnection with trusted others in secure attachment.

DEDICATION

I dedicate my clinical research project to all of you who have traveled the road with me that has become my doctoral education, especially Dr. Robert Yoshimura, Psy.D who started me on my own Hero's Journey in 2011. I am grateful to my chair and pillar of positivity, Dr. Lianne Philhower, whose thoughtful words and energy have pulled me forward through challenges that have made completion of this project possible. I appreciate Dr. Rick Trammel for his willingness to serve on my committee, and for his substance abuse knowledge. Thank you, Dr. Patrick Kamakawi'iole, who has been my faithful academic advisor and advocate throughout my graduate education. My deepest gratitude to my private practice mentor, Dr. James Spira, for his willingness to provide training, for regarding me as a colleague of equal standing while still a student, and for his delightful sense of humor and love of health psychology. Thank you, Dr. Cindy Goodness Zane, for heartfelt EFT supervision and guidance.

This body of work is particularly dedicated to the women of the Ke Alaula therapeutic community substance abuse treatment program at the Women's Community Correctional Center in Kailua, Hawai'i for trusting in me to have a corrective human connection when you have suffered unspeakable trauma and adversity in your lives at the hands of those you loved most. I am grateful to have been part of your efforts towards lasting sobriety and a renewed sense of self. Aloha oe no kou uhane, oe e lanakila.

My family, Aidan, Ryan, Evan, and Michael, made the ultimate sacrifice by letting me follow my dream. Finally, to my most beloved D, without you there would have been no impetuous to become the psychologist I need to be.

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CHAPTER 1

INTRODUCTION

In the United States, drug and alcohol dependence is a serious problem that produces an estimated public health cost of 600 billion dollars annually (NIDA, 2012). The National Survey on Drug Use and Health (2012) found that 9.2 percent of the U. S. population aged 12 years and up had engaged in prescription drug abuse or illicit substance use in the past 30 days. Substance addiction is predominately viewed and accepted as a brain disease after a long history of contentious views surrounding the etiology and treatment of drug and alcohol dependence (Inaba & Cohen, 2011; Koob & Volkow, 2010; NIDA, 2012; SAMHSA, 2012). Recovery from substance dependence follows an ongoing process of sobriety, in which treatment necessitates personalized and multifaceted approaches to be effective (NIDA, 2012, SAMHSA, 2012. Tronnier, 2015). Substance abusers are typically negatively affected for years despite current evidence-based symptom-focused treatment modalities such as Motivational Interviewing (MI) and Cognitive Behavior Therapy (CBT), along with 12-step self-help groups including Alcoholics Anonymous and SMART recovery, a behavioral-focused peer-supported model. The protracted and relapsitive nature of substance use disorders throughout the lifespan suggest that the present treatment modalities are not adequately addressing the root causes of addictions and therefore warrant the exploration of emotionally based treatment options to produce more enduring success rates in substance abuse treatment (Fletcher, Nutton, & Brend, 2015). A flourishing body of published works, originating in the 1970s, indicates that drug and alcohol dependence is related to attachment theory as part pf the Self-Medication Hypothesis (Duncan, 1974a, 1974b; Khantzian, 1997).

The extant literature regarding incarcerated women, addictions, and childhood attachment wounds sadly demonstrate an interconnectedness of these experiences, however in facilitating sobriety and preventing recidivism, prison-based substance abuse treatment often does not fully address the need for corrective emotional experiences as the prevailing substance abuse treatment is behavioral or cognitive in nature (Fletcher et al., 2015; Huang, Gundapuneedi & Rao, 2012; NIDA, 2018). A significant gender-based risk factor for female criminal justice system detainees is a history of early trauma and victimization (Keyser-Marcus et al, 2015).

Incarcerated women are far more likely, than their male counterparts, to report being raised in a substance using household, were childhood victims of sexual abuse or physical abuse, and as adults were pulled into substance use by their partner, and were subjected to intimate partner violence (Ashley, Marsden, & Brady, 2003; James & Glaze, 2006; Lynch, DeHart, Belknap, & Green, 2012). Eighty-two percent of female inmates reported having been seriously abused physically and sexually as children (Glaze & Maruschak, 2009). Furthermore, within this group, a significant number of female inmates have suffered attachment-based injuries as roughly thirty percent of their perpetrators are members of their own family (Ashley, 2003; U.S. Department of Justice, 2014a; 2014b). Research indicates early attachment wounds leave individuals vulnerable to chemical dependency, interpersonal victimization, childhood sexual abuse, including incest, and intimate partner violence as adults (Dow, 2011; Dykstra, Schumacher, Mota, & Coffey, 2015; Huang, 2012; SAMHSA, 2017; Vanderplasschen et al., 2013).

Ashley et al's., (2003) research indicates that not only are the antecedents to drug use different for men and women, women require different substance abuse programming with

interventions that are designed to foster the development of greater self-concept particularly in vulnerable women who identify as being victims of childhood abuse, sex workers, lesbian women, and victims of domestic or intimate partner violence. Along with the social and medical needs specific to women, the inclusion of a "nurturing and supportive group therapy environment with an emphasis on self-worth, and addresses the multiple roles women fulfill in their lives", was identified by Ashley et al (2003, p.22).

In spite of evidenced-based treatment in the form of short-term CBT and MI, relapse occurs frequently suggesting the need for an innovative substance abuse intervention that better addresses the contributing developmental aspects of drug and alcohol dependence (Fletcher et al., 2015). Attachment theory and attachment-oriented interventions, such as Johnson's Emotionally Focused Therapy (EFT) for individuals and couples, and Palmer's EFFT family therapy; Hughes' Attachment-Focused Family therapy; Greenburg's Emotion Focused Therapy; and Fonagy and Bateman's Mentalization-Based Therapy (MBT) have supplied a rich evidence base for empirical validation of various systemic therapies, yet empirical literature validating the use of attachment-based therapy for addiction treatment is scarce. In order to furnish a convincing argument for the theoretical inclusion of an attachment-based intervention, such as the use of EFT adapted for groups, in the current CBT dominated substance abuse programming, it is essential to explore the connection between female inmates' early attachment injuries, and attachment theory, which is the backbone of Johnson's EFT model.

Attachment Theory

Between 1940 and 1950 John Bowlby began conceptualizing the theory of attachment based on his work in the field of ethnology, and his observations of young children. He came to

believe the central tenet of attachment theory: human beings are biologically wired to form close emotional bonds with one another which are vital for survival, appropriate nurturing, development, socialization, and intimacy. This is not unlike same sex attachments women form for safety, acceptance, and human closeness needs within the criminal justice system (Forsyth & Evans, 2003). Bowlby's theory, as cited by Waters, Corcoran, and Anafarta (2005) attempted to describe the interpersonal relationships between primates and their caregivers when infants perceived danger, become alarmed, or were separated from their primary caregiver. According to Landa and Duschinsky (2013) Bowlby posited that infants' chances of survival were better when they formed healthy attachments with at least one parent or caregiver. When provided with a responsive and attuned caregiver, Bowlby found that infants felt safe and secure enough to venture away from the caregiver to play and explore their world knowing the caregiver represented a safe haven to which they could return for comfort (Holmes, 2014).

As maintained in Bowlby's theory, the attachment behaviors of clinging, searching, and crying are initiated by very young children in the absence of their mother or primary attachment figure in order to produce a reunification and sense of safety (Ainsworth & Bowlby, 1991). Bowlbian researcher, Mary Ainsworth found in her early research in Uganda and later in Baltimore, that infants who signaled their mothers to pick them up when distressed, and who received immediate comfort were far more secure, easily comforted, and readily returned to exploration of their environment as a result of maternal comforting (Ainsworth & Bowlby, 1991). A key observation noted by both researchers was that young children became belligerent towards the mother, or primary attachment figure, when that individual became unavailable through physical separation, rejection, or attended to another's needs despite frequent and

insistent bids for social interaction by the young child (Ainsworth & Bowlby, 1991). Ainsworth's work of 1971 and 1978 demonstrated that early attachment experiences between infants and their caregivers allow the child to create an internal working model of themselves (Bretherton, 1994).

Attachment-based research in the 1970s by Ainsworth and by Bowlby provided the first empirical evidence that an individual's internal working model was based upon the attachment figure's attuned and dependable responsiveness to the needs of the individual, and that the value of one's self-worth was associated with whether care was received in the manner desired. For example, Ainsworth found securely attached youngsters developed a positive schema of themselves as worthy of receiving care from consistent and attuned caregiver responses, and were equally able to form mental representations of others as supportive and caring (Bretherton, 1994; Bowlby, 1973). Over time, the relational pattern in the caregiver/child dyad conditions the child to react with reinforcing strategies such as smiling and cooing, that typically bring the primary caregiver into their immediate proximity (Ainsworth & Wittig, 1969). The baby's internal working model serves to form the strategies employed to successfully achieve a sense of relational security between self and caregiver (Ainsworth & Wittig, 1969).

Ainsworth's experiment, called the *Strange Situation,* produced two main attachment styles in infant-parent bonding that are carried forth into adult relationships: secure attachment and insecure attachment (Ainsworth & Wittig, 1969). Insecure attachment produced three types of insecurity with the fourth style being added by Mary Main's research in the mid 1980's (Ainsworth & Wittig, 1969; Main & Solomon, 1986). Secure attachment, as observed in the *Strange Situation* was characterized by the child feeling secure, happy and able to explore his/her

environment due to the caregiver's consistent, ready availability, and fairly immediate responses to the child's needs and signals for attention. The secure child was observed to have the ability to trust that their primary caregiver would meet their needs based upon the learned experiences of prior consistent and attuned responses from that individual. They also came to believe they merited care through this process. On the other hand, the insecurely attached children were observed to exhibit several different styles of attachment: Avoidant, Ambivalent, and Disorganized (Ainsworth & Wittig, 1969; Main & Solomon, 1986).

Avoidant Attachment was produced in children by distant and disengaged caregivers (Ainsworth & Wittig, 1969). These children did not readily explore their environment and often displayed a distant or avoidant response style themselves since they were apt to believe their needs were unlikely to be met (Ainsworth & Wittig, 1969). The caregiver who alternates between being neglectful or sensitive produced a child with an Ambivalent Attachment style. The young child has no choice but to believe s/he cannot consistently depend on needs being met (Ainsworth & Wittig, 1969). Thus the child the Ambivalently Attached child demonstrates anxiousness, insecurity, and anger in their behaviors towards the caregiver. Main and Solomon (1986) added Disorganized Attachment to Ainsworth's types after their study showed that when a caregiver exhibits extremely erratic responses towards a child, ranging from being afraid, being scary, being overly passive, or highly intrusive, the child becomes conditioned to believe there is no way to have their needs met. This results in confusion for the child and an inability to form accurate and dependable strategies to induce parental/caregiver attentiveness to their needs (Main & Solomon, 1986).

Adult Attachment

Another significant tenet in Attachment Theory, as it pertains to adults, is relationship maintenance with significant others in times of vulnerability or stress, over merely maintaining affectional and procreational bonds (Cowan & Cowan, 2007). Later research by Borhani (2013), which included the citation of much research before her own (e.g., Davidson and Ireland 2009; Doumas, Blasey and Mitchell 2006; Molnar, Sadava, De Courville, Perrier, and Colin 2010; Thorberg and Lyvers 2010) demonstrate that attachment styles formed in infancy and childhood carry forth into adulthood where they influence relational outcomes with others including adult love relationships (Borhani, 2013). Hazan and Shaver (1987) as cited by Coan (2010) indicate adults form interpersonal attachments that are comparable to those they learned and enacted in childhood with their primary caregiver, as a means of regulating social affect.

In presenting a sound theoretical argument for the inclusion of EFT in group substance abuse treatment during incarceration, it stands to reason that when the treatment population is largely made up of women who have suffered childhood abuse and trauma at the hands of their parents and caregivers, that these women may also bare significant attachment injuries. It follows then, that attachment injuries created in childhood and found in current adult relationships may be best resolved or corrected with an intervention rooted in Attachment Theory. Attachment theorists are not only found in the field of psychology, but are also active in the addictions field and their theories together, contribute to the construction of the proposed pilot program. The Self-Medication Hypothesis fundamentally bridges both fields by making the connection between attachment wounds for incarcerated women and their drug of choice in attempting to reduce intrapersonal distress.

A description of attachment-based EFT and the current research findings on its effectiveness in relationship building, and adaptation from couples' and family work to incarceration-based SUD treatment could be useful in sobriety maintenance will be presented. Lastly, the proposed delivery system of EFT will be presented in Chapter II**.** The majority of substance abuse programming for offenders is provided in the Therapeutic Community model (Dow, 2011). The stages of EFT treatment appear to be a good match for the TC model since the phases of community progression within the model have a similarity to the way in which EFT is delivered (Graham & Wexler, 1997).

In order to link attachment theory, EFT, and relapse prevention for women, the literature review in Chapter II will cover the statistics on incarcerated women and their predisposing problems that have contributed to substance abuse and incarceration. Relapse and recidivism rates associated with current prison-based TAU in federal and state prison recovery programs will been presented. Attachment Theory and its relation to the Self-Medication Hypothesis, and EFT, as they relate to substance abuse programming as a potential in reducing relapse rates following release is to be discussed. A discussion follows of the current research findings on the effectiveness of EFT in relationship regulation, and how this may be useful in providing incarcerated women in SA treatment with tools other than Cognitive Behavioral Therapy (CBT) to cope with dysfunctional relational patterns, fear of partner loss, and disconnection from social resources that can lead to loss of abstinence and eventual recidivism.

Rationale for the Study

One of the most important parts of a theoretical paper is the rationale for the study, as it provides the context for the prevailing literature or lack thereof, and allows for the presentation

of evocative reasons to engage in the study (Rojon & Saunders, 2012). Existing literature indicates that there are gender differences in reasons for relapse, however due to lack of research concerning gender-specific relapse following release from prison-based substance abuse treatment, there has been little to no attention directed at treating the underlying symptoms of relapse for women. This statement can easily be overlooked as a simplification of the complex context of substance abuse relapse without knowing more about how the problem arises. In addition, understanding the context of the problem based upon the existing evidence and its theoretical underpinnings makes it easier to contemplate its practical applications, which will be addressed following discussion of the context of the problem.

Women in the Criminal Justice System: The Context of the Problem

Nearly 2.4 million men and women in the United States were locked up in 2016 in federal, state, and local jails across the country, distinguishing the United States as having more prisoners than any other country in the world (Flatlow, 2014). One in five were imprisoned for a drug related offence; furthermore, half of all inmates reported having an alcohol and/or drug problem at the time of conviction (Wagner & Rabuy, 2017). Roughly 6,300 (56%) women in the Federal prison system were serving sentences for a drug offense, while over 75,000 (47%) of men were imprisoned for similar offenses (Carson, 2015). At the state level, 69.2% of female inmates were found to have a substance abuse problem or abused drugs during the U.S. Department of Justice 2007-2009 study that was published in 2017. There were 56.9% of male inmates in the same category for that time frame.

Women involved in the American Justice System present with a multitude of gender-based experiences that are uniquely different from those of their male counterparts, thus

requiring diverse treatment methodology (NRCJIW, 2016). Since 1980, United States prison statistics indicate there has been a troubling and profound increase in the number of women involved in the criminal justice system over the last 25 years due to greater law enforcement efforts, stringent sentencing laws for drug offences, and barriers to community reentry following conviction that specifically affect women (Carson, 2015). Women's prison populations increased from 26,378 in 1980 to 215, 332 in 2014, more than a 700 percent increase in female inmates over a 34-year period (Carson, 2015).

While there are more men than women in the criminal justice system today, the increase in the number of females entering the system has outpaced that of males by 50 percent (Carson, 2015). Not only did female incarceration rates increase eightfold since 1980, they rose across local, state, and federal facilities as well as those included in parole or probationary status for a total of 1.2million women under the supervision of the criminal justice system (Carson, 2015; Kaeble, Maruschak, & Bonczar, 2015; Minton & Zeng, 2015). Although arrest rates have decreased in the last 10 years, the decrease for males in 2014 is more notable at 22.7 percent as compared to women at 9.6 percent (FBI, 2015). Despite the recent decrease, more than 1.3 million adult females were arrested across the U.S. in 2014 leading to a 44 percent increase in the local jail population in the last 13 years over state and federal populations (Glaze & Kaeble, 2014).

Facility statistics compiled by the Bureau of Justice Statistics (BJS) census released in 2015, indicated the number of female offenders in local U.S. jails increased by 48 percent from 68,000 to over 100,000 between 1999 and 2013, making them the fastest growing population within the correctional system since 2010 (Minton, 2015). Male prisoners serving more than a

year in state and federal facilities between 2012 and 2013 increased by 0.2 percent, yet female numbers rose by nearly 3 percent during the same time frame (BJS, 2014). More women than men are convicted and serving time for drug offenses; and at the state level, women represented 25 percent of the total drug offenses in 2013, compared to 15 percent for the men (BJS, 2014).

The female incarceration rate varies greatly from state to state, though on average 65 out of every 100,000 women nationwide were serving time in 2014 (Carson, 2015). Rates for the number of African American women in state and federal prisons has been declining while numbers for white women has been on the rise since 2000 (Carson, 2015). However, black women still outnumber white women by more than two to one in all penal institutions except local jails. For every 100,000 women in the general population, 109 African American women are imprisoned, in comparison to 64 per 100,000 for Hispanic women, and 53 per 100,000 for Caucasian women (Carson, 2015; Carson & Sabol, 2012). In reviewing the individual states by incarceration rate, Oklahoma has the highest rate in the nation with 142 per 100,000 women while Rhode Island had the lowest incarceration rate at 12 per 100,000 (Carson, 2015).

In examining offense types across genders, men lead women by 17 percent in committing violent crimes and public order type crimes, whereas women commit nine percent more property crimes such as fraud, larceny/theft, or drug offenses such as possession or trafficking than men (Carson, 2015; FBI, 2015). In examining the nature of female violent crime, it was found that women more often perpetrated violence in the home against their family members (Van Dieten, Jones, & Rondon, 2014). It is not known whether the women who recidivated in this study also had a substance abuse problem, however, the rate of recidivism for the women in their study indicate 25 percent of the women are arrested for a new offense within six months of release.

Thirty percent of women recidivated within 12 months of release months of release, and 68.1 percent were reoffended five years after release from incarceration (Snyder, Durose, Cooper, & Mulako-Wangota, 2016).

The rationale for this theoretical paper has thus far introduced the existing evidence that there are more women in prison than ever before, they are largely serving time for drug offenses, and they relapse and recidivate for different reasons than men. As a volunteer substance abuse counselor for the past two years in a Therapeutic Community, called Ke Alaula, located within the Women's Community Correctional Center (WCCC) on the island of Oahu, I was interested in the practical applications of how to deal with relapse and recidivism in female inmates. I began to observed a need for adult attachment re-patterning within intimate and family relationships as a means to provide greater sobriety and relapse prevention skills.

I provided pre-trial and sentenced female offenders of maximum to minimum custody levels with substance abuse treatment in a 50-bed residential substance abuse treatment TC program, run by Hina Mauka, under contract with the Department of Public Safety (State of Hawaii, 2018). The core content of the Ke Alaula program is comprised of Cognitive Behavioral based classes on drug and alcohol education, relapse prevention, skill building; and courses such as Seeking Safety, Grief, Trauma, and Parenting, as well as individual and group counseling. Over time I noticed that some of the women who completed our program in the first year I worked there had returned with fresh charges during my second year. This occurrence peaked my interest since the women who returned seemed as though they had made sufficient progress in treatment at time of program graduation; that it seemed unlikely they would return. I wondered what had gone awry on the outside, and whether our program might have failed to

address any issues associated with their relapse and recidivism.

I asked the recent recidivees and inmates who had experienced multiple incarcerations about the reasons that lead to their relapses, and was told in a single word, “relationships”. In probing further with the women on my counseling schedule, the overwhelming response was that they turned back to substances to numb their pain, anger, or disappointment when there was a breakdown in secure bonding, attachment needs were not met in their romantic or family relationships, or a betrayal-injury such as cheating had occurred. I assessed my clients’ responses to the typical triggers associated with relapse, such as being exposed to others using drugs and alcohol, or returning to places of previous use, being subjected to indirect or direct social pressure to use, experiencing positive emotional states similar to a substance induced state, experiencing a lapse in judgement, or exhibiting irresponsible and risky behavior, and experiencing negative emotions. Most women said they were able to handle the typical trigger situations over incidents with romantic partners and close family members, since they had enacted numerous role plays in which they practiced refusal skills, and typical trigger-stopping responses.

As noted previously, literature on the causation of substance abuse relapse for women, once they have left drug and alcohol treatment, is fairly scant. It has been noted that women tend to relapse when problems arise in new relationships started during recovery, yet the specific factors in these difficulties have not been studied with any depth (Walitzer & Dearling, 2006). The stress of reunification with children, family members, and spouses or partners can also be difficult to cope with for newly released offenders (CSAT, 2005) The female parolee is potentially faced with the interpersonal stress of returning to unresolved problems with her

husband or partner; family members who may still be distrustful and angry over the ex-offenders' prior drug use; and abrupt resumption of lapsed parental roles; financial burdens, as well as drug use within the family or neighborhood (CSAT, 2005). Aspects of the parole or furlough program can also contribute to a parolee's anxiety such as the considerable effort required to adhere to random drug testing, residential detention, electronic monitoring, and other surveillance issues required to remain in the community (CSAT, 2005).

The social cost of the paucity of research studies concerning interpersonal reasons for relapse is that women will continue to move through the revolving door of substance abuse and prison confinement without satisfactory resolution of their past and present problems. Therefore, the rationale for this theoretical paper is to provide a practical application from which to address the gender specific reason to relapse for women by introducing an intervention during their substance abuse treatment that tackles that issue.

Purpose of the Study

The purpose of this study is to better meet the criteria set forth in the newest *Principles of Drug Addiction Treatment: A Research-Based Guide, third edition,* which states that treatment must be readily available to individuals seeking substance abuse treatment, and effective treatment is to provide services for all the individual's needs, not just the chemical dependency (NIDA, 2018). It is my belief that the inclusion of Emotionally Focused Family Therapy (EFFT), an empirically validated EFT intervention, is readily adaptable as a therapeutic intervention for women's substance abuse treatment groups within a prison-based therapeutic community program, to meet the criteria stated above. EFT and EFFT provide a solid link between theories of attachment across fields of study, and the abuse histories and relapse experiences of female

inmates (Johnson et al, 2005, 2019; Palmer & Efron , 2007; Tavallaei & Talib, 2010). I also believe the guiding role of various theories, such as the Self-Medication Hypothesis, Bowlby's attachment theory, as it relates to the forming of early life experiences; subsequent substance abuse, and the phenomenon of adult attachment, help piece together a framework for a much more comprehensive means to reduce relapse produced by interpersonal mis-attunment in female substance abusers once released from prison, than the current CBT treatment modality. The purpose of including EFT treatment with the usual substance abuse treatment programming in female inmate substance abuse recovery programs is to provide women with additional tools other than CBT to cope with dysfunctional relational patterns, fear of partner loss, and disconnection from their primary social resources that can lead to loss of abstinence and eventual recidivism (Johnson, 2019; Johnson & Brubacher, 2016; Johnson et al., 2013).

By clearly describing the various attachment based theories in substance use, and in social bonds that people form with each across the lifespan, it is possible to link non-attachment based models to other concepts in treatment to arrive at a possible intervention framework (Lynham, 2002). For example, the Therapeutic Community concept of substance abuse treatment delivery is not rooted in attachment theory, but in Transactional Analysis, (TA) a psychoanalytic method for greater ego-strength development through social interactions between its members (Ross & Auty, 2018). My primary purpose is to provide a sound theoretically-based argument for adjunctive treatment of a specific subculture's (female inmates) experiences with intimate relationships as it relates to relapse, rather than to test a hypothesis that predicts future behaviors once released into the community (Bendassolli, 2013). The secondary purpose is to present and articulate what the possible delivery method of EFFT in a TC might look like to the treatment

provider, based on the existing literature regarding TCs and the observations I have made concerning relapse and recidivism while working with women in a level three state prison TC. and incorporate these observations into the existing literature and theories regarding substance abuse relapse, the current substance treatment methods available in prison, possible interventions that match the reasons for relapse in women.

Research Questions

By undertaking a theoretical clinical research project rather than a qualitative or quantitative, the types of research questions I will be asking differ significantly since the responses will be gleaned from the existing literature, and therefore will be derived from supposition and not from confirmatory and concrete evidence. I aim to answer several research questions by engaging in this theoretical study. The initial research question to be answered is whether providing adjunctive treatment in the form of EFT, adapted for groups, during substance abuse treatment while incarcerated, is likely to minimize interpersonal distress in intimate and familial relationships. Second, would the delivery of EFT, adapted for groups, in a therapeutic milieu, be likely to aid women in forming corrective bonding relationships that assist in healing childhood attachment injuries? Third, would EFT, adapted for groups, be likely to facilitate sobriety for female offenders once released from prison? Finally, if EFT, adapted for groups, were to be effective in the treatment condition, could adding EFT for either individuals, couples or families to aftercare further reduce relapse rates for women?

Significance of the Study

There are multiple significant aspects related to the problem of substance abuse relapse for women. One of the fundamental problems inherent to chemical dependency is its relapsitive

and remitting pattern (Wexler, Melnick, Lowe, & Peters, 1999). Reasons for relapse are affected by complex sets of factors that exceed the scope of this paper, however, relapse is generally influenced by pre-existing problems, severity of substance involvement, stressors, coping skills, efficacy to implement one's coping mechanisms, social factors, treatment variables, and history of prior relapse (Walitzer & Dearling, 2006). Marital conflict has been identified as a primary cause of alcohol relapse for women by Walizer and Dearling (2006). Women in their study also reported experiencing negative affect and interpersonal problems prior to relapse.

Including EFT formatted for prison substance abuse programing would be an innovative way to tackle one of the primary reasons female ex-offenders relapse and recidivate: experiencing difficulties in new or existing love relationships once released from prison (Sack, 2018; Walitzer & Dearling, 2006). EFT, an evidenced based treatment regimen for couples, and EFFT for families, and EFIT for individuals, is not currently included in evidenced-based substance abuse treatment planning or programming, however, research on Attachment Theory and addictions have produced results that appear to demonstrate that EFT, and its derivatives could be a beneficial addition to substance abuse treatment.

Another significant issue of this study is that in addition to the attachment injuries and early victimization, women in prison typically come from lower socioeconomic levels, are apt to be part of marginalized or colonized ethnic minorities, may be mothers of young children, or have children from multiple partners, and were likely unemployed when arrested. Incarcerated women also tend to come from generationally dysfunctional homes where parents were neglectful, physically or emotionally absent, physically or emotionally abusive, used drugs and/or drank excessively. Their parents or caregivers may also have been involved in criminality

or held in the criminal justice system (Dow, 2011). Women also are highly likely to enter incarceration with histories of mental health problems such as anxiety, depression, and Posttraumatic Stress Disorder (PTSD) (Dow, 2011; Dykstra et al., 2015). Many of these women were introduced to drugs and alcohol by perpetrators during drug-facilitated sexual assault, or were used by the victim as a means of coping with or reduce affective distress related to childhood attachment injuries, as well as current emotional and physical trauma (Clark, Reiland, Thorne, & Cropsey, 2014; Dow, 2011; Harper, 2011).

Incarcerated men also share some of these histories, however the research over the last two decades has shown that risk of interpersonal victimization is far greater for women than for men; and women are much more likely to develop Posttraumatic Stress Disorder (PTSD) with greater chronicity of persistently severe symptoms following betrayal-based trauma (BCCEWH, 2009; Delker & Freyd, 2014; Dykstra et al., 2015; Fletcher, Nutton, & Brend, 2015). Langan and Pelissier's (2001) study found that female inmates used drugs more often than their male counterparts, used harder substances, and for differing reasons than male inmates. Dow (2011) also cites Briere and Richards (2007), Herman, (1992) and Pearlman's (1997) findings that symptom severity among incarcerated women has been attributed to childhood insecure attachments produced by abuse and neglect at the hands of their parents or caregivers. As a result of these findings, society could benefit from this study if the criminal justice system were to provide substance users with additional services during treatment to successfully reenter society.

The provision of services that could reduce relapse and recidivism for this population of women, could significantly minimize the vast public expenditure on inmate housing costs (Hinds, Kang-Brown, & Lu, 2018). Since the individuals most effected by prison time are

women of lower socioeconomic status, ethnic minorities, and members of marginalized populations who might not ever be able to afford long-term residential drug and alcohol treatment in the private sector, it could provide an affordable way to treat this segment of the American population (Dow, 2011; Keyser-Marcus et al, 2015). Taking all the aforementioned issues into consideration, the theoretical significance of this study is that preventing relapse, in turn, may produce a multiple pronged benefit of helping women develop better bonding patterns with their romantic partners, and their own children, maintaining long term sobriety, reducing the cost of prison for the American taxpayer, and lastly, possibly increase public safety by reducing female recidivism,

Chapter Summary

In conclusion, this chapter serves to set the stage for the research concerning the interrelatedness of incarcerated women with chemical dependency, and childhood attachment injuries that may be carried forward into adult relationships. Prison-based substance abuse treatment is not presently addressing the need for corrective emotional experiences within intimate relationships for women that may facilitate sobriety (Huang et al., 2012; NIDA, 2018). The rationale for this theoretical study is to provide a compelling argument for inclusion of EFT in treatment for female substance users in the hope of giving them more tools to successfully reenter society and their lives.

CHAPTER II

REVIEW OF LITERATURE

It is well-established across the medical and addictions fields that drug and alcohol dependence is a brain disease induced by chemical changes that alter the structure and function of the brain and behavior (NIDA, 2007; 2012; 2018). Not everyone who uses drugs and alcohol develops a tolerance or dependence, but for those who become addicted, the ability to stop using their drug of choice becomes highly compromised. Despite the gravity of using addictive substances in the face of dire personal and social consequences many individuals are able to recover from substance abuse and maintain sobriety, however a multitude of enduring factors contribute to the chronicity of substance use, and can interfere with continued abstinence and recovery (Fletcher, et al, 2015; McLellan et al., 2000). Menicucci and Wermuth (1989) and Zenali et al. (2011) found that it is within the predisposing risk factors of genetic traits, psychiatric history, and social relationships-such as influence of peers and parents, and parental nurturance that Bowlby's attachment theory has potential for risk-factor mitigation (Fletcher et al., 2015).

Bowlby's attachment theory is highly relevant to the study of substance abuse treatment for incarcerated women due to the fact that insecure attachment has been linked to a lack of attuned emotional support in childhood, the continued attachment difficulty in adult relationships, and the abuse of substances to regulate emotional states by a number of researchers (Borhani, 2013; Khantzian, 2014; Mikulincer & Shaver, 2005; Moser, Johnson, Dalgleish, Lafontaine, Wiebe, and Tasca, 2016). Research done with depressed mothers and their infants appears to best illustrate the attachment styles involved in distress regulation. Dawson et al.'s (2001) research, as cited by Coan, Allen, and McKnight (2006), indicated that insecurely

attached infants of depressed mothers, have a tendency to evidence right-sided prefrontal asymmetries as an indication these infants, like their mothers, had begun utilizing avoidance or withdrawal as emotion regulation strategies. Santona et al., (2015) also cited confirmatory findings of how distress regulation is negatively impacted by insecure attachment for the infant. Cicchetti and Toth (2009); Goodman et al. (2001) and Wardle (2001) all found depressed mothers to be less involved, inattentive, or overtly rejecting behavioral responses effected the ability of their babies to regulate their emotions and behaviors, sustain positive affective states, and to regulate received sensory input (Santona et al., 2015) Furthermore, when studying depressed mothers and their infants, Santona et al., (2015) also found that these mothers reported greater incidence of emotional-behavioral and internalization problems in their babies. These findings are in line with previous research demonstrating "affectionless control" parenting appears to contribute to the development of internalizing problems for the little one.

Attachment in Adulthood

Bowlby's research in 1969 and 1979 made it clear that attachment in not solely a childhood based phenomena, as seeking to remain close to significant others continues across the lifespan. A plethora of research indicates the attachment styles learned in childhood persist into adulthood where they affect adult love relationships and those with friends and family (Meier, Donmall, Barrowclough, McElduff, & Heller, 2005; Mikulincer & Shaver, 2007; Riggs, Paulson, Tunnell, Sahl, Atkison, & Ross, 2007; Widom, Czaja, Kozakowski, & Chauhan, 2018). It is from this Bowlbian-Ainsworth framework that Johnson and Greenburg began extrapolating their adult attachment theory in romantic relationships to form a theory that is known as EFT (Johnson & Brubacher, 2016; Johnson & Whiffen,1999).

Other attachment theorists, such as Mikulincer and Shaver (as cited in Moser et al., 2016) and Cowan and Cowan (2007) also believe Bowlby's concept of proximity seeking between people in close relationships across the lifespan is a distress regulation method. In fact, caregiver-infant relational patterns developed in childhood appear to carry forth into adult relationships, shaping the interpersonal exchanges with friends, family and adult romantic partnerships (Beckes, Gonzalez, Maresh, Brown, & Hasselmo, 2017; Borhani, 2013; Coan, 2010; Coan et al., 2006; Cowan & Cowan, 2007; Mikulincer & Shaver, 2007).

Substance abuse severity is associated with having a greater number of traumatic episodes, as well as poorer outcomes in recovery programs (Keyser-Marcus et al., 2015). Childhood trauma and abuse seems to be correlated with an increase in psycho-pathological vulnerability, specifically substance use disorders and depression (Huang, 2012). This effect becomes noticeable quite quickly in adolescence. Adolescents with and without childhood exposure to abuse were put through diffusion tensor brain imaging (DTI) every six months for a five years to determine if neural changes were associated with the development of psychopathology or substance use problems. Teens who were abused as children that went on to develop substance use disorders during follow-up were shown to have developed significantly lower fractional anisotropy (FA) values in their right cingulum-hippocampal projection more so than controls. White matter disruptions as indicated by lower fiber density, smaller axonal diameters and demyelination of their white matter.

The Self-Medication Hypothesis and Its Link to Attachment Injuries

A large body of research indicates that physical abuse, emotional abuse, or neglect in childhood can lead to intense, threatening, dysphoric, and volatile feelings due to the exploitation

of the attachment relationship between the child and parent (Briere, 2002). The National Association of Adult Survivors of Child Abuse (2006) indicates that these painful and emotionally disturbing feelings may persist into adulthood in the form of PTSD and personality disorders. It is here that the link between attachment and substance abuse for incarcerated females is made via Khantzian's Self-Medication Hypothesis (SMH). In the 1970s views about the cause of substance abuse were divided into two camps: one view being that people used drugs and alcohol as part of self-destructive or pleasure-seeking behavior while the other focused on the reinforcing and pharmacological effects of substances on the brain (Tronnier, 2015).

In the 1980s, Khantzian, a Harvard Medical Center psychiatrist, developed the SMH along with colleagues, Mack and Schatzberg. The theory was derived from five decades of clinical work in the addictions field, where he concluded that drug and alcohol use is a means to compensate for painful affects and distressing psychological states in an attempt to self-soothe (McKernan, Nash, Gottdiener, Anderson, Lambert, & Carr…, 2015). The SMH is further predicated on two distinct principles. The first states that drugs and alcohol become addicting due to their ability to mitigate one's psychological suffering, while the second principle posits that an individual's drug of choice (DOC) is specific as to the psychological and physiological effects it produces in the user (McKernan et al., 2015). For example, stimulant drugs boost mood, self-esteem, confidence, and provide an energizing effect in individuals feeling depressed, whereas heroin or alcohol's sedative properties may be chosen to dampen feelings of fear, anxiousness, and loneliness (Khantzian, (1977, 1974; Ruglass, 2014). Therefore, according to the SMH, chemical dependency is primarily a means of emotional pain relief rather than a pleasure seeking fix (Tronnier, 2015). Khantzian posited that substances may provide some short-term

pleasure, however it is their repeated use as a means of reducing unpleasant affect that leads to addiction (Tronnier, 2015).

Despite wide acceptance of the SMH, its critics point out that Khantzian based his theory solely on his clinical observations rather than through quantitative studies (Plume, 1985). Additionally, many of his patients indicated prior histories of psychological disorders that predated their substance use. He and his colleagues also do not account for predisposing factors, or that most people who use alcohol or other drugs are able to manage their usage and do not develop dependency. Dackis and Gold's (1984, 1985) model contradicted Khantzian's in that they insisted negative affective states were produced by substance dependency rather than the cause (Plume, 1985). In 1987 Cocores countered Khantzian's theory with the dopamine (DA) deficiency hypothesis of drug seeking behavior that implicated DA as the primary reinforcing neurotransmitter in the mesolimbic dopamine reward pathway (Koob & Volkow, 2016). Khantzian later amended his theory is 1999 proposing that greater negative affect is directly related to more addictive substance use. Hall & Queener's (2007) study with 70 methadone patients failed to find the relationship Khantzian predicted.

McKernan et al., (2015) acknowledge that the SMH has been criticized for the variability in prior replication studies of Khantizian's hypothesis concerning his drug-specificity postulate and his amended theory. McKernan et al., asserted that prior attempts at replication did not arrive at validation due to methodological limitations, and their study attempted to rectify these limitations with 304 substance-dependent treatment seekers in testing the second principle of the SMH. In doing so, they employed theory-congruent heterogeneous, personality-derived measures to identify personality types, and classified addiction types through a medical record-based

algorithm and two independent raters. They predicted that three groups, divided by their DOC (depressant, stimulant, or opiate), would exhibit differences in personality characteristics and emotional-regulation strategies. Hypothetically, that users of depressants would demonstrate defenses of repression, over-controlled anger and inhibited emotional expression of depression, whereas those whose DOC was opiates were hypothesized to manifest greater levels of aggression, anger, trauma, poorer ego functioning, externalized antisocial behavior, and depression. The third group, with a preference for stimulants, was hypothesized to experience dysphoria, manic-depressive symptoms, paranoia, and lowered emotional inhibition levels (McKernan et al., 2015). Their study produced statistically significant support for the SMH with regards to the personality functioning of individuals whose DOC were either depressants or opiates, though not for stimulants (McKernan et al., 2015).

Khantzian does not dispute that neuroscience has provided conclusive evidence that drug and alcohol dependence and relapse are based on the physiological changes brought on by chemical reactions in neural pathways (Khantzian, 2014). To those who debunk Khantzian's SMH theory, he notes that neuroscience and other fields have failed to prove why drugs and alcohol have such an incredible psychological hold on some people and not others (Khantzian, 2017). Regardless of whether an individual's substance abuse is preceded by psychological difficulties or vice versa, the SMH theory aids treatment professionals in getting at the root of addiction without dispelling biological approaches or social factors. In fact, Khantzian (2017) states that if the SMH theory is incorporated into other treatment approaches it may further our understanding of the complexity of addiction. Examining substance abuse through an attachment lens requires that treatment strategies focus on acquiring coping mechanisms to mitigate

interpersonal problems, anxiety, depression, and self-esteem issues rather than focusing solely on the symptoms of chemical dependency (Ruglass, 2014). Most importantly, addiction recovery has been found to have greater potential for success when it is fostered by secure attachment bonds, and relational connection (Borhani, 2013; Molnar et al, 2010).

Conflicting Results Concerning Relapse

It has previously been noted that a primary reason women relapse on drugs and alcohol is related to experiencing problems in new romantic relationships early in recovery (Sack, 2018). That observation conflicts with the findings of Prendergast et al., (2011) who found that single, never married women, who were not in a romantic relationship were four times more likely to be re-arrested in the 12-month follow-up period than women who had been previously married or were currently in a relationship. A possible explanation for these findings is that there was not a committed companion available to share the stress load with the ex-offender, and that substances may have been used for that purposes as discovered in other findings (Borhani, 2013; Khantzian, 2014; Ruglass, 2014)

Other fields see the addiction problem differently in that it is a disease rather than a means of self-regulation. Jellinek's disease model tends to remove the distinct responsibility for choosing to drink or drug from the individual once the substance has changed the brain's reward, motivation and memory systems. Jellinek's stage model of disease indicates that following changes to the brain and body, individuals continue to use the substance to feel normal, and that the chemical and structural changes in the brain lead to cravings to use and continued use despite severe biopsychosocial consequences (Butcher, Hooley & Mineka, 2014). Neuroscience has provided conclusive evidence that addiction and relapse are based on the physiological changes

brought on by chemical reactions in neural pathways (Khantzian, 2017). To those who debunk Khantzian's SMH theory, he notes that neuroscience and other fields have failed to prove why drugs and alcohol have such an incredible psychological hold on some people and not others (Khantzian, 2017).

Improving Relationships to Aid Substance Abuse Recovery

Oxytocin, a neuropeptide, has been associated with prosocial behavior in the central nervous system control of neuroendocrine responses to stress in animal studies (Heinrichs, Baumgartner, Kirschbaum, & Ehlert, 2004). In 2003, Heinrichs et al (2004) exposed 37 healthy adult men to the Trier Social Stress Test, thus determining that the effects of social support from the participant's best friend lowered cortisol levels, elevated mood, and lessened anxiety responses to psychosocial stress in humans. Gianunzio's research in 2009 found that new relationships in early substance abuse recovery for women produced key elements of interpersonal support and self-efficacy to abstain than it did for males (Gianunzio, 2009). In addition to that finding, the number one reason for drug and alcohol relapse following prison release occurred in the context of poor social supports (Binswanger et al., 2012).

Affect regulation, in a social context, has also been found by numerous researchers in the early 2000's to regulate physiological arousal of the cardiovascular system, bring about a reduction in basal glucocorticoid levels, reduce threat-related activity of the brain, and in doing so produces better health and lengthens lifespan (Coan et al, 2017). Previous research has established that relational partners are involved in the regulation of emotions in adult relationships as they were between young children and their caregivers (Mikulincer & Shaver, 2007). Coan et al. (2006) and Coan (2010) indicate that in an effort to conserve neural resources

when problem solving, an individual's brain is less activated when accompanied by a romantic partner rather than a stranger, and becomes highly activated when left alone under threat. Coan and colleagues hypothesized that proximity to social resources, such as a loved one, would serve to buffer the participants' perception of threat, thus regulating negative affect. Sixteen married couples participated in the study, whereby the wives where threatened with electric shock while undergoing three functional magnetic resonance imaging (fMRI) brain scan conditions (Coan et al., 2006).

In this small, but important experiment, wives held the hand of a stranger, held their spouse's hand, or were scanned alone during threat of shock to the ankles. When scanned solo, activation was seen in brain regions that commonly become activated when anticipating pain, plus, increased activity was observed in the "posterior cingulate, ventral anterior cingulate cortex, postcentral gyrus, and supramarginal gyrus" (Coan et al., 2006, p. 1034). The increased activation is suggestive of coordination of threat-related arousal and the possibility of needed musculoskeletal activity (Coan et al., 2006). The fMRI scans of the women who held the anonymous stranger's hand also displayed the typical activation of anticipated pain regions, as well as the superior colliculus, right dorsolateral Prefrontal Cortex, caudate and nucleus accumbens.

Coan (2010) suggests the additional brain region activation seen with stranger handholding is indicative of additional vigilance and self-regulation efforts. The brain scans of women who held their partner's hand varied in respect as to whether they were in a good relationship or one of lesser quality. The fMRI results of women in more secure spousal relationships exhibited less threat-related neural activation in the right anterior insula, superior

frontal gyrus, and hypothalamus. More activation was exhibited by the right anterior insula, superior frontal gyrus, and hypothalamus of the wives in the less secure relationships, as these regions are associated with marked threat significance and the discharge of stress hormones. In other words, social resources, such as the presence of a romantic partner, mitigated the number of problems an individual's brain needs to solve and reduces the number and magnitude of the brain regions activated to problem-solve a threat.

Coan et al. (2017) replicated this study with 110 couples, including both men and women with fairly equal numbers of people who were married, living together, dating, or just friends. Moreover, we sought here to assess the moderating impact of both perceived social support and relationship status on the regulatory impact of handholding. The results provided conclusive evidence that the presence of significant others, regardless of status, moderated the numerous neurological systems involved in behavioral and cognitive threat responses. Furthermore, the participant's expectation that social support is available when required reduced the severity of distress, and reduced threat-based neural activity (Coan et al., 2017). None of the aforementioned studies were not done with substance abusers or with incarcerated individuals, however the conclusion that social support offsets stress reactions is relevant to all human beings.

Emotionally Focused Therapy (EFT)

EFT is steeped in the Bowlbian belief that attachment bonds continue across the lifespan as a fundamental survival mechanism utilized by all primates. It has become the leading empirically validated form of couples' therapy (Byrne, Carr, & Clark, 2004). The strong attachment component of Johnson's EFT model helps to normalize rather than pathologize the less than secure attachment styles produced in childhood, and perpetuated in adult love

relationships (Johnson, 2019; Johnson & Brubacher, 2016). Her couple's therapy model is based on the concept that adults need to co-regulate their emotional states within a love relationship, but become distressed due to destructive interactional patterns that are developed and maintained within the dyad (Johnson, Hunsley, Greenberg, & Shindler, 1999).

Not unlike Ainsworth's distressed infant who cannot locate the mother who has left the room, adults commonly react to forms of disconnection within the couple relationship, by pursuing their withdrawing partner or shutting down and withdrawing themselves (Johnson & Greenman, 2006). In turn, these pursuing and/or withdrawing behaviors lead to a vicious cycle of negative affective states between the romantic partners. Maladaptive attachment strategies can be reshaped through EFT into optimal partner bonding through primary emotional responses that form the basis for personal autonomy in adulthood, while still trusting and connecting with dependable significant others. (Brubacher, 2017a; Johnson et al, 2005; Johnson, 2016; Johnson et al., 1999). Unlike other theories and interventions that are produced as the result of data analysis in research studies, Johnson and Greenberg co-developed Emotionally Focused Couple Therapy in 1985 by examining videos of couple therapy in order to elucidate the change process in a humanistic experiential model aimed at couple distress. was the first therapeutic intervention to integrate Karl Ludwig von Bertalanffy's systems theory, and humanistic-experiential theory as conceived by Carl Rogers and Fritz Perls, respectively (Johnson & Greenman, 2006). Johnson and Greenberg richly combined these theories within the strong attachment base to produce an empirically validated model for solving the dyadic difficulties if adult love relationships (Brubacher, 2017a).

Greenburg and Johnson have since parted to further develop their theories. Greenburg

and Elliot went on to develop Emotion-Focused Therapy for individuals, and Johnson deepening the concepts of the original EFT model (Brubacher, 2017a). Although both therapies have similar names, a shared abbreviation, and a shared beginning, they differ significantly. Greenburg and Elliot's model is concerned with intrapsychic individual therapy, and is also known as process-experiential therapy due to its emphasis on emotions as the change element (Brubacher, 2017a). Greenburg's Emotion Focused Therapy has been adapted for use with couples in substance recovery, though not within criminal justice system programming. Although Johnson's EFT's co-regulating attachment steps have not been tested or validated for use during substance abuse treatment, or with couples separated during incarceration, or conjointly incarcerated as a same sex couple, many facets of EFT and attachment theory are relevant to the emotional regulation, prosocial behaviors, and bonding with others for support and comfort that are part of substance abuse treatment (Johnson, 2002; Wiebe et al., 2017).

Johnson's EFT model was selected over Greenburg's model as a better fit for inclusion in a women's prison substance abuse recovery program due to several key factors: its strong attachment focus, and manner in which it re-organizes and produces positive interactional bonds that shift rigid self-perpetuating negative dynamics away from ineffective bonding strategies towards safe connection (Johnson, 2016; Johnson et al., 1999). Other factors include its generalizability with ethnicities, its ability to help many different kinds of couples, including same sex couples, and treatment settings as well as its work with trauma survivors (Johnson, 2002; Johnson, 2016).

EFT is specifically designed to mitigate distress in adult love relationships and has been proven to do so (Wiebe et al., 2017). Johnson's EFT model retains the original three stages and

nine steps she and Greenburg developed to reshape couple's attachment bonds (Jorgenson, 2017). Stage one is the De-escalation Stage containing the first four steps: Assessment, Identifying the couple's negative cycle and their attachment needs, Accessing the underlying attachment emotions, and Framing the couple's problem with regard to their cycle of interaction, their attachment needs and the fears that arise from these needs not being met (Johnson, 2013). Stage two is all about restructuring the bond and this is accomplished with steps five through seven. In step five the therapist helps the couple access implicit needs, identify long-marginalized emotions, fear or rejection, and examine models of self by identifying and engaging these core feelings in the moment (Johnson, 2013).

Step six is about promoting acceptance and affiliation between the partner in order to expand the constricted cyclical interactional patterns between the partners (Johnson, 2013). Step seven is where bonding events are restructured to allow for greater emotional engagement through the expression of attachment needs by evocative questioning, and therapist lead reflection (Johnson, 2017). The final stage (three) is called the Consolidation Stage since the remaining two steps are concerned with finding new solutions to practical issues in the relationship, as well as enacting new and healing ways to deal with problems within the relationship (Johnson, 2017).

Distressed Relationships in Adulthood

Emotionally Focused Therapy provides a framework for learning about couples and the problems they experience in their relationships. Johnson (2002) outlined nine key elements of distress in adult relationships that EFT is able to address. First and foremost, Attachment Theory indicates the universal human truth, that when we are close to our attachment figure we are likely

to feel less afraid, find meaning in hopeless situations and share the load of joint problem solving. When a relationship is distressed one or both partners is experiencing a lack of emotional responsiveness to cues for closeness and bonding (Johnson, 2002). Secondly, individuals feel traumatized when they are separated from their attachment figure, leading to anxiety, fear, and rigid interactional responses between the partners. Third, the more an individual can effectively depend on another, the more independent and stable that person becomes in facing stressors.

The fourth key element is that distress behaviors are predictable in their pursuing or withdrawing nature and are equally predictable in eliciting the opposite reaction in the other partner. Fifth, When the relationship is in distress, it becomes difficult for the partners to maintain a balance in other facets of their lives. As partner distress increases, it raises the level of stress from avenues, such as an incestual past, PTSD, or from prior domestic violence. Sixth, the therapist can track the emotional responses of the distressed couple and reorganize them into cues for clearer communication. Seventh, evolutionarily we are wired to connect with a small number of others. When this connection goes awry, human beings utilize a limited number of fairly predictable behaviors to try to reengage these significant others. Eighth, an individual's internal working model of self is shaped and defined by the recurrence of responses he or she receives from his or her attachment figure. Lastly, change events in therapy allow partners to safely reach out emotionally to their loved one to be received empathically (Johnson, 2002).

EFT has been successfully used to treat depression, chronic illness, and anxiety (Johnson & Greenman, 2006). The EFT model has achieved more positive therapeutic outcomes than any other couple's therapy, has achieved the largest effect size, and has produced stable results over a

36-month period—similar to the first relapse measure for ex-offenders (Johnson & Brubacher, 2016). EFT has been adapted for use in psychoeducation settings in South Africa and in community settings all over the world in its *Hold Me Tight* workshops (Johnson & Brubacher, 2016). An important aspect of EFT that may be helpful and appreciated by women who are incarcerated is its de-pathologizing approach to being co-dependent on another person for regulation. In prison, inmates that have paired up with another person for companionship and bonding are repeatedly talked down to and made to come to terms with their wrongful behaviors by prison staff. Research by Cuen (2016) points out that what is normal bonding between human beings should not be labeled as co-dependent or enmeshed.

The National Association of Adult Survivors of Child Abuse (2006) indicates that the most damaging aspect of child abuse is not the physical abuse or neglect, but rather the exploitation of the parent-child attachment that renders the child unsafe in relationship with others. In 2013, Dalton, Greenman, Classen, and Johnson conducted a study with 24 couples in which the female partner had suffered childhood abuse. Through random assignment they were given 20 sessions of EFT or placed in the control group. Seventy percent of the couples in the treatment group reported being no longer distressed and the female partners reported significant reductions in their trauma symptoms of dissociation, interpersonal sensitivity, and phobic avoidance of interpersonal interactions (Johnson & Brubacher, 2016).

Of further interest to the female incarcerated population is Johnson and MacIntosh's 2008 research with 10 couples in which one member had experienced severe chronic sexual abuse in childhood (Johnson & Brubacher, 2016). This study has particular relevance to female inmates who have had childhood incest perpetrated on them, in which they may have even been forced to

bear the assailant's children (A. Cook, personal communication, April 13, 2018). This study indicated EFT's potential to be used in relapse prevention since the women reported a decrease in depressive symptoms and an increase in the quality of their relationships (Johnson & Brubacher, 2016). Although EFT or its derivatives have not been used with an incarcerated population, an eight-week affect regulation and attachment-based intervention for incarcerated adolescents produced by Keiley (2002) yielded the unexpectedly positive results of lessening staff-inmate conflicts. This effect has the possibility of occurring amongst incarcerated female inmates and adult corrections officers as inmates learn to communicate their needs more effectively and without interactional aggression or withdrawal.

Alleviating Intrapersonal Stress Through Social Means

One of the most important and validating studies done with EFT examined how emotionally regulating partner relationships can be. Johnson et al (2013) took Coan (2010) and Coan et al.'s, (2006) studies further, by investigating how EFT treatment for couples in moderate relationship distress would change neural response to threat of shock while handholding in an fMRI scan. Couples who met criteria for less-than-secure relationships as measured by the Dyadic Adjustment Scale (DAS), were scanned before and after EFT sessions to determine the effectiveness of EFT on a distressed relationship in mitigating activation in brain regions of interest (identified by Coan et al., 2006) associated with threat. The couples attended between 13 to 35 sessions depending on the severity of their relational problems, and their ability to progress through the EFT change events (Johnson et al., 2013). Once a couple was able to share their attachment-related needs with one another, and review their treatment gains with their therapist, the EFT treatment phase was concluded and the couple proceeded to the post-treatment *f*MRI

handholding experiment (Johnson et al., 2013).

Johnson et al.'s study results are based on the 23 couples out of 35 who completed the study. The results demonstrated several pertinent pieces of information: first, post-therapy DAS scores indicated a significant increase in marital quality, which suggests that EFT is able to change the way the brain encodes and reacts to threat of shock during spousal handholding (Johnson et al., 2013). Second, stranger handholding effects after EFT were greater than anticipated, and effects were larger among the most distressed couples, suggesting a "social safety in numbers" response. Johnson et al.'s team posited this could possibly indicate that EFT had helped those in lower quality relationships to be more open to support from others, including others outside the relational dyad. Third, a significant decrease in Dorsolateral Prefrontal Cortex (dlPFC) activation noted only during handholding between spouses seems to indicated that couples benefitted from a relational proximity in order to "share the load" of dlPFC glucose consumption when the PFC is challenged to produce self-control strategies while undergoing threat (Johnson et al., 2013). Four, the study produced an interesting finding that threat-related activity in the dorsal anterior cingulate (dACC) and parts of the PFC during the alone condition were noted to have increased as a result of EFT treatment. Johnson et al (2013) speculate that increased activity in these ROIs suggests that by increasing social interdependence upon partner resources, it may be less tolerable to be alone under threat.

Emotionally Focused Family Therapy (EFFT)

EFT was originally developed for couple therapy and has successfully been adapted for use as a therapy modality for individuals and families (Johnson, 2019). A version of EFT, called Emotionally Focused Family Therapy (EFFT), was developed in 2006 by Gail Palmer and Don

Efron, as a model to alleviate family distress through an attachment lens. Thus far, a group therapy model has not been developed in EFT, however, EFFT appears be a highly useful therapy model from which to create a group prototype for use with small groups of incarcerated women. Since female prisoners tend to organize themselves into "pseudo-families" of their own accord, and prison-based substance abuse treatment TCs utilize the "family pod" concept in organizing and grouping small clusters of inmates for peace keeping, and hierarchical mentorship roles within their programing, EFFT's systemic interventions may prove viable and valuable within this context (Kreager et al., 2015; CSAT, 2005a).

EFFT is designed to provide clinicians with an effective blueprint to assist families in understand the emotional signals they send to one another (Palmer & Efron, 2007). Like EFT, EFFT is a collaborative model that is client centered and respects each family member (Palmer & Efron, 2007). It also combines experiential techniques with structured step-by-step systemic interventions, not unlike those found in EFT for couples (Johnson, 2004). The EFFT interventions are designed to help family members de-escalate emotions and end patterns of negative interactions that block effective bonding, attachment, and security (Palmer & Efron, 2007). Stavrianopoulos, Faller, and Furrow's (2014) EFFT work goes beyond the typical illustration of the change process between a couple to demonstrate how the therapist together with the parents and adolescent form a triadic communication system that results in greater access to emotional healing.

The EFFT model, like EFT, conceptualizes distress through an attachment lens whereby lack of response or partial response to the child or adolescent's attachment needs by his/her parents is met with the child's coping strategies of avoidance or anxiety. This results in a

communication breakdown and ineffective parenting that leads to personal psychopathology (Stavrianopoulos et al., 2014). The premise of the EFFT approach is for the therapist to effectively manage change events between an adolescent and his/her parent(s) as well as with the dyadic subsystems that occur between the child and siblings; the child and the mother; and the child and the father (Stavrianopoulos et al., 2014). EFFT interventions require that the therapist have a clear understanding of the familial difficulties in terms of the behavior of the child that produces discord in the family and the parent-child relationship (Palmer & Efron, 2007; Stavrianopoulos et al., 2014). Therapeutically the goals of EFFT are to produce positive change in the dysfunctional family system by producing connection where there is limited emotional accessibility and responsiveness between parents and child (Stavrianopoulos et al., 2014).

Like EFT, treatment in EFFT follows three stages. The first stage is to identify the negative interactional cycle that exists between family members, thus the initial presenting problem is addressed in a family session followed by assessment of the family dynamics, all the while building a person centered therapeutic alliance (Johnson, 2004). The therapeutic alliance is created through therapist accessibility, and validation, and reflection of the personal experiences of each family member. Within the EFFT model, the parent-child subsystems are treated in separate dyadic sessions (format follows EFT) in order to understand the nuances of the negative emotional interactions between particular pairs and how this impacts the family dynamic as a whole (Johnson, 2004). The rigid distress patterns both parents and children exhibit when becoming emotionally insecure are brought to light in the session. This helps all parties to recognize predictable problematic responses such as withdrawal, pursuing, blaming, and appeasing that members of the family engage in an attempt to force or control aspects of the

change they are seeking (Johnson, 2004). Below the typical responses to unmet attachment needs lie the common attachment strategies of avoidance and anxiety that are commonly used as adaptive attempts to correct for insecurity when bids for attachment and familial security are not met, which are identified for each family member (Johnson, 2019; Stavrianopoulos et al., 2014).

The second stage of EFFT is devoted to restructuring the futile reactions that where elucidated in stage one. The therapeutic work is to access and expand the unmet attachment needs of the child while assisting parents in becoming more emotionally available and responsive. Change is facilitated by the enactment of the child reaching for parent to meet previously unmet attachment needs and helping the parent acknowledge the child's vulnerability in making the request as well as meeting the child's bonding needs. The therapist is responsible to support the child and parents in working through their anxiety and fears associated with becoming vulnerable with each other as they reconnect in the session (Johnson, 2019; Stavrianopoulos et al., 2014). Consolidation of the familial changes is the focus of the third and final stage in EFFT. At this stage the family will have acquired reengagement skills that reflect their new connections and bonds with one another. Prior to terminating treatment, the therapist works to help the family resolve any remaining issues and sets the stage for the family to move forward on their own accord with greater positive affect, mindfulness of vulnerable reaching and bids for connectedness (Johnson, 2004).

Process of Change

Family and couples EFT provide clients with similar interventions that foster bonding and attachment with loved ones (Johnson, 2019). It is evident that EFT and EFFT interventions elicit salient positive alterations to attachment and security (Johnson, 2019). Research

demonstrates that anxious and avoidant-attached individuals experienced greater attachment security following 8 to 20 sessions of EFT with the effect still intact two years' post-treatment (Burgess Moser et al., 2015; Johnson, 2019; Weibe et al, 2016). There are primary differences between the two EFT modalities in terms of shared feelings, and actions between the parties being treated. For example, in couple therapy, the therapist works to enhance engagement, positive accessibility and responsiveness. The family therapist is focused on assisting parents in accepting, understanding, and attuned responsiveness to their offspring's attachment vulnerabilities, and the receptivity of the child to the new parental care (Johnson, 2019). In couples' work there is a focus on greater intimacy, whereas in family therapy the goal is to produce greater resilience and intrapersonal growth in the child and parental agency (Johnson, 2019). In both couple and family EFT, the goal of treatment is to produce a better working model of self and dependable others and helps provide a secure base from which to explore the world and a safe haven to return to.

Prison-Based Substance Abuse Programming

EFT has established itself as a viable intervention with the ability to help individuals, couples, and families; and well as trauma survivors. It appears to be a good match for inclusion in residential substance abuse treatment for incarcerated women based on its numerous strengths (Johnson, 2002, 2017). As a therapeutic intervention it is directly connected to this population as a result of their reported histories of childhood trauma and/or neglect largely at the hands of their own parents, family members, and caregivers (Delker & Freyd, 2014; Dykstra et al., 2015; Fletcher et al, 2015; Keyser-Marcus et al., 2015). EFT has been applied with a diverse range of distressed couples in numerous settings across the globe, making it highly generalizable

to new treatment populations and settings (Johnson, 2017).

It is well known that substance abuse (SA) in the general population comprises a highly complex set of medical and mental health problems which are typically associated with difficulties across numerous domains such as being undereducated, unemployed, experiencing legal and criminal difficulties, conflictual interpersonal relationships, trauma and abuse histories, as well as psychological comorbidity (Vanderplasschen et at., 2013). Between 40 to 60 percent of individuals with chemical dependency eventually recover, however numerous factors can persistently interfere with sustained sobriety (Fletcher et al., 2015). Predisposing and perpetuating factors such as genetics, psychiatric conditions, unstable parental and familial care, cultural mores, antisocial peer groups, and interpersonal stress have all been proven to influence relapse (NIDA, 2018).

The abuse of alcohol and drugs produces its own set of physical, mental, and social problems, although their use may serve to medicate the distress caused by the aforementioned pre-existing factors, including early childhood attachment injuries. Taken together, these factors indicate that individuals held in the state or federal prison system are some of the most vulnerable in the U.S. population. They appear to be in need of more tools than are currently provided during incarceration to prevent relapse and subsequent recidivism (Vanderplasschen et al., 2013). Ironically, substance abuse treatment during incarceration provides the U. S. government the unique opportunity to include hard-to-reach and underserved or marginalized populations in long-term residential substance abuse treatment, while housed in a fairly stable setting at a reasonable cost. Drug treatment during incarceration may offer the only opportunity for certain individuals to obtain long-term SA treatment that not only addresses drug abuse, but

encompasses medical and psychological care, and social welfare in a gender-based setting (NIDA, 2018). Unfortunately, the 2010 Center on Addiction and Substance Abuse (CASA) Columbia report stated that substance abuse treatment in prison is not widely available for the 65 percent of inmates in the U.S. who meet criteria for a substance use disorder. Only 11 percent of these individuals actually receive treatment while locked up. The Federal Bureau of Prisons (BOP, 2018a) reported that as of May 3, 2018 there were 183,857 federal inmates in various types of custody arrangements across the country. As of April 28, 2018, a total of 79,190 individuals had committed drug-related Federal offenses, which accounted for 46.2 percent of the total offenses for that month, yet only 37,599 inmates were receiving treatment in either residential drug treatment, non-residential, drug education, or transitional drug treatment out in the community (BOP, 2018a).

Binswanger et al., (2012) identified several factors that led to non-mandated inmates being passed over for drug and alcohol treatment such as not having a prior SUD, not reaching DSM-5 diagnostic criteria for substance use disorder, limited bed space in treatment programs, and simply choosing not to apply for SA treatment despite having a need. Those that are mandated to a prison-based drug and alcohol treatment program usually have been previously diagnosed with a SUD, have had prior treatment, and continue to record drug-related offenses. According to Binswanger et al., the crime-drug association is far more relevant to seeking prison-based treatment than a prior clinical diagnosis.

At present, department of corrections substance abuse treatment is generally delivered much the same way private sector care is: through individual treatment plans that address the biopsychosocial factors of addiction through manualized cognitive behavioral evidenced-based

curriculum. Structured, abstinence focused drug and alcohol group education make up the courses designed to teach relapse and recovery skill building. Individualized and group counseling is a large part of prison programming, as is peer-led behavior modification, and facility mandated randomized drug testing (Substance Abuse Treatment, 2016). Addiction is also commonly treated with time-limited CBT, Motivational Interviewing (MI) and open-ended 12-Step self-help groups (Fletcher et al., 2015). CBT and MI are the treatment modes du jour, yet a quarter of all offenders who received treatment through the criminal justice system relapse and reoffend, making the case for a different type of substance abuse treatment that may increase the effectiveness of in-prison treatment (Langan & Levin, 2002). The chronicity of the addiction cycle seems to lend itself better to longer treatment and treatment that deals with the root of problem.

The Federal Bureau of Prisons states that its substance abuse treatment strategy keeps evolving to apply the advances within the substance abuse treatment field as they become evidenced based, however, improving relationships, while part of substance abuse recovery, has not been a top tier priority. (BOP, 2018b). The current evidenced-based practices for correctional programs are designed to reduce relapse, criminality, recidivism, and misconduct while inmates are still incarcerated. Programs are then designed to increase prosocial and societal norms; improve education and employment status for return to the community by reducing health and mental health symptoms; and improving relationships (BOP, 2018b). A growing body of research spanning the last fifteen years, across different social science and medical fields, indicates that social support offsets stress reactions in individuals, yet evidenced-based treatment that specializes in reforming individual, couples, of family interactions is not offered.

Substance abuse treatment during incarceration is provided in two basic types of treatment modalities: nonresidential and residential programs (BOP, 2015). Nonresidential programs are further delineated into Intensive Day Treatment (IDT) or Intensive Outpatient (IOP). Residential Drug Treatment Programs (RDAP) can be Dual Diagnosis RDAPs, Therapeutic Communities (TC), or Modified Therapeutic Communities (MTC) which, like Dual Diagnosis RDAPs, serve those with SUDs and comorbid psychological and/or medical problems (BOP, 2015). Despite the high incidence of co-occurring mental and substance use disorders, only seven programs for inmates with co-occurring mental and substance use disorders currently operate in the U. S. prison system, of which only three had been researched for effectiveness (Center for Substance Abuse Treatment [CSAT], 2005a; Edens, Peters, & Hills,1997). RDAPs are located within the Federal prison system while TCs operate at the state level (BOP, 2015). In addition, federal detainees who complete RDAP can petition for sentence reduction, while TCs typically do not provide sentence reduction. Inmates can expect to matriculate through either program for nine to twelve months although it may take some inmates longer to move through the phases of treatment based upon their individual needs (BOP, 2015).

Prison-Based Therapeutic Communities

According Melnick and DeLeon, (1999) the Federal Bureau of Prisons has indicated that residential Therapeutic Communities, derivatives of mental health and self-help methodology, are among the most successful incarceration-based substance abuse treatment programs due to the intensity of treatment offered and the community's role as the mechanism for change (DeLeon, 2000). Incarceration-based TCs are fairly recent adaptations to the Therapeutic Community concept, however the incarceration period provides a substantial opportunity for the

state or federal government to halt the cycle of addiction and criminal activity (Mitchell, Wilson, & MacKenzie, 2012). The standards of operation for TCs have been established by Therapeutic Communities of America and the Office of National Drug Control Policy who provide field testing and oversee the 120 standards across 11 domains for the successful operation of a TC (CSAT, 2005a)

Wexler and Prendergast (2010) reported that by including SUD treatment with criminal justice sentencing, recidivism and substance use could be reduced while providing cost-effective substance abuse treatment and improving public safety at the same time. Within this model, prison inmates who have been selected or mandated to participate in an incarceration based TC are housed together away from the general population in order to maintain a drug-free prosocial environment that is focused on rehabilitation (CSAT, 2005a; De Leon, & Wexler, 2009). Segregation of program attendees allows for new growth in interpersonal skills based on safety and positivity (CSAT, 2005a).

TC Treatment Goals and Structure

There are four universal treatment goals for TCs. These are to help the program participant to become first and foremost, become abstinence from substance use; cease any and all criminal behavior; to enroll and participate in a school or work program; and lastly, to attain successful social adjustment CSAT, 2005a ; DeLeon, 2000; Graham & Wexler, 1997). These goals are secondary to maintaining security and safety within prison-based TCs (CSAT, 2005a). TC programs are commonly structured to be completed in a minimum of six to nine months and typically consist of three to four stages or phases (Graham & Wexler, 1997. Treatment achieved through a progressive phase system where individuals acquire more responsibility and privileges

as well as greater consequences for infractions as they move through the program has been found to be especially effective with prison populations (CSAT, 2005a). In the initial or orientation stage, new inmates are acculturated to the existing social milieu of TC peer members, staff, rules, procedures, and operative norms. The second phase, and core segment of treatment, focuses on education regarding substance abuse, changing attitudes regarding criminogenic thinking, and helping the inmate identify triggers and behaviors related to initiating substance abuse. Lastly, in the final stage of the program, the inmate prepares for re-entry into aftercare programs and society (Graham & Wexler, 1997).

The primary objective underlying the *community as method* approach of modern TCs is that the community itself, through peer and staff role modeling of successful sobriety and psychological adjustment, becomes the intermediary between right living, abstinence, as well as psychological and prosocial adjustment (DeLeon, 2015; Freudenberger, 1987). Participants acquire the greatest therapeutic and educational benefits for introducing personal change and continued abstinence into their lives when they fully participate in and learn to utilize the TC activities, relational regulation, and course knowledge as part of their sobriety toolkit (DeLeon, 2015). The systematic approach of the TC, its rules, standards, the behavioral expectations between its members, and continual staff assessment helps the TC member progress towards rehabilitative beliefs, attitudes and behaviors (DeLeon, 2015; Freudenberger, 1987). TC residents have the opportunity to garner positions of responsibility, or work privileges by demonstrating greater involvement in program objectives and by focusing on their emotional issues (CSAT, 2005a).

To evaluate the effectiveness of prison-based drug and alcohol programs in reducing

recidivism and maintaining sobriety, Mitchell et al, (2012) conducted a review of 74 incarceration-based programs with 93 percent of the programs having been conducted in North America, (88% United States and 5% Canada), four percent carried out in Australia, and one percent each in Taiwan and the United Kingdom. Of the programs evaluated, four intervention programing types were identified in order of majority: TCs, counseling programs, narcotic maintenance, and boot camps (Mitchell et al., 2012). They examined SUD treatment effectiveness on post-release recidivism and relapse for prison-based treatment and found that programs enforcing narcotics maintenance had the largest and statistically significant average effect size of 2.10, TCs had the second largest at 1.33, while counseling programs and boot camps were less than one.

Mitchell et al. (2012) found that TCs had moderate effects when it comes to drug relapse and recidivism while narcotics maintenance programs had better treatment outcomes for relapse prevention. One of the significant analytical findings of their research study of drug relapse outcomes were that not many of the mean effect sizes were statistically significant (Mitchell et al., 2012). Overall, they discovered that prison-based SUD treatment did not reduce measures of drug use once released, despite variations in sample, methods, or treatment characteristics (Mitchell et al., 2012) Earlier research by Wexler et al. (1999) found that when prison-based substance abuse treatment was followed up by similar aftercare treatment the rate of relapse and recidivism could be reduced from roughly 75 percent to a little bit more than 25 percent in the 36-month period following release.

Belenko, Hiller, and Hamilton's (2013) review of 26 North American and Western European studies of prison-based TCs over a 34-year period determined that when combined

with aftercare treatment post release, TC intervention can lead to a decline in recidivism and relapse rates. Seventy-five percent of the studies demonstrated favorable outcomes for the TC treatment group in reducing reoffending by five and a half percent. Mitchell et al. (2012) noted that while many of these studies showed modest success rates for TC drug and alcohol treatment the studies often compared an untreated population to TC treatment, or that study designs where flawed in not being able to offer randomized trials, or that only rates of recidivism were measured and not relapse rates, or that studies did not examine gender differences in post-incarceration return to substance use or criminal reoffending. The effectiveness of prison-based drug and alcohol programs in reducing recidivism and maintaining sobriety has demonstrated that TCs, narcotics programs, and adding aftercare treatment to the current treatment regimen significantly reduces relapse (Belenko et al., 2013; Mitchell et al., 2012).

NIDA indicates in its third edition of the *Principles of Drug Addiction Treatment: A Research-Based Guide* (2018) that of the 13 principles of effective drug treatment the fourth and fifth principles are to meet the multiple needs of individuals suffering from addiction, besides the actual drug abuse, and that it is critical to remain in treatment for at least 90 days. Finally, research has found that the success of mandated or coerced treatment within the prison system is based on length of time spent engaged in the rehabilitation treatment content; and that outcomes for mandated and voluntary treatment were roughly the same (Miller & Flaherty, 2000).

Based on these recommendations, it is clear that incarcerated women with substance abuse backgrounds need to be in recovery treatment for at least three months, and receive interventions that address their needs beyond chemical dependency. As previously stated, it is well known that in the last 20 years a large body of research concerning substance abuse

treatment for women has consistently demonstrated that women have a greater incidence of trauma and abuse in childhood, have been involved with child protective services, often suffer violence in their teen and adult relationships, are substance abusers, and tend not to be financially independent, have engaged in criminality, and may have been homeless prior to arrest (Prendergast, Messina, Hall, & Warda, 2011; Vanderplasschen et al., 2013). Not all of these issues are addressed in prison programming, however most prison-based residential treatment programs include group instruction in trauma, grief, and parenting skills along with substance recovery (BOP, 2015; NIDA, 2018).

Dr. David Sack, M.D., a board certified physician in addiction psychiatry and addiction medicine, and chief medical officer of several addiction and mental health programs across the country, noted through his 40 years of experience in the field, that the leading reason women relapse on drugs and alcohol is related to experiencing problems in new romantic relationships early on in their recovery (Sack, 2018). However, treatment with regards to maintaining meaningful romantic relationships in adulthood, is not covered during substance abuse programing, yet this population is known to carry attachment injuries produced in childhood into their adult lives and relapse in relation to negative affect experienced in intimate relationships as ex-offenders (Sack, 2018; Vanderplasschen et al., 2013; Walitzer & Dearling, 2006).

CBT and other evidenced based therapeutic interventions that are presently implemented in prison-based substance abuse treatment have demonstrated the ability to curb relapse and recidivism rates by half when incarceration-based substance abuse treatment is reinforced with aftercare treatment (Olson & Lurigio, 2014). If additional services other than CBT, can be added to the TAU in this treatment setting, offenders who receive treatment might be spared from the

revolving door of drug use, criminal activity, and re-incarceration (Wexler et al., 1999). In order to ascertain how EFT could be added to TAU, the connection between early attachment wounds and subsequent substance use must be made.

Ethical and Diversity Issues in Prison SA Programs

The most important ethical consideration in providing substance abuse treatment in prisons are related to the treatment environment itself. Prisons are often violent, jarring, and psychologically damaging environments due to the depersonalizing and dehumanizing aspects of prison life (CSAT, 1993; CSAT, 2005). For example, the collecting of urine samples that determine SUD program adherence requires that a corrections officer view the inmate in the act of urinating (CSAT, 1993). Prisoners may feel a sense of hopelessness, powerlessness, shame and guilt, due to the conditions found in criminal justice system, which are counterproductive to the goals of substance abuse treatment. Confidentiality in prisons is almost non-existent largely due to safety and security reasons and this may affect treatment outcomes, although most inmates come to accept the limited confidentiality that exists in a prison treatment setting that do not occur in similar client settings on the outside (CSAT, 1993). A case in point may be that individual counseling may occur in open cubicles rather than in a closed room with a slotted window whereby corrections officers can see or hear the inmates and substance abuse counselor's interactions.

An important diversity aspect, not often considered when treating female inmates, that lends itself well to introducing EFT-based education to SA treatment is the counterculture of inmate identity, and the relationship roles unique to prison stays (CSAT, 1993). Women's prison's differ significantly from men's prison in terms of the subcultural organization developed

to deal with the impact of incarceration. Men's prisons are typically organized around gang membership for safety, being part of the drug culture, bringing the street life into prison, and inmate-on-inmate sexual violence as a means of control and hierarchical dominance (Skarbek, 2012).

A notable aspect of prison culture for female inmates that appears to be relevant to introducing EFT-based curricula into SA programing is strongly correlated with gender expectations of sexuality, family relationships, and the way women identify themselves while doing prison time (Bowker, 1999). Bowker (1999) reviewed several relevant qualitative studies from the mid-1960s to the late 1970s. Studies by Ward and Kassebaum's (1964) and Giallombardo (1966) found that female inmates were far more likely than male inmates to engage in same-sex romantic attachments behind bars, in fact they often engaged in a social system unique to women's penal facilities in which they formed "prison families" in order to combat social isolation, exert control over their lives, and re-establish romantic connections that were missing from their lives while incarcerated (Bowker, 1999).

Fifty years after the first cultural studies of women's prison experiences were conducted, Kreager et al.'s (2015) work on female inmates' romantic ties, friendship networks, and social hierarchies found the forming of "prison families" in prison has remained a constant subculture over time (Bowker, 1999; Kreager et al.,2015). This familial need may be met in a more prosocial and non-coercive manner within prison-based TCs specifically designed for women since the structure of the TC is often based on hierarchical roles and family pods (CSAT, 2005a).

Another diversity issue not often addressed in prison-based substance abuse programs is that most programs were originally designed for men (Langan & Pelissier, 2001). The changes in

women's incarceration rates indicate that this concern needs addressment. The Center of Substance Abuse Treatment initiated the National Evaluation Data Services (NEDS) contract to analyze secondary data in the substance abuse field in producing policy and practice changes back in 2001. Orwin, Francisco, and Bernichon (2001) authored the meta-analytic Technical Report which produced the NEDS Analytic Summary in July of 2001 in an effort to judge the effectiveness of women's substance abuse treatment programs between 1966 and 2000. The review of 33 studies yielded three primary treatment types of women-only in treatment versus women without treatment, women-only as opposed to mixed-gender treatment, and enhanced treatment rather than treatment as usual (TAU).

Enhanced treatment in this project referred to the provision of child care, parenting classes, female-only group therapy, workshops on assertiveness, family planning, self-esteem, and sexuality (Orwin et al, 2001). The authors employed a logistic regression model for substance use, criminal activity, and arrest following treatment, and while they were not able to support the hypothesis that members of the women's only group would not be significantly less likely to be apprehended than those in the mixed group, they found that re-arrest in the year following treatment was largely influenced by marital status (Prendergast, et al., 2011).

Interestingly, women who were single, having never married or not in a romantic relationship were four times more likely to be re-arrested in the 12-month follow-up period than women who had been previously married or were currently in a relationship (Prendergast et al., 2011). It is not known whether the stability of a bonded adult relationship provided needed responsiveness and secure attachment that may have aided in reinforcing non-criminal activity, however, the study did conclude, through the limited comparative studies available at the time,

that there was a lack of gender-based treatment for women (MacIntosh & Johnson, 2008; Orwin et al, 2001; Prendergast et al., 2011).

Regardless of these findings, female-only treatment services are not always procurable in the public sector; however, they are the norm within the criminal justice system. This does not inherently mean that women's prison-based SA programming is gender-responsive to the multifaceted treatment needs of female inmates since it is not as well studied or supported in the literature as is men's programming (Prendergast et al., 2011).

Integrating EFT into Prison-based SA Treatment

As previously indicated, Belenko et al. (2013) and Mitchell et al. (2012) found that the prison-based drug and alcohol programs that were effective in reducing relapse and subsequent recidivism were narcotics programs, and TCs, albeit by adding CBT aftercare treatment to the current CBT treatment protocols. It was also found that the majority of incarcerated-based substance abuse treatment is delivered in a TC or modified TC format such as RDAP. Based on these findings, the proposed delivery of EFT to TAU is through the TC format with follow up aftercare treatment as well. Coincidently, the three progressive phases of a TC program lend themselves well to the three stages and nine steps of EFT.

Owing to the fact that the initial phase within a TC acculturates new attendees to its social milieu created by the existing TC peer members, the staff, and its operative norms, it is during this phase that the De-escalation Stage of EFT could be introduced. The introductory period into the TC can be fraught with anxiety and fear for new members since any change in residential placement within a prison brings with it safety concerns and worries about possible predation from guards and other female inmates (Cuen 2016; Stoller, 2003). Learning to form

secure connections with others rather than reacted with fixed negative appraisals of others offers each partner to opportunity to form a safe haven in the midst of a chaotic place like prison. The secure base found in another individual provides the safety to explore their own presenting concerns in treatment as well as learn to identify the six core emotions of EFT (Johnson, 2017). This is a prime time for inmates to gain experience with basic emotional cues from one another that focus on anger, sadness, surprise, disgust, fear and joy. By becoming familiar with their own actions tendencies surrounding these core emotions they may be better able to make more accurate appraisals of others as well as communicate their own needs (Johnson, 2017).

By combining EFT with this initial phase of acculturating into the TC, women would have the opportunity to address their own and others mis-attunement of emotional cues (Johnson, 2017). The *community as method* approach in the TC allows for peers and facilitators to successfully model the mutual accessibility and responsiveness of attuned relationships. This would serve to provide corrective experiences in relating with others that they lack from their own attachment history. The second TC phase focuses on education regarding substance abuse, changing attitudes regarding criminogenic thinking, identify triggers and behaviors related to initiating substance abuse. This core educational TC phase is an ideal time to address the restructuring interactions that EFT provides in its Stage two. Partners learn to soften rigid interactional styles that developed over time from early attachment injuries. This stage gives inmates a chance to advance interactional development that was delayed in childhood. Refining their skills in interacting that assists them in getting their needs met is fundamental to relationship building, but may serve to get sobriety needs met as well.

Through EFT, inmates would gain experience with what it feels like to be securely

connected to their "TC family" and female partner-if they have one. Comfort, connection, and caring are what creates trustworthy bonds between people (Johnson, 2017). They would learn their behavioral cycle when they experience disconnection and whether they tend to protest, cling, become depressed, or detached in the face of unmet attachment needs. It is during this stage that inmates learn to identify their part in the "attachment dance". Through EFT inmates would have the opportunity to rewrite their internal working model of self by learning the reciprocal bonds of adult engagement and disengagement (Johnson, 2017).

Lastly, in the final stage of the TC program, the inmate prepares for re-entry into society (Graham & Wexler, 1997). During this phase the TC is focused on imbuing right living, abstinence, psychological and prosocial adjustment, and relational regulation (DeLeon, 2015; Freudenberger, 1987). This fits well with the third step of EFT, where the focus is on consolidating issues and practicing emotional balance between people. Through secure attachment bonds each partner in the couple or TC family learns to be less emotionally flooded when there is a disconnection or a partner feels their bond is being threatened. The relational skills of tuning into each other's emotions to ask for their needs to be met, gaining practice in meta-perspective taking, and learning how to receive care to facilitate one's ability to self and co-regulate.

Chapter Summary

The extant substance abuse literature clearly indicates that drug and alcohol dependence is a brain disease induced by chemical changes that alter the structure and function of the brain and behavior (NIDA, 2007; 2012; 2018). Fletcher et al. (2015) cite Menicucci and Wermuth (1989) and Zenali et al's (2011) findings that the drug and alcohol dependency carry with it the

predisposing risk factors of genetic traits, psychiatric history, and the effects of social relationships-such as peer and parental nurturance or lack thereof. Damaging interpersonal relationships, such as those experienced by adult survivors of childhood trauma in the form of sexual and physical abuse, incest, and neglect can influence individuals to self-medicate painful affect associated with unmet childhood attachment needs (Huang et al., 2012; Keyser-Marcus et al, 2015; Khantzian, 2014, 2017; NIDA, 2018).

Khantzian and Albanese (2008) identified that individuals who have been traumatized in childhood are more likely to turn to substances to help themselves withstand or regulate unpleasant affect produced by difficulty in acknowledging, managing, and maintaining a coherent sense of self in relation to their early negative experiences with others. Besides experiencing difficulty in regulating their own behavior, and self-care, they struggled considerably with their ability to initiate and maintain consistent relationships with others that could provide comfort and social support (Khantzian & Albanese, 2008). Brief periods of moderate substance use may temporarily alleviate dissonant self-concept and upsetting emotional states, however excessive long-term use is a pathway to addiction Khantzian, 2012; Tronnier, 2015). The literature concerning the Self-Medication Hypothesis convincingly supports the notion that Attachment Theory offers the potential for risk-factor mitigation in substance abuse treatment (Fletcher et al., 2015; Tronnier, 2015).

Attachment Theory indicates that when individuals, of any age, are close to their attachment figure they are less likely to feel afraid in hopeless situations and can readily demonstrate the ability to share the cognitive load of joint problem solving (Johnson, 2008). It also states that individuals feel distressed when they are separated from their attachment figure,

leading to anxiety, fear, and rigid interactional responses wit close others. It further states the more an individual can effectively depend on another, the more independent and stable that person becomes in facing life stressors (Johnson, 2008).

CHAPTER III

EMOTIONALLY FOCUSED GROUP THERAPY FOR SUBSTANCE ABUSE TREATMENT (EFGT-SA)

Introduction

The third edition of the *Principles of Drug Addiction Treatment: A Research-Based Guide,* put forth by NIDA states that, "no single treatment is appropriate for everyone," (NIDA, 2018, p.3) yet substance abuse treatment is currently dominated by cognitive and behavioral interventions. The purpose of this research study is to include an empirically validated intervention in substance abuse treatment that is specifically designed to address attachment-based factors in drug and alcohol dependence (Fletcher et al.,2015; Tronnier, 2015). The use of Emotionally Focused Therapy adapted for groups, along with the principles of the Self-Medication Hypothesis, and Bowlby's attachment theory, as it relates to the forming of early life experiences and adult attachment across the lifespan, help piece together a framework for a much more comprehensive means to reduce relapse produced by interpersonal mis-attunement. The primary purpose of including EFT and EFFT-based treatment, modified for prison TC substance abuse treatment groups, along with TAU is to provide a greater match in intervention methodology to the incarcerated female substance user's particular attachment-based problems and needs that underlie her drug and alcohol dependency (Brubacher, 2017; Khantzian, 2017; NIDA, 2018; Tronnier, 2015).

The name of the proposed pilot drug and alcohol treatment program is Emotionally Focused Group Therapy for Substance Abuse Treatment (EFGT-SA). The aims of the proposed pilot program give prominence to adult co-regulation and social bonding needs within small groups in accordance with attachment theory (Bowlby, 1969; 1982); provide incarcerated

women with additional tools other than CBT to cope with dysfunctional relational patterns, fear of partner loss, and disconnection from their primary social resources that can lead to loss of abstinence and eventual recidivism (Johnson et al., 2013; Johnson & Brubacher, 2016); provide a two-pronged change process for distress and repair; and addresses strategies for personal patterns of affect dysregulation (Tronnier, 2015). This pilot study is designed to deliver a comprehensive, multifaceted, and multimodal approach to SMH-informed substance abuse treatment programming by combining the Therapeutic Community milieu of substance abuse treatment, that has been used for over 50 years to produce greater ego-strength development through the social interactions between its members, and EFT/EFFT adapted for use with groups (Ross & Auty, 2018).

Theoretical Foundations

There are several theories incorporated in the Emotionally Focused Group Therapy for Substance Abuse Treatment (EFGT-SA) pilot program, beginning with the TC delivery setting, Bowlby's attachment theory, the SMH that informs why substances are used to calm painful affect, and finally EFT/ EFFT that inform the group intervention. The foundation chosen for this correctional facility-based pilot program is the drug-free residential TC model due to the positive social elements in its perspective, approach to treatment, program model, and the treatment process (DeLeon, 2000). Overall, the TC model imparts a corrective counterbalance to the typical prison environment of intimidation, manipulation, and hostility which can lead to or exacerbate existing fear, anger, and frustration; leading to further maladaptive behaviors in "doing one's time" (DeLeon, 2000). EFGT-SA could be delivered outside of a TC, however, the TC provides ample social opportunities for its members to utilize EFGT in its educational groups

and family pods (DeLeon & Wexler, 2009; Johnson, 2017).

Second, the TC's pro-social values of safety and peer-led therapeutic environment in which to address TC use of peer influence to foster positive behavioral, cognitive, and emotional changes that promote right living and recovery (DeLeon, 2000). The hierarchical model is designed to improve personal and social responsibility as its members move through the stages of treatment thereby reducing the effects of *social loafing*, where unmotivated individuals attempt to hide their issues and avoid accountability (DeLeon, 2000; Latané, 1979). Furthermore, all therapeutic and psychoeducational interventions of a TC are intended to raise a client's consciousness of their behaviors and attitudes towards self and the impact they have on others, thus making it an ideal setting and delivery system for attachment-based interventions, such as EFT and EFFT, that emphasize secure attachment and emotional co-regulation with safe others (Fletcher et al., 2015; Johnson, 2019). In addition, the stages of TC treatment, which start its members as novices who progress toward becoming program mentors, are informed by the psychosocial theory of human development which, incidentally for many female inmates, may have been interrupted by trauma and/or the use of drugs and alcohol (DeLeon, 2000). Finally, four fundamental principles of social learning drive all TC operations. The first being that behavior changes are derived from the interplay between an individual, her peers, and the environmental milieu. Secondly, the observation and emulation of role models leads to new beliefs. Thirdly, by observing and modeling after esteemed others. Ultimately, the overarching process of change in a TC is that the community itself operates as the change agent.

The fundamental theory to the EFGT-SA pilot program is attachment theory, however the SMH informs why substances are used to calm painful affect, and are useful introducing the

topic of chemical dependency to group discussion. Substance abuse treatment requires its participants to understand why drugs and alcohol were used as a means to compensate for painful affects and distressing psychological states (McKernan et al., 2015). Khantzian posited that substances may provide some short-term pleasure, however it is their repeated use as a means of reducing unpleasant affect that leads to addiction (Tronnier, 2015). The two principles of the SMH serve as topics to be addressed in EFGT-SA interventions. The first states that drugs and alcohol become addicting due to their ability to mitigate one's psychological suffering, while the second principle posits that an individual's DOC is specific as to the psychological and physiological effects it produces in the user (McKernan et al., 2015). For example, group members can be asked to discuss how stimulant drugs boost mood, self-esteem, confidence, and provide an energizing effect when feeling depressed (Khantzian, 1977, 1974; Ruglass, 2014). Or how heroin or alcohol's sedative properties may be chosen to dampen feelings of fear, anxiousness, and loneliness (Khantzian, 1977, 1974; Ruglass, 2014).

Theoretical Underpinnings of Attachment Theory

The theoretical underpinnings of the EFGT-SA pilot program are rooted in attachment Theory. Central to Bowlby's Attachment Theory are ten foundational tenants. First, that attachment is an intrinsically motivating force, amongst all human beings, across the entire life span People of all ages seek and maintain interpersonal contact with their significant others and close family relationships in natural, and healthy co-dependent relationships (Bowlby, 1988). Second, autonomy is achieved through the security of co-regulatory dependency (Woolley, 2007). Third, attachment figures such as spouses, parents, caregivers, partners, provide the safety and comfort necessary to feel a sense of security in the world. Security provides an essential

safeguard against life's stressors and uncertainty and is referred to as a safe haven (Johnson, 2004; Woolley, 2007). The forth underpinning of attachment is the development of a secure base from which to explore the world; without it human beings are less likely to risk exploring themselves and their world (Johnson, 2004; Woolley, 2007). Fifth, accessibility and responsiveness are needed to build secure bonds. Sixth, attachment needs are intrinsically activated by feelings of fear and uncertainty, and compel comfort and attachment seeking behaviors (Johnson, 2004; Woolley, 2007).

Attachment theory provides a basis for understanding adult attachment patterns as they relate to interactions between the self and others (Fraley, 2019) The seventh underpinning of attachment is that separation distress is a predictable human pattern. Work by Fraley and Shaver (1998) indicate that infant-caregiver relationships translate directly to adult romantic relationships and, despite some exceptions, function similarly. The infant and parent separations recorded in Ainsworth's strange situation have been likewise observed in naturalistic research conducted by Fraley and Shaver of adults' airport separations. The eighth tenant postulates that when seeking behaviors do not elicit the comfort of the loved one, protest behaviors will be evidenced fairly quickly. Repeated unsuccessful bids for reconnection result in one of two responses: anxiety or avoidance (Fraley & Waller, 1998; Johnson, 2004). Finally, models of self are central whether individuals view themselves as being worthy of loving attachment, and being responded to in a timely manner. Moreover, the belief that one is worthy of such care is formed, maintained, and changed by emotional interaction and communication in partner or parent-child attachment relationships (Fraley & Waller, 1998; Johnson, 2004). Moreover, the problematic dynamics seen in couples and child-parent relationships is viewed as a learned response to

previous and current threats to secure attachment and bonding with one another (Fraley, 2019).

Assumptions of the EFGT-SA Pilot Program

The Assumptions of the EFGT-SA pilot program are formulated using a combination of the assumptions that are key to EFT for both couples and families. EFT for couples operates from 10 basic postulates, while EFFT utilizes three. Central to both EFT and EFFT is the belief that conflict can be viewed as attachment dilemmas resulting from the distress of separation or unmet human bonding needs (Johnson, 2004; 2019). These relationship difficulties continue to be maintained by inflexible negative interaction patterns that are indicative of felt fear and give rise to all-encompassing and highly absorbing states of grief, anger, and fear (Johnson, Maddeaux, Blouin, 1998). Thus, the key assumptions are as follows: One, a secure attachment bond is built by becoming accessible and responsive to a partner or a child; Two, emotions are the target and agent for change; Three, emotional responses frequently lead to adaptive behaviors; Four, negative emotions are exhibited as either primary or secondary emotions, thus the aim of the program is to access the deeper primary emotions such as sadness, hurt, fear, shame, and loneliness, and minimize the more reactive secondary emotions. These are typically displayed as fear, anger, jealousy, resentment, and frustration and create a tendency to push loved ones away; Five, Individuals, whether in dyads or triads, get caught up in negative repetitious cycles of interaction when secondary emotions rather than primary emotions are expressed or displayed; Six, a circular pattern of negative interaction cycles ensues that begets insecure attachment, which leads to another negative interaction; Seven, rigid interactions reflect and produce negative emotional states and these produce more rigid interactions; Eight, the pattern in which individuals find themselves in does not represent a pathology or a

developmental delay, but an adaptive response in which they are coping the best they can in the moment, using their current psychological resources; Nine, although expression of attachment needs maybe cultural bound, defined. They are a universal human need; Ten, new relational experiences are what produce lasting change in relationships, and EFT-based therapeutic intervention provides these change events in a secure and loving frame (Johnson, 2004; 2019; Keiley, 2011).

Conceptualization of the Process of Change

Johnson (2019) indicated that there is a dearth of research examining change in attachment security between couples and families, but asserts that the interactions inherent to the EFT and EFFT interventions provide the most salient positive alterations to attachment and security. The process of change within the pilot EFGT-SA program is conceptualized through an attachment lens informed by the EFT model. Group members are taught to attend to and identify one another's emotions. Through validating the expressed emotion of a group member, they are collectively able to help one another feel understood, thus meeting an essential human need to be heard and received emotionally by those in our inner circle.

Change is produced in EFT for couples is conceptualized as occurring through the deepening of engagement with emotions and the creation of organizing and associative bonding interactions with the partner, (Johnson, 2019). It is the change events in therapy that allow partners to reach out safely and emotionally to their loved one to be received empathically (Johnson, 2008). In EFT for individuals, therapists focus on integrating disparate parts of self to improve self-concept and emotional reactivity that distances adult attachment (Johnson, 2019). The conceptualization of the process of change in EFFT is slightly different in that it is less

focused on the creation of mutually accessible and responsive engagement between romantic partners as it is in helping parents recognize their child's vulnerabilities in order to prime parents to attune to the attachment needs of their child (Johnson, 2019; Palmer & Efron, 2007). Overall, the process of change in all branches of EFT is directed towards facilitating safe connection with self and others (Johnson, 2019).

Rationale for the Pilot Program

Human beings are predisposed to socially interact with one another, making group therapy an efficacious therapeutic tool for growth and change in treating drug and alcohol dependence (CSAT, 2005b; Sugarman et al., 2016). Group substance abuse treatment has been found effective in reducing isolation, providing mentors in members who are further along in their recovery, and in providing a cohesive recovery atmosphere where similar goals are being exercised in community. Furthermore, substance abuse treatment groups are especially suitable for treating the common psychological symptoms of depression, isolation, and shame that often accompany substance abuse (CSAT, 2005b; Sugarman et al., 2016). The corrective experiential nature of the EFT-based pilot is designed to help female inmates overcome poor childhood attachment histories in an effort to reduce dissonance when re-entering partner and parent-child relationships following incarceration (Glaze & Maruschak, 2009; Lynch et al, 2012).

EFT for couples and families, like attachment theory, has been found to simultaneously focus on the integration of the self and the system to which the self belongs (Johnson, 2019). The interventions within the three stages of couples or family-based EFT provide moment-to-moment transactional emotional reconstruction within and between those involved in the therapy (Johnson, 2019).

Unfortunately, therapy and substance abuse treatment in the judicial system is constrained by the limit of taxpayer funding for such programs making individual therapy time-consuming and costly, therefore it makes financial sense to offer a group-based pilot program. A substantially more important reason to produce a group-therapy based pilot program is its therapeutic factors. Yalom and Leszcz (2005) identified 11 essential therapeutic factors in group therapy which are particularly salient for group substance abuse treatment. A history of substance dependency coupled with incarceration can be overwhelming. Group therapy blended with the TC model, in which treatment providers have achieved sobriety or have become peer mentors due to their successful movement through the treatment program, is beneficial in the installation of hope that clients can get better, and achieve renewed personal connections that are useful in maintaining sobriety (Ashley et al., 2003; CSAT, 2005a; Yalom & Leszcz, 2005).

Group treatment provides a modality to impart psychoeducation about attachment needs across the lifespan as well as substance abuse. Furthermore, information of a personal nature shared between group members can help share the burden of similar struggles, motivate or give others the courage to change. An important aspect of group therapy and the TC treatment setting is that members learn to exhibit altruism by helping others through the process (Yalom & Leszcz, 2005). The corrective process of EFT's couples and family therapy is that is provides new ways to connect emotionally that were previously lacking (Johnson, 2019). Yalom (2005) states that the corrective recapitulation of the primary family group occurs consciously and unconsciously in group therapy, thus naturally complementing the substitute family of the TC and the "prison-families" inmates create for themselves (Bowker, 1999; Kreager et al., 2015).

Group therapy for substance users can be useful in the development of socializing

techniques since people tends to isolate from social contact over time when using drugs and alcohol. Engaging in meaningful ways and maintaining good boundaries are social skills that group therapy can take advantage of. Yalom's therapeutic factor of imitating behaviors is a modeling tools group members can utilize in learning how to manage painful affect. More experienced members have the opportunity to demonstrate to new members how to move away from rigid and dysfunctional behavioral patterns and negative interpersonal interactions. Groups provide a format for interpersonal learning. For women with substance abuse and trauma histories this may be one of few times in their lives they can experience honest communication with a group of people who have the ability to provide respectful and honest feedback (James & Glaze, 2006; Keyser-Marcus et al, 2015; Lynch et al., 2012).

Yalom's (2005) group cohesiveness factor allows for group members to feel that they are valued by the other members of the group and that the relationships they form within the group are meaningful. This aspect of group therapy will be important in helping group members to feel safe enough to self-disclose and risk being vulnerable in order to access personal growth and change. Another important group factor identified by Yalom (2005) is catharsis. Group-based interaction can provide its members with insight to problem solving as they listen to how others have dealt with similar problems. This insight may produce a release of strong emotions that serve to help the individual reconnect with parts of self and others that have not been previously accessible. Issues surrounding the existential factor of death or losses in life may be particularly pertinent to those with trauma and substance abuse histories. Group membership can aid in discussions of existential issues by providing a secure base and sense of community from which to explore difficult life concerns.

Need for the Program

The protracted and relapsitive nature of substance use disorders throughout the lifespan suggest that an adequate treatment response has yet to be developed that adequately addresses the root causes of drug and alcohol dependence (Fletcher et al., 2015). Review of the extant literature regarding incarcerated women indicates they more likely than their male counterparts to report being victims of sexual abuse, physical abuse, and intimate partner violence (James & Glaze, 2006; Lynch et al., 2012). In fact, 82 percent of female inmates reported having been seriously abused physically and sexually as children and about thirty percent of their perpetrators were their own family members of family (Glaze & Maruschak, 2009; U.S. Department of Justice, 2014a; 2014b). Empirical research demonstrate that early attachment wounds leave individuals vulnerable to chemical dependency, interpersonal victimization, childhood sexual abuse, including incest, and intimate partner violence as adults (Dow, 2011; Dykstra, Schumacher, Mota, & Coffey, 2015; Huang et al., 2012; SAMHSA, 2017; Vanderplasschen et al., 2013).

The EFGT-SA pilot program is designed to address a gap in the literature, and in the treatment of substance dependency for women with childhood trauma histories. It is well-known that prison-based substance abuse treatment does not fully address the need for corrective emotional experiences since the prevailing substance abuse treatment is behavioral or cognitive in nature (Fletcher et al., 2015; Huang et al., 2012; NIDA, 2018) It stands to reason that the inclusion of a program designed to produce secure attachment in female inmates with child abuse and substance abuse histories with treatment as usual has the potential to facilitate sobriety and prevent recidivism (Downs et al, 2015; Fletcher et al., 2015; Tronnier, 2015).

Program Fundamentals

Substance abuse treatment designed specifically for women is largely focused on providing medical care for pregnant woman more than education, group, couples, or family therapy, yet according to the American College of Obstetricians and Gynecologists, only 6 to 10 percent of women entering the criminal justice system are pregnant (ACOG, 2011). A meta-analysis of 38 studies performed by Ashley et al, (2003) found that treatment modalities tailored towards the special needs of women should encompass a nurturative, therapeutic, and supportive, group environment that emphasizes positive self-concept, and treatment that addresses the multiple roles of mother, daughter, intimate partner, and friend in a woman's life. Stohr et al.'s (2001) studies of residential treatment for state prisoners found that blended treatment models in prison-based treatment in which different approaches to substance abuse treatment have been mixed or blended together have also been proven effective for prison populations.

Structure of the EFGT-SA Program

As previously established**,** the setting of the EFGT-SA program is a prison-based TC, therefore, the overall structure of the EFGT-SA program follows the TC model of inmates progressing through three to four phases of substance abuse treatment supported by peer mentorship in community involvement and prosocial activities (DeLeon, 2000; DeLeon & Wexler, 2009; Melnick & DeLeon, 1999). Within this setting, EFT adapted for group substance abuse treatment, will be utilized to provide the unique intervention of providing corrective emotional experiences as they apply to self-medication behaviors and thinking. EFGT-SA is designed to closely follow the EFFT treatment model, in which a therapist or facilitator guides four or more individuals through the stages and steps of EFT-based treatment.

Structure of the Intervention/ Program

A hypothetical scenario has been designed to illustrate how the EFGT-SA program would function, based in part, on the EFFT work of Keiley (2011). The hypothetical intervention illustrates the basic structure of the EFGT-SA intervention from client engagement, assessment and diagnosis, reframing of the interactional cycles, producing change, producing emotional engagement, and termination of therapy. The proposed EFGT-SA intervention takes place between four members of a family pod in a TC whose members are, "Carla," "Jenni," "Lisa," and "Magdalena." None of these people are actual participants of the Ke Alaula program I worked at, but represent the typical substance abuse treatment client in the program. Carla represents the senior member of the pod, who will be graduating from the program shortly, followed by Magdalena, who has completed Phase Two to the TC program. Lisa represents a client who has completed Phase One, and Jenni represents a client has just completed the Orientation Phase. The pod has been faced with a group "pull up" because their newest member, Jenni, has been caught stealing food from the dining hall for the second time and may be expelled from the program for rule violations and misconduct. Group members are angry with her that her behavior reflects badly on their family pod and puts all members in jeopardy of facing consequences for poor pod performance in comparison to other family pods who do not have a member who has acted in a non-prosocial manner. What follows is a sample depiction of the EFGT-SA intervention in action from when the family pod meets with the EFGT-SA therapist for the first time until treatment termination.

The initial goal in EFGT-SA engagement is for the therapist to actively create a therapeutic alliance with all parties in the therapy room. In this vein, the therapist would strive to

form a relationship with Carla, Jenni, Lisa, and Magdalena in which each woman feels the therapist is warm, empathic, emotionally receptive, and is understanding of each pod member's *felt* experience of their joint situation and feelings about it (Keiley, 2011). The intervention that occurs at this point is to join with each participant through the newly formed therapeutic alliance to explore each member's experience of the problem they are communally facing. Keiley (2011) indicates that it is important that therapist reflect to herself what it would be like to be each woman in the pod, how it might feel to be living in the circumstances each member finds herself, and what one would feel, do, and think as a result.

The job of the EFGT-SA therapist during client engagement is to validate, normalize and reflect each members' responses with regards to their presenting affect, behavior, and cognitions in order to help the group and its individual members fell entitled to their emotional experience and responses in a non-pathologizing manner (Keiley, 2011). In reflecting the affect, behavior, and cognitions of the group members, the therapist would also admit any error in her interpretations of those experiences as a means of demonstrating authenticity, genuineness, and continued empathy. The presenting problem is then co-defined by the group members and their therapist, once the therapist has heard from each member what they believe the presenting problem to be and how that is affecting her and the group as a whole. For example, the presenting problem for this family pod might be stated as: "Our pod is receiving a demerit because Jenni stole food from the dining room and we are angry that her behavior is negatively affecting all of us." The therapist focuses not on the content of the discussion, but on the process of the interactions between the group members in the room. The therapist begins to reframe interactional cycles in the very first session by reframing each member's experience from an

attachment perspective, while noting important pivotal past events (Keiley, 2011).

> *Therapist:* Carla, you were saying that you feel frustrated that you have given Jenni multiple chances to change her behavior, but you feel that she lets you and the pod down by continuing to act selfishly and without regard for the consequences that befall all of you when one person gets out of line. You are likely wondering to yourself why you have given her so many chances, and you likely feel angry at her and somewhat disappointed in yourself for not following the protocol in reporting her behavior, is that right?
> *Carla:* Yes, I am responsible for the pod, so ultimately her actions reflect on my ability to lead us so I'm really irritated at myself that I let her take advantage of my good intentions by giving her extra chances.
> *Lisa:* When I first came to prison, I was hungry too, but I found ways to take my mind off of it, instead of stealing. Nobody likes taking the rap for someone else's mess up!
> *Therapist:* I'm glad you mentioned that Lisa, let me work with each of you one at a time, so I can get a clear idea of what's happening here then I'll come back to you, okay?
> *Lisa:* Okay.
> *Jenni:* I'm always in trouble! You guys are always downing me and expecting me to be perfect. I tried to tell you all I was still hungry.
> *Therapist:* Jenni, I see you are frustrated that you are still hungry at times, and perhaps your feelings are a little hurt that when you communicated this to your pod mates they didn't respond the way you felt they ought to, is that how it is for you?
> *Jenni:* Yeah, I kind of expected them to have my back in here, but they are just like my step-father, always saying he is going to help, but then he never comes through for me.
> *Therapist:* It sounds like you are saying that you wanted to count on Carla, Lisa, and Magdalena to provide for you, but your feelings are hurt because this reminds you of a time when your step-father promised to help you with something in the past but didn't come through as you anticipated, do I have that right, Jenni?
> *Jenni:* (looks at the floor) Yes, but it wasn't just one time. He always made false promises.
> *Magdalena:* I'm so angry you put us in jeopardy by stealing food, Jenni! (sighs) If you get hungry between meal you need to buy snacks from the Prison Canteen, I told you this before. You have to follow the rules, just like we do!
> *Therapist:* Magdalena, I understand you, Lisa, and Carla are mad that Jenni did not exhibit the expected prosocial behavior in the TC. This must be particularly upsetting for you all when you have been following program rules. Let's see if we can't work together to help each one of you, and the pod as a whole, to come to terms with this issue. How does that sound?

By the end of this and subsequent sessions, each member should feel accepted by the therapist, that the group is a safe place to emote, and experience a sense of hope that the therapist will be able to help. The therapist begins to have an idea what the problem is, the group

members' interactional styles and the attachment positions held by the members (Keiley, 2011). During the assessment and diagnosis step, the therapist's goal is to track and reflect the cycles of interaction between and within the members by continuing to identify the process of the interactions with regard to affect and attachment behaviors such as pursuing or withdrawing. The therapist assembles this information as a whole from observation, the members' descriptions, and subsequently reflects the groups' interactional process back to them (Keiley, 2011).

> *Therapist:* I understand, Jenni, that when Carla barked at you to shape up, you just shut her out because it hurt you to hear so much disappointment in her voice, especially because she is a peer mentor who is really important to you. (Turns to Carla) So, when Jenni blocked you out, Carla, you berated her further because it appeared that she was rejecting your mentorship and guidance, and you didn't want her to do that to you. You really wanted her to listen and heed your instructions and warnings.
> *Carla:* I just wanted to help her to do what is right and expected for herself, the pod and as a TC member. I didn't mean to come off all bossy, like I'm so perfect.
> *Therapist:* So, it's not that you're perfect, you really care for Jenni as well as the rest of your pod and want everyone to succeed by helping in the way you know how to.
> *Jenni:* I just feel like I'm always the one in the pod getting things wrong. I get so defeated.
> *Therapist:* Carla, when you hear that Jenni feels like she's always getting things wrong, how does that make you feel?
> *Carla:* I feel sad that she becomes defeated. That isn't what I wanted at all. I was trying to help her follow the rules by reminding her.
> *Therapist:* So, you feel saddened Carla, when your reminders have the opposite effect and she turns away from you. You feel sad that you lost your connection with Jenni. It saddens you because you really wanted to help her because you care about her.
> *Carla:* Yup, that's it. I didn't intend to turn her off or push her away.

At the end of this session, the pod members will have achieved an expanded view of what the issue is between them and be able to begin to acknowledge how their interactions can contribute to the interpersonal difficulties they are experiencing. The end goal is for the members to feel safer than when the session began, feel more comfortable and accepted by the therapist (Keiley, 2011). The next session involves the reframing of interactional cycles between the members, while accessing the vulnerable feelings of the pod members that may have gone

unacknowledged within the context of the defensive emotional experiences that maintain the cycle (Keiley, 2011). Emotions such as fear, sadness, hurt, or shame are not often overtly expressed in conversational interactions with others, while anger is more likely to be displayed in the face of unmet attachment needs (Johnson et al., 2005; Keiley, 2011).

When anger is expressed towards others, their emotionality is typically responded to in one of two ways, sullen silence and physical or emotional withdrawal, or a similarly angry reaction indicative of the individual's attachment positions (Jorgenson, 2017; Keiley, 2011). Neither response will bring closure to the discussion or produce proximity seeking behaviors in either party. In fact, the negative interactional cycle tends to escalate, leading to greater distress in both parties as feelings of vulnerability are triggered by greater physical and emotional separation from those one is attached to (Jorgenson, 2017; Keiley, 2011). Feelings of fear of abandonment, anger at rejection, sadness, and panic may arise for the party whose anger causes others to withdraw and become silent. Feelings of intimidation, anger, and unworthiness may surface for those who withdraw in the face of angry outbursts (Jorgenson, 2017; Keiley, 2011). Withdrawers may begin to feel afraid that no matter how they respond, it will be received positively and they are likely to be viewed as incompetent, leading to a sense of hopelessness or helplessness (Keiley, 2011). The therapist's role is to reframe the communication in order for the group members to access their vulnerable feelings that they are hiding from the others through defensive behaviors, thus bringing them to the forefront in the therapeutic dialogue (Keiley, 2011).

It is fundamental that the therapist utilize the EFT interventions of accessing vulnerable feelings by bringing the participants' focus to the emotional experiences in the moment (Johnson

et al., 2005; Jorgenson, 2017. The emotional experience is expanded upon, and reprocessed through the use of EFT interventions such as validation, the heightening of emotions, evocative responding, and empathic speculation (Johnson et al., 2005). Validation serves to keep the client from blaming themselves (Johnson, 2002; Johnson et al., 2005; Keiley, 2011). The heightening of emotions can be accomplished with the use of four mechanisms, which are to repeat a client's particular phrase to heighten its impact; maintain a consistent focus on each client's vulnerable emotional responses while blocking attempts to change the topic, exit the conversation, or vent at other group members; use of metaphors or images by the therapist to delineate the members' felt experience; and heightening physical reactions such a catch in the throat or sinking feeling in the pit of one's stomach (Jorgenson, 2017; Keiley, 2011).

> *Jenni:* I feel like shrinking into nothingness when I see the expression on their faces. They know I messed up. They look so disappointed in me, that I will never amount to anything.
> *Therapist:* Jenni, the look on your face tells me that you are hurt, and you see the disappointment of the others and you shrink inside, not wanting to let them down, but knowing that you have. You shrink down inside yourself trying to hide away from the disappointment. Can you tell Carla, Magdalena, and Lisa how scared you are of disappointing them?

The use of empathic speculation or inference as an intervention involves the therapist inferring what the client's state and experience is in the moment based upon, above all, the therapist's ability to empathize with the group, her keen knowledge of each person's attachment patterns, as well as her ability to make use of the contextual, interactional, and nonverbal cues present in the session (Johnson et al., 2005; Keiley, 2011). The therapist can utilize inferences when the client is using defensive strategies as a way to elicit understanding of attachment-based fears. The therapist should take care not to make inferences in a confident manner or too far in

front of the client's own understanding of their own felt sense, but conjecturing tentatively about the leading edge of the client's emotions (Jorgenson, 2017; Keiley, 2011).

With evocative responding, the therapist focuses on the emergent experience of the client, through sensate reactions, or the conflicting components of a response. Repeating the client's own words back may help the client hear what they have said and either correct or acknowledge their understanding of their own emotional experience.

> *Lisa and Magdalena:* (crying) We are going to cut ties. You keep doing this. This is too much to bear for us. We hate watching you hurt yourself and drag good people down with you! You are replacing drugs with food to feel good! We tried to save the friendship, but for what?
> *Jenni:* (draws knees up to her chest and wraps her arms around her legs, hiding her face in her lap) I never wanted to hurt you guys. I don't want to lose you.
> *Therapist*: Ladies, I hear you saying that you believe Jenni's behavior is another form of addictive behavior that she is using to cope, and that if you help her then you would be enabling her. You have all tried ways to help her, to face the possibility of consequences and head them off, but now you must also make safe choices for yourselves that involve enforcing boundaries. You were afraid of losing her friendship if you reported her, but you're willing to lose your friendship if it ultimately saves her through tough love, is that right? (turning to Jenni) I can see by your body posture that you are feeling afraid. You're so afraid of losing them. Is it that you want to hide from them, hide from feeling ashamed, and lost without their support?

These interventions would be utilized for multiple sessions as the therapist works with each member of the group to reframe their individual and shared experiences. The reframing of the within and between emotional experience can initially lead clients to feel anxious as they anticipate being received as unlovable to self and others, but is ultimately freeing and cathartic if a secure base has been provided by the therapist (Johnson et al., 2005; Keiley, 2011). It is here at this point that the client is finally able to come to an understanding of their own emotions and begin to process how they contribute to the cycles within their relationships. This new understanding serves to embolden the client with a sense of self-efficacy that they have to

personal power to change their interpersonal patterns (Johnson et al., 2005; Jorgenson, 2017; Keiley, 2011).

Reframing also serves to allow each group member's attachment wounds to surface and attachment needs and longings to emerge, where they can be elucidated and clarified (Johnson et al., 2005; Jorgenson, 2017; Keiley, 2011). It is important to note that the corrective change of being received despite being vulnerable will likely not remain a permanent change if this is not experienced in a heighten emotional state in session (Keiley, 2011). The subsequent change events the therapist choreographs in the next stage of therapy is equally important. Here, the therapist works to keep group members actively engaged without resorting to old patterns of behaviors. In other words, the therapist keeps those who typically blame or become critical of others from going on the attack, and for those whose pattern is to withdraw or emotionally shutdown in the face of angry interpersonal interactions remain actively engaged (Johnson et al., 2005; Jorgenson, 2017; Keiley, 2011). The therapist assists the group members in expressing their vulnerability and attachment needs directly to needed others. As positive interpersonal interactions develop members gain confidence in their ability to properly express their attachment needs and have them received by the significant others in their lives.

> *Therapist*: Jenni, can you turn to your pod mates and tell them what you just told me? Can you say to them –I become so distraught that I let you all down. I get scared that you won't care about me anymore, just like my step-father did, so I shut down and avoid you. I don't have to face your disappointed reaction when I shut you out. I don't have to acknowledge my embarrassment and shame for my failings.
> *Jenni*: (hides her face in her hands) Oh my gosh, that's so hard to say looking in their faces. I can't do it! It feels like I will be swallowed up if I say it. They will see I'm soft and not the tough girl I try to be.
> *Therapist*: Of course, you're afraid, you've been rejected and hurt in the past. You aren't used to saying what you really feel to others you care about because you're afraid you will see their disapproval and disappointment. Pushing others away first has been an easy

defense mechanism to stop the pain before it starts, and it has been going on for so long, hasn't it? Perhaps you wonder if anyone ever really cared for you? You ask yourself why anyone would care about you when you've been drinking, drugging, and stealing for years, is that right?
Carla: It's okay, Jenni, you can say it.
Jenni: I'm afraid they don't mean it, that they'll turn on me once I admit it to them.
Therapist: They are here for you. Can you tell, Lisa, and Magdalena, and Carla how scared you are that you'll be rejected and how frightening it is to take that chance?
Jenni: I'll get hurt, I just know it.
Lisa: I'm not going to hurt you and neither are Carla and Magdalena. We want to help you. We've been trying to help you all this time, but you've been closed to our help.
Therapist: Ladies, do you hear what Jenni is saying? What do you feel in your bodies when she says she's afraid to trust you won't hurt her?
Magdalena: Yes, I hear her. My heart hurts that she is scared.
Lisa: My body aches that she's so sad.
Therapist: Your heart hurts (nods to Magdalena) and your body aches (looking at Lisa) Of course that is happening for you, your pod mate is feeling afraid to be rejected. Can you tell Jenni that?
Carla: I can say it for all of us.
Therapist: Jenni, do you hear Carla saying she speaks for all of your pod mates? That they won't reject you and they feel your pain? How do you feel about that?
Jenni: Yes. I feel a little bit hopeful.

It is at this stage that each member of the pod can view the others differently, and new, more authentic interactions a beginning to form. Our hypothetical client, Jenni, who would normally withdraw physically and emotionally is engaging with her peers and is able to stay in the moment with her discomfort in her own fears and vulnerability, while relaying them to the therapist and the others. More critical members, like Lisa, are able to soften and acknowledge the attachment needs they have of wanting to help and re-connect.

The next step is to continue the emotional engagement that was just established with group members in subsequent sessions. The primary goal, moving forward, is to emphasize the development of new solutions to old interpersonal difficulties (Keiley, 2011). The therapist's role is less directive now that group members have learned to relate with self and others in a deeper more authentic way (Keiley, 2011). The therapist utilizes redirection, and encouragement and

support as interventions to facilitate continual progress towards attachment bonding, and interrupting old cycle patterns as they occur with the goal of facilitating deeper connections (Johnson et al., 2005; Keiley, 2011).

> *Therapist*: I can see the shift in your relationships now. You are all interacting with each other in a constructive and positive way now, even when you talk about tough topics like drinking and drugging. I hear you telling each other what you're thinking rather than keeping it bottled inside you and stonewalling each other. (turning to Jenni) I see that you are able to listen to Carla without hiding your face because you're ashamed of yourself. This is a big step forward for you!
> *Carla:* (grins) I feel closer to Jenni, Bu I also feel closer to Lisa now because I see how much she had to change her hard stance on Jenni's behavior. She wanted to kick her out of the group, but once she realized how afraid Jenni was to do the right thing her heart melted for her.
> *Magdalena:* Yes, I see that too. My heart feels like it expanded when we were able to let go of our hard edges and be kinder with each other. We needed to understand where each other was coming from.

Finally, therapy comes to a close after eight to twenty sessions. The therapist focuses on consolidating the changes that have been established of the course of treatment through encouragement and support. She also helps the group members reflect on process and how they fell about it. Group members would be encouraged to discuss their feeling about the changes they have been through individually and as a member of the group. An aftercare plan for each individual should also be discussed before terminating treatment. Members should leave therapy understanding that they can expect to feel disconnected from themselves and people that they are close to at times, but that there are ways to re-establish bonds with self and others (Keiley, 2011).

> *Therapist*: It is normal that once you are furloughed and moving on with your lives, you may feel less positive about each other than you do right now. You could even feel as though you have lost the bond you three have worked so hard to nurture and grow. If this were to happen in the future, what are some things you could do if this happens to you?
> *Carla:* We could come back for more counseling.
> *Therapist:* That is a possibility, although all of you have learned how to mend attachment wounds and build relationships through the hard work we have done together. What else could you try?

Jenni: I probably need to remember what it felt like when I was so afraid to face my fears.
Lisa: I'm going to try to remember not to yell at people that I want to connect with so that I don't end up pushing them away again with my angry attitude. I will have to take a calming breath and lower my voice before I approach my loved ones.
Therapist: Yes, that's right! You are all ready to do this your own.

The result of the structure of the EFGT-SA pilot program should produce greater relational flexibility within and between the participants. Pilot program participants should be able to take risks in becoming vulnerable with one another and with themselves. Participants in the pilot program should have learned how to be responsive to others, allowing themselves to become emotionally receptive, along with supporting emotional receptivity among others in the program (Keiley, 2011). A palpable sense of connectedness and attachment with others should be the end product of therapy. Participants should be able to report a decrease in negative self-concept and interactional cycles with others that would previously have led to the desire to self-medicate with substances (Keily, 2011).

Topics Covered

In addition to the EFGT-SA intervention the topics covered in the TC curriculum would be typical of those covered in any substance abuse treatment program. For example, triggers to drug and alcohol use, perceptions about substance abuse, the history of drug use and the legality of certain substances, relapse prevention, parenting, family concepts, trauma and grief recovery for adult women, self-care, and Seeking Safety. Topics specific to the EFGT aspect of the program would cover psychoeducation relevant to Mary Ainsworth's Strange Situation (Ainsworth & Wittig, 1969) and Bowlby's (1973, 1979) Attachment Theory as it pertains to the lifespan. Pilot participants would benefit from psychoeducation as to how to heal attachment wounds and build better attachment bonds in partnered and family relationships (Johnson, 2008).

Appropriate Membership of Intervention/ Program

The proposed EFGT-SA pilot program is intended for use by medium to minimum security risk post-sentenced non-pregnant female inmates with histories of drug and alcohol dependency and childhood abuse or neglect. EFT for couples and families is a non-pathologizing treatment modality and is appropriate for those who suffer from anxiety or depression, particularly if it stems from traumatic experiences (Johnson, 2019). It follows that EFT for groups would accept similar clients to its program. For obvious safety reasons, inclusion of inmates needing detoxification services, or who have certain physical disabilities, significant medical conditions or debilitating diseases that pose a risk to self and others such as tuberculosis, hepatitis, and HIV/AIDS; or who are pregnant may not be suitable for inclusion (CSAT, 2005). Offenders may be admitted to the pilot program at the discretion of the prison facility and its administrator. Of the aforementioned individuals, the program is best suited for women who are not antisocial, psychotic, violent, or still using drugs and alcohol (CSAT, 2005; Johnson, 2004, Johnson et al., 1998). EFT has been successfully used to treat depression, chronic illness, and anxiety, therefore individuals that exhibit theses comorbidities may also be included (Johnson & Greenman, 2006).

For Whom the Program is Best Suited

The EFGT-SA program is best suited for women who report and have histories of co-occurring histories of early trauma and victimization, specifically childhood victims of sexual abuse, physical abuse, or neglect that were perpetrated on them by members of their family (Ashley, 2003; Glaze & Maruschak, 2009; Keyser-Marcus et al, 2015; U.S. Department of Justice, 2014a; 2014b). Appropriate participants are also women who were pushed into

substance use by their partner as adults, and were subjected to intimate partner violence (Ashley, Marsden, & Brady, 2003; James & Glaze, 2006; Lynch et al., 2012). Women who identify as lesbian or as sex workers that also meet criteria for substance abuse treatment would also be appropriate for the program do to their vulnerable status (Ashley et al., 2003).

Screening Process

Thorough and comprehensive screening and assessment are fundamental to successfully matching individuals with the appropriate treatment that addresses the close relationship and key contribution between prior sexual or physical abuse and substance abuse. Screening guidelines for prison substance abuse treatment programs have been established to screen for eligibility to receive treatment; suitability for the program; assess the scope of offenders' treatment needs, safeguard against releasing criminal justice detainees in to the community without having received appropriate treatment; and to screen for comorbid mental health issues or special needs that may preclude placement in a treatment program (CSAT, 2005). It is common practice in the criminal justice system for screening instruments to cover substance use history, motivation and desire for treatment, the severity and frequency of use (CSAT, 2005). Screening also covers the inmates' criminal involvement, general and mental health issues, and any special considerations such as literacy level, language barriers, physical or developmental disabilities, and history of trauma or abuse (CSAT, 2005). Criminal justice suitability is also considered, such as custody level classification and time left to serve (CSAT, 2005).

A typical all-encompassing screener utilized by the prison system is the Addiction Severity Index (ASI) developed by McLellan et al. (1980, 1992). The ASI, as a NIDA supported instrument that has been validated for use with adult criminal justice offenders, is used

frequently for the screening, assessment, and treatment planning of adult offenders (CSAT, 2005; McLellan et al. 1985, 1992; Peters et al. 2000). Important to the EFGT-SA pilot program is that the ASI measures a number of diverse aspects of psychosocial functioning as it relates to substance abuse. This instrument is able to provide treatment providers with accurate estimates of the inmate's history and recent use of substances of abuse. This instrument should only be administered and scored by a qualified substance abuse counselor (CSAT, 2005).

Dow (2011) and Dykstra et al. (2015) found that women who enter incarceration are often positive for histories of mental health problems such as anxiety, depression, and Posttraumatic Stress Disorder (PTSD) therefore identifying these disorders along with severe antisocial and psychotic disorders are fundamental to screening for the EFGT-SA program. Antisocial and psychotic disorders are strong predictors of treatment suitability and completion ability and are an important factor in the screening process. The Minnesota Multiphasic Personality Inventory, second edition, revised format (MMPI-2-RF) (Ben-Porath & Tellegen, 2008) is often used in correctional settings in order to correctly classify or assign inmates to housing units or prison programming based on findings of psychopathology (CSAT, 2005).

Due to the identified gender-based risk factor for female criminal justice system detainees of early trauma and victimization histories is it important to include screening for trauma (CSAT, 2005; Dow, 2011; Dykstra et al., 2015; Keyser-Marcus et al, 2015). Unfortunately, screening for sexual and physical abuse is not prevalent within the criminal justice system despite the need (CSAT, 2005). The purpose of trauma screening for the EFGT-SA pilot program is two-fold. First, a positive trauma screen serves to indicate that the inmate meets inclusion criteria for this

program, and secondly it provides useful information regarding the extent of the trauma in order to plan for needed treatment supports that address lack of engagement in program due to psychological issues related to traumatic experiences. Appropriate trauma screening can be accomplished with any number of the following instruments: Bernstein and Putnam's (1986) Dissociative Experiences Scale (DES); Blake et al.'s (1998) Clinician Administered PTSD Scale (CAPS); Briere's (1995) Trauma Symptom Inventory (TSI) or Foa et al.'s (1993) Posttraumatic Disorder Scale (PTDS) (CSAT, 2005).

Screening specific to adult attachment problems is necessary for pre and post-evaluation of effectiveness of the EFGT-SA pilot program. The Adult Attachment Interview (AAI) is a research tool developed by George, Kaplan, & Main, (1986, 1996) to be administered before and after treatment to assess adults' strategies for identifying, preventing, and protecting themselves from the perceived dangers associated with interpersonal relationships. The AAI provides facilitators and treating therapists of the EFGT-SA pilot program with conceptualizations of developmental disruption and adulthood distortions of cognitive processing of information associated with relevant to feelings, thought, and behavior (George et al., 1996). Administration of the AAI is reserved for those who have received proper training in the instrument.

A final consideration is that ongoing screening may be necessary throughout the pilot program to identify symptoms of depression, anxiety, and other mental disorders that may not have been initially detected. It is important to recognize, that for this subset of the female prison population, forced abstinence conditions inherent to the prison-based TC model prevents participants from utilizing substances, which may have been their primary means of coping with negative affective states related to their traumatic pasts (CSAT, 2005). Without their usual means

of coping, participants may begin to exhibit symptoms of mental disorders that can interfere with treatment (CSAT, 2005).

Role of Therapist/Facilitator

The Role of Therapist/Facilitator in EFGT-SA is to help participants learn corrective attachment cognitions, emotions, and behaviors that they can apply in their lives once reunified with their loved ones following completion of their sentence. The therapist in the pilot program i facilitates relationship repair experiences between the group members as though they represent a version of the inmate's own family unit on the outside. This is done by helping the "pseudo-families" engage in secure emotional bond through accessing, expanding, and engaging their primary emotions and attending to unmet attachment needs. The facilitator invites group members to explore their own emotional blocks while teaching them skills to attend to, validate, label, and meet the emotional needs of their "loved ones". Facilitate the Modification of the distressing cycles of interaction that create and maintain attachment insecurity in members of the group and foster positive cycles of accessibility and responsiveness)

Therapist Training

The EFGT-SA pilot drug and alcohol treatment program is designed to be implemented by social science professionals such as certified addiction counselors, social workers, marriage and family therapists, psychologists, professional counselors, and other mental health professionals. These professional would be required to have a minimum of a master's degree in social sciences and have completed the basic trainings in EFT and/or EFFT through the International Centre For Excellence In Emotionally Focused Therapy (ICEEFT) (ICEEFT, 2019). The Therapist would not need to be certified in EFT/EFFT, however it is recommended.

Training begins with a four-day EFT Externship given by Certified EFT trainers and Supervisors. During the Externship training, participants are taught the basic concepts and theory of Emotionally Focused Therapy via lecture, videotape, observation of live interviews, and participant exercises. Externship training is designed to teach participants to identify the three stages and nine steps of treatment. Participant learn to identify the distressing cycles of interaction found in couples and families. How to end cycles of blame and disengagement are taught in order restore and deepen the emotional bond between partners and family members (ICEEFT, 2019).

Following the Externship, therapists are encouraged to participate in Core Skills training to further their knowledge and deepen their understanding of EFT theory. The Core Skills training focuses in greater depth on specific steps of the therapy process model through further didactic instruction, demonstrations from training tapes, and live demonstrations with couples or families (ICEEFT, 2019). Information covered in Core Skills focuses on assessment, the creation of a collaborative working alliance, and the mapping out of negative interactional patterns between individuals (ICEEFT, 2019). Participants then learn to identify and access underlying attachment-based emotions, and models of self that drive the dysfunctional cycles. The next learning module in Core Skills assists learners in focusing on re-engaging withdrawers, while subsequent learning modules in the training focus on pursuer softening (ICEEFT, 2019). Formal and informal supervision is made available to participants to obtain feedback for case presentations from their own work with couples and families in order to help learners hone their skills in the model (ICEEFT, 2019).

Ethical Issues

There are several ethical issues that need to be taken into account when working with offenders. The prison environment is known to be violent, dehumanizing, stigmatizing, and can produce a sense of loss of personal identity, feelings of hopelessness, shame, guilt, and powerlessness (CSAT, 2005). Some inmates may experience feelings of trauma or hopelessness associated with being incarcerated. Pre-existing Posttraumatic stress disorder (PTSD) symptoms may be exacerbated by confinement and prison culture (CSAT, 2005). Inmates needs for safety from the exploitation and violence of other inmates and prison staff, and ability to cope with life behind bars are to be addressed with each incoming client to the EFGT-SA pilot program (CSAT, 2005). Clients should be monitored for depression, anxiety, and suicidal ideation.

An often overlooked issue in treating detainees in the judicial system is the assumed identity and culture of being an inmate. When offenders enter prison they find that the inmate population is organized according to strength, power, and race and that a prison culture exists among inmates and between inmates and guards. Some offenders may feel victimized by society, are wrongfully imprisoned, or take pride in being a rebel in a counterculture or join a prison gang to keep safe from other inmates (CSAT, 2005). A hardened attitude may be assumed as a protective mechanism against being victimized by others and can interfere with group membership in treatment (CSAT, 2005). Clients who indicate that coming to treatment would put them in danger of being perceived as weak by other inmates may not be the best fit for the program or may require greater counseling during the orientation phase of the program to overcome these obstacles to safety and self-concept.

A distinct subgroup of prison cultural are inmates who are serving life sentences. This

subgroup may experience “disculturation” in which the culture they identified with previously is replaced completely by the prison-based world they must live in for the rest of their lives (CSAT, 2005; Goffman, 1961). Some of the permanent “disculturative” adjustments these inmates face are that relationships with friends and family may be permanently altered, along with typical adult lifecycle milestone events such as raising a family, pursing educational, career, and personal interests, and retirement. Finally, women selected for substance abuse treatment in a state facility may be concurrently facing charges at the federal level and therefore may not wish to disclose their substance use in the event it prejudices their case (CSAT, 2005).

Program Assessment/Evaluation Protocol Form

EFT for individuals, couples, or families does not utilize an evaluation form to ascertain whether participants have achieved secure attachment at the end of treatment, rather the meeting of in session treatment markers by the participants determines treatment success (Johnson, 2004). The overall goal of the EFTG-SA treatment program is to resolve adult attachment concerns by reducing attachment insecurity, and foster the creation of secure bonds with close others (Johnson, 2004). Participants complete the AAI post-treatment and compared with the pre-treatment interview results. In addition, participants and facilitators complete the EFGT-SA Program Assessment/Evaluation Protocol Form (see Appendix A) in order to rate the task markers that signify whether the goals of treatment have been met. Participants complete the form as a self-report, while facilitators complete it much like a teacher’s report. The EFGT-SA Program Assessment is designed to evaluate attainment of the therapy goals on a Likert scale of one to five, where one indicates the participant strong disagrees that they met the goal and five demonstrates strong agreement with goal attainment. The EFGT-SA Program Assessment is a

compilation of 16 EFT treatment goals created by De Bruin (2016) and Johnson (2004).

Chapter Summary

The use of Emotionally Focused Therapy adapted for groups undergoing substance abuse treatment in a prison-based therapeutic community is designed to provide a framework for possibly reducing relapse based on painful affect associated with mis-attunement in interpersonal relationships. It is also meant to provide a greater match in intervention methodology to the particular attachment-based problems that incarcerated female substance users face (Brubacher, 2017; Khantzian, 2017; NIDA, 2018; Tronnier, 2015). The proposed EFGT-SA pilot program would be effective with minimum to medium security risk post-sentenced non-pregnant female inmates. It is best suited for female inmates who are positive for a history of childhood trauma perpetrated family members in conjunction with substance abuse problems (Ashley, 2003; Glaze & Maruschak, 2009; Keyser-Marcus et al, 2015; U.S. Department of Justice, 2014a; 2014b).

The therapist/facilitator aids participants in repairative emotional experiences between the group members in pseudo prison families as though they represent a version of the inmate's own family of origin. Secure emotional bonds are formed through accessing, expanding, and engaging their primary emotions and attending to unmet attachment needs (Johnson, 2004). The hypothetical treatment scenario between four members of a prison dormitory pod clearly illustrates what the EFGT-SA program would look like structurally and functionally from client engagement to termination of treatment (Keiley, 2011).

Following personal change in treatment, a sustained effort to maintain the change is required. This is primarily accomplished through further recovery planning and prevention measures to avoid relapse. Clients released from the EFGT-SA pilot program would need to

continue to recognize and manage their personal relapse warning signs (Gorski & Kelley, 1996). Clients are encouraged to seek further EFT-based treatment for individuals, couples, and families as needed once released to the community, in order to maintain skills learned in therapy or to ameliorate symptoms of poor adult attachment.

CHAPTER IV

PROGRAM FINDINGS

Discussion of findings as they relate to original questions

The initial research question to be answered is whether providing adjunctive treatment in the form of EFT, adapted for groups, in a prison-based TC substance abuse treatment program is likely to minimize interpersonal distress in intimate and familial relationships. The empirical evidence for both EFT for couples and families offers strong support that an adaptation for groups is likely to be produced in the near future and will likely produce similar attachment results. In answering the second research question of whether the delivery of EFT, adapted for groups, in a therapeutic milieu, be likely to aid women in forming corrective bonding relationships that assist in healing childhood attachment injuries, it seems highly likely. The prison-based TC has been successful for decades and continues to produce a reduction in recidivism. Group delivery of substance treatment has likewise produced successful treatment outcomes. EFT, in all of its treatment modalities has been empirically validated, therefore it stands to reason that the combination of the three would provide women with corrective emotional experiences in the safe haven of trusted group relationships of TC family pods. These trusted relationships would provide corrective bonding relationships that assist in healing childhood attachment injuries.

The third research question to be answered is if EFT, adapted for groups, be likely to facilitate sobriety for female offenders once released from prison? It is likely that a number of women would find the EFGT-SA treatment to facilitate sobriety once released from prison due to their new found ability to understand that when their attachment needs are not met by partners or family members, that they do not need to return to old patterns of coping. They will have learned

a set of experiential skills that allow they to feel distress without becoming overwhelmed by it. Finally, the last research question to be answered is if EFT, adapted for groups, was effective in the treatment condition, could adding EFT for either individuals, couples or families to aftercare further reduce relapse rates for women? It stands to reason if a treatment is effective, continuing to utilize it in aftercare would further its positive effects.

Clinical Implications

The clinical and societal implications of the EFGT-SA program are not easily measured as statistical data collection for relapse is poor. Recidivism is much more easily quantified, yet parsing out recidivism due to relapse is not readily accomplished according to the National Survey on Drug Use and Health (2012). The clinical implications regarding the mental health of incarcerated women are positive in that greater affiliative responses and support from partners, children, and close others is important for reducing depression and anxiety associated with trauma histories (CSAT, 2005; Dow, 2011; Dykstra et al., 2015).

EFT outcome studies indicate that adults seek to co-regulate their emotional states within secure others, particularly in love or family relationships, and become distressed when previously developed dysfunctional interactional patterns thwart secure attachment (Johnson et al., 1999). Dalton et al (2013) found that following twenty sessions of EFT for couples, in which the female partner had suffered childhood abuse, 70 percent of couples who completed treatment reported no longer being distressed, furthermore, the female partners reported significant reductions in their trauma symptoms of dissociation, interpersonal sensitivity, and phobic avoidance of interpersonal interactions. It stands to reason that EFT adapted for prison groups in which the participants report childhood abuse would yield similar results as the treatment

protocol is highly similar.

Recommendations for Future Research

Future research is needed to develop manualized EFT-based treatment for prison-based substance abuse and trauma programing that specifically addresses the needs of minority, underserved, and marginalized men and women. Additional research is needed to accurately engage, assess, diagnose, and treat adult attachment in a group format. There is a continued need to develop women's substance abuse treatment programming that mitigates childhood attachment injuries that contribute to the use of drug and alcohol self-medication of painful affect associated with childhood sexual and physical abuse, neglect, and incest. Outcome studies are needed to better assess successful completion of group EFT treatment, with particular emphasis on preventing relapse and recidivism for criminal justice system detainees. Further reading in the area of EFFT is directed to the anticipated publication of Emotionally Focused Family Therapy: Restoring Connection and Promoting Resilience (Furrow, Palmer, Johnson, Faller, and Olsen Palmer) due out on June 23, 2019.

Conclusion

Mikuliner and Shaver, along with other attachment theorists, posit that distress regulation is ameliorated by proximity seeking between individuals in close relationships across the lifespan, and that caregiver-infant relational patterns appear to carry forth into adulthood where they shape intrapersonal and interpersonal relationships (Cowan & Cowan, 2007; Moser et al., 2016). Based on this finding, the proposed EFGT-SA pilot program appears to be a viable adjunctive treatment to the TAU found in the current prison programming as evidenced by its likelihood to minimize interpersonal distress in intimate and familial relationships (Dalton et al.,

2013). adult re-shaping of interpersonal exchanges with friends, family and adult romantic partnerships has clinical implications (Coan et al., 2006; Coan, 2010). Based on the decades-old success of TCs in reducing recidivism, the delivery of EFT, adapted for groups, in a therapeutic milieu that is prosocially organized furthers the likelihood of female inmates forming corrective bonding relationships and seeking close others to begin healing trauma and attachment injuries. Group delivery of substance treatment has likewise produced successful treatment outcomes. Furthermore, EFT, in all of its treatment modalities has been empirically validated to reduce painful affect, facilitate bonding and the meeting of attachment needs across the lifespan, therefore it stands to reason that an EFT group format would also provide women with corrective emotional experiences in the safe haven of trusted group relationships with peers who share the commonality of drug and alcohol addiction.

Learning to manage one's emotional responses within the controlled environment of a correctional facility substance abuse program is likely to facilitate short-term sobriety once released from incarceration due to the new ability to regulate emotions in the face of unmet attachment needs. Adding EFT for either individuals, couples or families to aftercare could further reduce relapse rates for women by continuing to build upon the positive effects learned behind bars.

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Appendix A

Program Assessment/Evaluation Protocol Form

Directions: Circle the rating that best indicates your level of agreement with your attainment of the EFGT-SA treatment goals.

Strongly Disagree = 1
Disagree = 2
Undecided = 3
Agree = 4
Strongly Agree = 5

Treatment Goals	Treatment Markers	Goal Attainment Rating Scale
Complete assessment of safety and contraindications for therapy	Participant meets safety criteria and does not exceed contraindications for therapy	1 2 3 4 5
Create an alliance where the participant feels safe and accepted by the group members and therapist	Participant reports feeling safe and accepted by the group, and trusts the therapist	1 2 3 4 5
	Participant discloses how she experiences the process of therapy	1 2 3 4 5
	Participant is able to collaborate with group members and therapist in establishing the goals of treatment as evidenced by her participation during the sessions	1 2 3 4 5
Enter into the experience of each group member in order to sense how person constructs their experience of group relationship.	Participant is able to describe the action tendencies of self and others in session	1 2 3 4 5
Begin to hypothesize about the vulnerabilities and attachment needs underlying the position of self and others	Participant agrees with the attachment need of wanting to matter to self and others	1 2 3 4 5
Track the cycle of interactions that perpetuate individual and group members' distress	Participant is able to describe their own and others' distress and the interactional cycle that perpetuate it	1 2 3 4 5
Begins to understand how the present attachment style developed and hypothesize about the blocks to secure attachment within between group members	Participant is able to share their attachment injuries and trauma history that led to coping through substance abuse	1 2 3 4 5
Begins to access the primary emotions that are often absent from individual awareness	Participant is able to identify their own and others primary emotions	1 2 3 4 5
Access the unacknowledged emotions underlying the interactional positions of self	Participant is able to articulate the emotions behind her behavior and subsequently access her underlying attachment need	1 2 3 4 5

Increase awareness of own role in relationship conflicts in terms of withdrawal of pursuing behaviors	Participant evidenced fewer withdrawing or pursuing behavior per session	1 2 3 4 5
Reframe problems experienced in group in terms of underlying emotions and attachment needs	Participant is able to recognize negative cycle as the common enemy rather than the other group members as evidenced by the realization all parties suffer painful affect and that no one person is to blame	1 2 3 4 5
Newly accessed emotions are experienced	Participant is able to utilize newly accessed emotions as evidenced by her ability to articulate her attachment needs to self and others	1 2 3 4 5
Help group members constructive deal with each other's new behavior and expression of emotions	Participant is able to listen and receive others newly shared vulnerability, as well as articulate acceptance of other's new behavior and expression of emotional experience	1 2 3 4 5
Create bonding events through emotional engagement that redefine interpersonal relationships by facilitating the formulation and expression of adult attachment needs amongst group members	Participant is able to clearly state her emotional safety needs in order to feel connected with others as evidenced by requests made for psychological contact and comfort in a prosocial manner (does not demand or blame to achieve the desired result)	1 2 3 4 5
Re-engage withdrawers in becoming aware of fear and shame related to unmet attachment needs	Participant is able to remain physically and emotionally present without avoiding engagement with others Participant actively seeks engagement	1 2 3 4 5 1 2 3 4 5
Soften blaming communications	Participant is able to remain physically and emotionally present without blaming others for her own emotional reactions	1 2 3 4 5
Consolidate new cycles of emotional engagement and interaction with others that results in secure attachment	Participant is able to engage in positive interpersonal interaction that simultaneously demonstrates personal vulnerability and positive emotional response to attachment bids from others	1 2 3 4 5

(De Bruin, 2016; Johnson, 2004)

Appendix B

IRB Letter of Certification

Appendix C

Title