Chapter II

Review of Literature

Introduction

This research project is a study of one aspect of family relationships in families that include teenage substance abusers. The aspect to be studied is cutoff of the parents from their parents, and the impact of such cutoff on: (1) the parents’ self-functioning; (2) the level of impairment in their teenagers; and (3) the teenagers’ cutoff from their parents. The study population is families of teenagers identified by one or another referral source as in need of a substance abuse evaluation. While the focus of this research is on the relationship system in the family, substance abuse is the problem that defines the population.

The goal of the literature review is to summarize current research about variables in teenage substance abuse, and to describe the evolution of family theories that provide the frame of reference for this study. Bowen Family Systems Theory, which originated the concept of cutoff, is reviewed in some detail. Finally the literature relating to the research instruments is examined. The effort to divide the literature into sections is a recognition that different paradigms are present and should be acknowledged in a study that focuses both on families and on teenage substance abuse.

The literature review has been divided into four sections. The first section includes an overview of the literature on teenage substance abuse, including the disease concept of addiction, the psychological pathology or social inadequacy theory, and the biopsychosocial model. The second section reports on the development of family theories about addiction, including substance abuse in the teenager. The family systems paradigm is a conceptual leap from the ideas of the first section. It proposes that a teenager's substance abuse has developed in the interactional patterns of the family system. The research on the characteristics of families that promote or impede the development of substance abuse is reported. The third section focuses on Bowen Family Systems Theory (BFST), exploring the theoretical framework that underlies this study of the impact of patterns of cutoff on families. The final section gives background research on the instruments used in this study.

Teenage Substance Abuse

The medical model of addiction is one model of thinking about teenage substance abuse. Alibrandi (1978) stated the theory as follows: "Addiction to alcohol, or other drugs, is progressive and a disease. In the case of alcoholism, although the cause may still be unknown, the characteristic train of symptoms is known. And these can be recognized as alcoholism symptoms in young people and used for early intervention of the disease" (p. 29). The author goes on to state that some individuals are biochemically predisposed toward addiction through faulty metabolism that can be inherited genetically.
Predisposition to addiction combined with a social toleration for the consumption of alcohol as a normal way to cope with stress produces widespread substance abuse (Alibrandi, 1978).

The addiction process is a compulsive, obsessive disease, which is not a symptom of some other physical or emotional disorder. "This means that other problems a chemical dependent may have--such as physical illness, disturbed family relationships, depression, unresolved grief issues, and trouble at school or on the job--cannot be treated effectively until the person stops using chemicals" (Schaeffer, 1987, p. 19). Chemical dependency is seen as a progressive, chronic, potentially fatal disease, which always gets worse if the person continues to use. Addiction is defined as loss of control and choice over the use of alcohol and drugs.

This concept of addiction is reflective of the symptoms of adult alcoholics. Researchers who advocate the medical model note that teenagers are different in several respects. They are more often polydrug users, trying anything available. They become heavily involved with substances more quickly, and this affects their emotional development. Finally, they develop more complicated defense mechanisms to justify substance use.

As the prevalent theory in the field of chemical dependency, the medical model of addiction is well known and is particularly utilized in in-patient, hospital settings. The focus for defining the problem is the constellation of symptoms that develop around the substance abuse of the patient, such as blackouts, habitual and excessive use of substances, and legal, school, and family problems. The treatment focuses on motivating the patient to take steps to manage the disease, in the same way that other patients are encouraged to manage hypertension or diabetes. As Schaeffer (1987) pointed out in the passage quoted above, it is not seen as appropriate or productive to examine or address other areas of the teenager's life until the substance use is arrested. The emphasis of the medical model is identifying the addiction process, educating the teenager in the disease concept of chemical dependency, and motivating the person to stop the use of drugs and alcohol. The lens for viewing the problem is physiological and genetic, with the emotional, social, and physical problems seen as an outgrowth of addiction.

Other writers who use the medical model have elaborated on what attracts teenagers to mood-altering chemicals. Why do teenagers use drugs? The reasons include: for fun, out of curiosity, for thrills, because of peer pressure, to increase their pleasure, to diminish pain, and because drugs are available (Maxwell, 1991). The impulsiveness of adolescence is cited as an important factor (Feigelman & Feigelman, 1993). Teenagers are not younger versions of adults. Instead, they are excessive, testing limits, establishing identities, and experimenting. According to these writers, the characteristics of the life cycle are important considerations in evaluating chemical dependency in teenagers. In these writers, the definition of the causes of the problem has widened from a physiological cause to include the developmental stages of adolescence.
Rather than basing vulnerability for addiction on a biochemical predisposition, Sherouse (1985) examined psychological traits common to teenagers who develop drug or alcohol problems. The author identified a healthy personality as based on the following characteristics: a sense of self-esteem, a clear-cut sense of identity, a set of goals, feelings of potency, enough stimulation to avoid boredom, a feeling that one’s world is reasonably stable, and an overall sense of meaning and coherence in one’s life. In the author’s view, teenagers who have a healthy personality may use drugs and alcohol, and may be influenced by societal and peer group norms for use, but will self-correct and learn from their mistakes (Sherouse, 1985).

Teenagers who abuse drugs have a different profile. They have low self-esteem, poor family support, poor friendship skills, and poor decision-making skills. They are immature, have a low tolerance for pain, have difficulty with communication and authority, and lack purpose in their lives.

From this perspective, the lens for viewing teenage addiction widens from a physiological one to one focusing on the psychological aspects and social vulnerability to drug abuse. Teenagers who are not accomplishing the developmental tasks of their lives use chemicals to fill in the deficits. They use drugs to escape pain, to feel grown up, to deal with negative feelings, to better relate to others, to feel more accepted, and to bolster low self-esteem (Sherouse, 1985).

Sherouse attempted to identify in psychological and behavioral terms the differences in teenage use of drugs and alcohol. The author pointed out that while drugs are available to most teenagers, some choose to use excessively and become dependent on drugs, and while others do not. When teenagers do not have a good foundation of coping skills, goals, and relationships, they are more apt to turn to chemicals. This examination of the psychology of teenagers prone to addiction places the locus for understanding the problem on the individual emotional makeup of the child, rather than on the physiology or even the social conditions in which the child lives.

One of the most comprehensive reviews of multiple risk factors was summarized in Beman's (1995) article on "Risk Factors Leading to Adolescent Substance Abuse". Beman explored demographic and statistical data on the use of alcohol and drugs by teenagers. Several of these studies focus on risk factors, citing demographic, social, behavioral, and individual characteristics. The demographic studies suggest that males have a higher rate of alcohol and drug use than females. The major risk periods for initiation into alcohol and marijuana use peaks between ages 16 and 18 and is usually completed by age 20.

Social risk factors include the influence of family, peers, and the environment. Families in which the use of alcohol or drugs is high, as well as chaotic families, tend to have more incidence of teenage drug and alcohol abuse. Adolescents whose peer group is involved with alcohol and drugs, and those who engage in other problem behaviors, such as rebelliousness and delinquent activities, are more at risk. Individual characteristics
such as poor academic achievement and low self-esteem, and the lack of motivation are positively correlated with use. A final risk factor is employment during the school year (Beman, 1995).

Beman introduces family influences as an important risk factor. One study suggested that the incidence of parental drinking was highly correlated with teenage use. The study found that 82% of parents who drank had teenagers who drank, while 72% of parents who abstained had teenagers who did not drink. The author speculated that the teenager models the adult behavior and that families with substance abuse in the parental generation are likely to create an environment in which teenagers may turn to substance abuse for escape. Families in which the father is absent or the parents’ standards of behavior and discipline are inadequate or inconsistent also produce children at higher risk.

From the range of research cited, evidence suggests that teenage substance abuse has many levels and is influenced by a number of factors, including physiological, psychological, family, community, and societal considerations. The lens of understanding this issue is widened from a physiological predisposition to a multivariable problem. These intersecting variables are addressed in the biopsychosocial model of substance abuse. Muisener (1994) attempted to integrate biological, adolescent psychological development, interpersonal determinants, community variables, and societal influences. The biological variable is at the center of the model with the other variables creating increasingly larger concentric circles. This model is based on the idea that each variable creates a context and is interconnected with the others.

According to the biopsychosocial model, the primary factors that predict teenage substance abuse are personality, family, and peer influences. Biological, community, and societal factors are secondary risk factors. Crucial variables in the development of substance abuse are the teenager’s inability to fulfill the tasks of adolescence, the functioning of the family, and the choice of peers. Family functioning includes the life factors that the family is facing (such as age of the parents or the number of children), the family dynamics (including family strengths and family coping mechanisms), family crises, and family dysfunction.

Muisener (1994) proposed that the emotional functioning of the family influences the development of the teenager and the teenager’s use of substances. He looks beyond single variables, such as family support or parental use of substances, to consider more complex issues such as the stresses on the family and family functioning over time.

As the literature review has indicated, teenage substance abuse lends itself to many points of view. How each writer describes this problem depends on his or her philosophical or professional point of view and on the particular focus he or she brings to examine the problem. Those who come from the medical world of adult alcohol treatment tend to focus on a group of symptoms that fit a disease model. Developmental psychologists examine the inability of at-risk youths to achieve the tasks of adolescence--
the sense of identity, interpersonal relationships, and goals that are necessary for moving to adulthood. Counselors look at the natural tendency of adolescents to experiment to be impulsive and to be influenced by their friends, and see the importance of the social milieu on decision making. Demographers trace trends of societal and government attitudes, the availability of drugs, and the attitudes and tendencies of the adolescent population as contributing to the level of abuse. The biopsychosocial model attempts to integrate and connect these various levels and to acknowledge the importance of the family in the developmental outcome of the teenagers.

**Family Therapy with Substance Abuse**

Literature that describes family systems, including those with addiction, is a theoretical shift from the viewpoints outlined in the previous section. The lens of the family researcher is less on the multiple factors that influence substance abuse than on the position of the teenager in the emotional life of the family system. The focus is no longer on the problems of the adolescent, but on how the teenager both reacts to and maintains the interactions of the family.

In the 1950s, families with alcoholic husbands were examined from the point of view of the wife. Steinglass (1979) saw the wife as being affected by the drinking and also contributing to it through her own psychopathology. In the late 1960s and early 1970s, family theory began to be applied to families with alcoholism. Specifically the ideas of Don Jackson and Gregory Bateson on homeostasis were applied to alcoholic marriages (Steinglass, 1979). This was the first time that alcoholism was conceptualized not as individual pathology, whether emotional, biological, or social, but as a relationship problem. Jackson termed the alcoholic marriage as a process in which two people strike an "implicit interpersonal bargain" and a "quid pro quo" between the passive alcoholic husband and the nurturing wife (Steinglass, 1985).

Family systems theory, as developed particularly by Murray Bowen in the late 1970s, placed the family and family relationship systems at center stage. Bowen wrote:

> Systems theory assumes that all important people in the family unit play a part in the way the symptom finally erupts. The process of drinking to relieve anxiety, and increased family anxiety in response to drinking, can spiral into a functional collapse or the process can become a chronic pattern. (Bowen, 1978)

Family members should not think of the problem as the drinker who needs to be cured. Rather, Bowen proposed that any member of the family could have an influence on the drinker’s behavior by changing his or her part in the interactional family pattern, which serves to maintain the drinker’s behavior.

A systemic approach to a family conceptualizes chemical dependency as a multi-determined phenomenon. Alcoholism is described as an interactive process between the
drinker and the alcohol, the drinker and himself, and the drinker and others (Bepko & Krestan, 1985). Over time, the family system becomes organized around the drinking. The alcoholic family fails to define appropriate hierarchical boundaries between the parental subsystem and the parents’ children. Often in the progression of drinking and reactions in the family, the members increasingly show over-responsible and under-responsible behavior. The lack of responsibility for self in the alcoholic is balanced by the over-functioning of the spouse, and this pattern is transmitted across generations to the children and their families.

Minuchin (1979) also contributed to the thinking about family systems. He wrote: "The family therapist must also recognize that the human family is a social system that operates through transactional patterns." The restructuring of a family through family therapy provided alternative transactions, always seeking to support individuation, as well as a sense of belonging to the family. Minuchin's ideas were instrumental in the development of a research project at the Philadelphia Child Guidance Center (Stanton & Todd, 1982). Utilizing structural family therapy with drug addicts, many of whom were adolescents, the researchers found that certain relationship patterns were exhibited in their research families. One of the most common was a close mother-son relationship combined with the father who exhibited distance from the family. In many families, the addict was discounted as a person, over-protected, and treated as helpless (Stanton & Todd, 1982).

Haley (1980) asserted that the time of greatest change in a family is when someone is entering or leaving the family. When a child fails to disengage from the family, this allows the parents to continue to focus on the child and derails the young person from their developmental course toward independence. "For therapy, it is best to assume that the problem is not the young person but a problem of a family and young person disengaging from one another" (Haley, 1980, p. 32).

Fishman (1988) continued this discussion about the parent-child relationship. The development of identity and social competence by the teenager are based on the social relationships inside and outside the family. "Adolescent maturity is gained within the context of progressive and mutual definition of parent child relationships" (p. 8).

According to Reilly (1975), adolescent drug abuse is a symptom of a family dysfunction, which reflects a defect in the "launch sequence" through which the adolescent is prepared for gradual disengagement and separation from their family. The drug dependency plays a functional role in the family by uniting family members around this one concern. In using the family system as the reference point, these theorists consider the function that the addiction serves in the family, rather than the characteristic or pathology of the user.

As these ideas about the family as a system became better known in the field, more clinicians applied them. E. Kaufman (1979) reported the usefulness of the family genogram and family chronology in the treatment of adolescents with substance abuse.
These techniques allow the family and therapist to understand the evolution of family patterns over time. Systems theory also emphasizes that family change can occur even if only one member is available for consultation. Theoretically any person who changes their part in the patterns of the family will create a context for change for other members.

Addressing the family as a system affected by alcoholism or drug abuse can be accomplished in a variety of treatment situations. Elkin (1984) reported that families come into treatment through three routes: when a spouse is drinking, in early sobriety, and when a child is identified as the problem. Each of these situations allows the systems-oriented clinician to begin to discuss the patterns of family interactions around the addiction if there is a systems view of the family.

Laudergan and Williams (1993) described the family program at Hazelden, a highly regarded in-patient treatment center. This model integrates Bowen’s theory with a traditional psychoeducational program on chemical dependency.

Bowen's family systems theory provides a framework for conceptualizing partial independence in working with the chemically dependent family. Bowen sees the unit to be worked with as being the family rather than the alcoholic patient. The part of the family having the most capability for change should then be encouraged to recognize the ability to change and to begin to consider alternative family roles and responses. (Laudergan & Williams, 1993, p. 98)

Another example of a systems-oriented treatment program is the Purdue Brief Family Therapy model used for the treatment of adolescent alcohol abusers. This is an integrative model that employs theoretically compatible skills from structural, strategic, functional, and behavioral family therapies. It focuses on the interactional, rather than individual, nature of the problem, is present-oriented, and uses direct interventions. The goal is to reestablish appropriate parental influence and interrupt the dysfunctional behavioral sequences and patterns in the family (Trepper et al, 1993).

Family systems theory reframes the problem of adolescent substance abuse as an outcome of the original attachments in the family. P. Kaufman (1979) described her work with families of adolescents in a therapeutic treatment community:

Our overall goal is to restructure the family in such a way that each individual has a chance for optimal development in the family. Children are helped to have direct access to the adults in the family. Spouse transactions are helped to be clear and unambiguous. (p.98)

The outcome of these interventions with the family is that 90% of this program’s drug-addicted teenage clients graduate from high school.

How a researcher thinks about a problem influences the questions the researcher asks, the focus of the research, and the proposals for intervention. Teenage substance
abuse is an excellent example of how a problem can be examined from many frameworks...

The research has focused on measuring family functioning. The most widely used measurement of family functioning is Olson’s Circumplex Model, which has been developed over time into Family Adaptability Cohesion Enmeshment Scale (FACES) I, II, and III (Olson, Sprenkle, & Russell, 1979; Olson, 1986). This model measures family cohesion and adaptability. Family cohesion is measured as disengaged, separated, connected, and enmeshed. Family adaptability is viewed as the ability of a family to change in response to situational or developmental stress, and is measured as rigid, structured, flexible, and chaotic (Smart, Chibucos, & Didier, 1990). This instrument tool has been used with a wide variety of research populations in an effort to measure the functioning of families on these specific axes. The following are a few of the studies that relate to teenage substance abuse.

"Separated" families, as measured on FACES I, were more at risk for substance abuse problems in adolescents, and were found to have a larger than expected number of persons who were diagnosed as schizophrenic and having narcissistic and borderline personality disorders. Extreme closeness was also correlated with drug abuse (Brook et al., 1983). Researchers who used FACES had consistent results that adolescent drug users and abusers were less involved, more separate, and more emotionally cutoff than nonusers (Clifford, 1989, Shilts, 1989).

Dillon also reported the correlation of number of life changes in the family to the development of substance abuse in teenagers (1990).

Low cohesion prohibited interdependence in alcoholic families; high cohesion (enmeshment) impeded individual autonomy (Preli, Protinsky, & Cross, 1990). In subsequent studies, high cohesion was positively correlated with low drug use in adolescents (Malkus, 1992; Protinsky & Shilts, 1990; Reineck, 1988, Volk, 1990). Family size, number of parents in the home, and birth order were also correlates of use (Malkus, 1992), as was the level of stress the family experiencing at the time of the substance abuse (Fisher, 1990). Barnes (1990) hypothesized that support and control, which are correlated with low adolescent drug use, may be a function of overall family cohesion, adaptability and communication, which were measured through the FACES.

Despite its widespread use, many researchers question the accuracy of the FACES to measure the variables being tested. Doherty and Hovander (1990) questioned whether the Circumplex Model actually captures the traits of cohesion and adaptability in families. In a different study Friedman et al. (1987) discovered that families reported themselves as disengaged and rigid, while the family therapist saw them as enmeshed. No change was found in families who were tested before and after they received structural family therapy (Fritz, 1989, Sharp, 1990).

These cited studies illustrate the range of research on families in which a member developed a substance abuse problem. Each researcher sought to distill and measure the
significant family variables that may contribute to the development and maintenance of the problem, as well as measure a variety of interventions. This overview demonstrates the wide range of thinking and research designs that attempt to address this problem in families.

Numerous studies describe characteristics that contribute to teenage substance abuse. Foxcroft and Lowe (1995) reported that more substance abuse was found in authoritarian and neglectful families. Race and gender were not found to be significant variables for teenage use. In a study of 932 youth by Brook, Whiteman, and Gordon (1983). Black and Hispanic youth were found to drink less than their White counterparts, but experience more problems as the amount of alcohol they drank increased (Barnes, 1990). Siegel and Ehrlich (1989) found that youth who came from a high socioeconomic status were more anxious and more depressed than their counterparts. There was no correlation between socioeconomic status, impulse control, self-esteem or moral development. Highly correlated in their study was the relationship of high drug use to poorly connected family relationships. Other researchers have found little multiethnic differences. Wills, Vaccaro, and McNamara (1992) tested 1,289 adolescents, finding parental emotional support, academic competence, and positive affect protective aspects against substance abuse.

Other factors associated with drug abuse in an adolescent include: divorce, absent parents, absent father (Palmer, 1989), low cohesion in family, little closeness in family, and lack of communication (Jurich, Olson, Jurich, & Bates, 1985). Drug abusing adolescents see their parents in less control of the family (Fagan, 1989). Testing 1,380 adolescents over a three-year period, Johnson and Pandina (1991) found that the parental use of alcohol was secondary to the quality of child-parent interactions which were related to the child’s problem drug use, delinquency, and use of emotionally focused coping techniques.

In contrast, family social support was the most accurate predictor of high levels of autonomy, purpose, and interpersonal dynamics for adolescents (Skarie, 1988). High levels of support and moderate levels of control are associated with non problem behavior, while high levels of use are correlated with alienation from family and rejection by parents (Kandel, Kessler, and Marguilies, 1987). The authors found that closeness to parents shielded adolescents from hard drug use and encouraged relationships that were drug free.

From this extensive research, it is clear that there is a broad consensus that teenage drug abuse among adolescents is crucially related to family relationships. Although the words--cohesion, adaptability, support, and discipline--used to describe family traits vary in the different studies and come from different theoretical origins, a common theme that emerges from the research is that an emotionally disrupted family produces adolescents with greater difficulties, including substance abuse. When a family can nurture and offer some structure and guidance for their children, a protective veil surrounds their offspring, which is not correlated to socioeconomic status or racial or
ethnic background. If the family is disrupted—through external stress or the internal emotional difficulties of one or both of the parents, or stresses between them—then the teenager is less capable of making a smooth and functional transition to adulthood. This central idea is a unifying thread in the research studies in the literature.

**Bowen Family Systems Theory**

The evolution of Bowen’s ideas came from the shift over time from an individual to a systems orientation. The theory resembles a fabric woven from the interplay of the major concepts, which will be described. The literature cited gives a breadth and depth of understanding of this theory as a context for the research questions that have been chosen. These questions explore the relationship of two emotional patterns, cutoff and self-functioning, which are studied over three generations in families with substance-abusing teenagers.

In the "Epilogue" to *Family Evaluation*, Murray Bowen (Kerr & Bowen, 1988) traces his odyssey in systems thinking. Born the oldest of four children to an undertaker in a small town in Tennessee, he became interested in medicine early in his life. Originally he had intended to become a surgeon, but became interested in psychiatry while serving in the Army in World War II. In his psychiatric residency, as he trained to be an analyst, he began to examine the scientific basis of Freudian theory. After the war, Bowen went to work for the Menninger Foundation in Topeka, Kansas where he continued his psychoanalytic studies, his clinical work, and his readings in science.

At the Menninger Clinic, Bowen treated a variety of clinical problems, including schizophrenia, alcoholism, and depression (Kerr & Bowen, 1988). But unlike some of his colleagues who followed the psychoanalytic principle, which discouraged contact with the families of patients, he met with and began to study the relationship systems of the people he treated. His initial research involved the families of hospitalized schizophrenic patients. He was intrigued by the impact of the visits of the family, particularly the mother, on the schizophrenic’s behavior (Kerr & Bowen, 1988).

Psychoanalytic investigators had labeled the mother-schizophrenic interaction symbiotic. Symbiosis from a Freudian viewpoint is seen as unconscious conflicts and unresolved feelings between a mother and an impaired child. In studying the process in the families he observed, Bowen took a major step toward constructing a theory about humans that is consistent with other scientific research. In 1954 he received a grant from the National Institute of Mental Health (NIMH) to research families of schizophrenics. This grant lasted for five years and involved hospitalizing entire families of schizophrenics for periods of several months to a year. According to Kerr and Bowen (1988), two observations became apparent in the initial stages of the research—that the involvement between the schizophrenic and the mother was more intense than previously believed and that the intensity was characteristic of the relationships in the nuclear family. "The emotional functioning of individual members was so interdependent that the family
could be more accurately conceptualized as an emotional unit" (Kerr & Bowen, 1988, p.7).

In studying the family as an emotional unit, a theoretic leap was made from conceptualizing the family as a collection of individuals to the view that the family functions as a system in which the functioning of one member is influenced by and influences other members. In the initial research on schizophrenia, Bowen began to identify several patterns of reciprocal interactions characteristic of human families. These included the projection of anxiety on a member who became symptomatic, as well as the overfunctioning/underfunctioning, dominant and submissive, and quiet and emotional relationship postures.

In the NIMH project, he began to identify concepts that described the processes he and his fellow researchers were observing in the families. Rather than thinking about the individual as a separate entity, he documented a person’s emotions and behavior within the context of their relationship system. The family diagram was developed to document the facts about the relationships in the family. However, a description of the relationships did not explain how they operated. Concepts such as differentiation, triangles, nuclear family emotional system, fusion, and cutoff were formulated to describe the emotional process underlying the behavior. The ideas, which Bowen developed about families, were always grounded in a scientific footing of the human’s evolutionary heritage in the natural world. Bowen stated: "If evolution ever becomes an accepted science, then human behavior will also be a science." (Kerr & Bowen, 1988, p. 362).

In 1959 the NIMH project ended and Bowen moved to the Department of Psychiatry at Georgetown University where he researched families seen on an outpatient basis. Although these families exhibited less severe problems than his hospitalized population, he concluded that the concepts he had developed were as applicable to them. He thought that the same relationship processes were present in every family, but varied in how they operate based on the functioning level of the family.

Central to Bowen theory is the idea that families exist on a continuum of functioning. At one end of this continuum, members are highly reactive to and dependent on one another, with family members exhibiting more symptoms. At the other end of the spectrum, people are more autonomous from one another, more able to define and direct their lives, and less prone to symptoms. The differences between the ends of the continuum are not in the nature of the reactions, which are basic to all humans, but in the intensity of the reactions. For example, in a relaxed and capable family, parents promote the independence and self-reliance in offspring with nurturing support. The connections allow the child’s identity to emerge and flourish. At the other end of the continuum, parental love is overbearing, intrusive, and inhibits the child’s development. These are two ends of the same process of parental care, but the emotional intensity or fusion in the relationship system varies. Rather than thinking of pathology in an individual, Bowen conceptualized a spectrum of functioning into which all families fall, which he labeled the scale of differentiation (Kerr & Bowen, 1988).
The concept of differentiation is central to understanding Bowen’s other concepts of family systems theory. Each member of a family is influenced by interactions and emotional reactivity to other members. However, how they react is based on the level of emotional maturity (differentiation) of the members of the family. Emotional patterns do not create problems in a family, but are rather a reflection of the differentiation of the individuals. While this may seem like splitting semantic hairs, this distinction is crucial to Bowen Theory. Change is seen as the ability of any family member to become less anxious, less reactive, and more thoughtful about their part in the interactions. Change in one person creates a shift in the interactional patterns.

Of central importance to the concept of differentiation is the interplay of individuality and togetherness in the operation of the emotional system of a family. Individuality is a biologically rooted force which propels an individual to function as an independent and distinct entity. It is a force for being separate, to feel, act, and think for oneself. The force for individuality in no way precludes an individual working cooperatively with others toward a common good, but it does presuppose that a person is capable of thinking about and taking responsibility for their part of the cooperation.

Togetherness is a force that propels an individual to function as part of a group, to submerge their identity to the desire to please others. It creates a sensitivity to the thoughts and an orientation to the feelings of others. In each individual, both forces are operating simultaneously and affect the stability and level of cooperation in a group.

These are complicated concepts based on Bowen's study of evolutionary theory. However to describe the ideas in a basic way, those individuals who can maintain their individuality while staying connected to others have more ability to function in a thoughtful, nonreactive manner, based on their principles and ideals for life. Maintaining individuality does not mean disconnecting from or not cooperating with others, but managing one's reactivity and sense of direction despite the disagreement of others. From Bowen's viewpoint, those who can develop and maintain their individuality, as well as work cooperatively with others, fall at the higher end of the spectrum of differentiation.

In contrast, at the lower the level of differentiation, the greater percentage of life energy is bound by relationships, both by acceptance of others and reaction to others. A person's life becomes dependent on the feelings and desires of important relationships or cutoff from them. Automatic reactions and feelings dictate decisions, rather than reflective decision-making. At times, people are so flooded by environmental stimuli and relationship cues, there is little energy left over for their own lives. Togetherness forces, also labeled enmeshment, result in the intense joining together of identities so that the reactions of one individual translate to reactions in the other (Kerr & Bowen, 1988).

Gilbert (1992) described the varying degrees of maturity in humans in another way: "Individuals vary in their ability to adapt—that is, to cope with the demands of life and to reach their goals" (p. 18). A level of basic self is influenced by a person's ability to
separate emotionality from the primary relationship system, while at the same time staying in emotional contact with the important people in her life. A basic contradiction exists in these ideas: if a person has a level of basic self that allows them to think about and act for their life direction, then they are freer to be connected in meaningful and open communication in relationships. If they are so fused that they are always considering the reactions of others to what they do, then they will have less freedom to maintain an adult attachment. "Human beings will attempt to complete the self in relationships to the degree that it is incomplete by itself" (Gilbert, 1992, p. 22). This need for attachment is what fuels the enmeshment in a relationship.

Friedman (1985) found that "differentiation means the capacity of a family member to define his or her own life’s goals and values apart from the surrounding togetherness pressures, to say ‘I’ when others are demanding ‘you’ and ‘we’. It includes the capacity to maintain a (relatively) non-anxious presence in the midst of anxious systems, to take maximum responsibility for one’s own destiny and emotional being" (p.27).

The level of differentiation in parents influences the functioning of their children. The ability of two parents to maintain their identities and to relate to one another and others will affect how they raise their children. Parents who cannot maintain their own functioning will have more difficulty in raising independent, successful children. Bowen termed the passing of emotional functioning from one generation to the next the multigenerational transmission process (Bowen, 1978; Kerr & Bowen, 1988; Papero, 1990).

The actual process of differentiation being passed from one generation to the next can only be surmised in a conceptual way. What can be observed is the emotional functioning and patterns of a family across generations. What level and types of symptoms reappear in families? Substance abuse, as well as manic-depression, cancer, diabetes, heart problems, domestic violence, and a myriad of other symptoms form patterns across generations in families. Multigenerational transmission processes, according to the theory, pass on a functional level from one generation to the next, which could include, but is not restricted to, these patterns. The parents' emotional functioning or level of differentiation is instrumental in determining the ability of their children to form a separate identity as well as a productive connection with them.

Researchers at the University of Connecticut, School of Family Studies, have written and researched differentiation and individuation in families. Sabatelli and Mazor (1987) examined the constructs of individuation, differentiation, and identity formation, concluding that the level of differentiation of the family mediates the individuation process and the formation of identity.

Anderson and Sabatelli (1992) elaborated on the concepts of differentiation and individuation, words that are often used interchangeably. Individuation, according to the authors, is conceived as a phase-specific developmental process of separating self from
identification and dependence on others. This assumes significance in infancy and adolescence, in that a satisfactory level of individuation is thought to be necessary to master developmental tasks. These authors distinguished individuation from Bowen’s concept of differentiation, which emphasizes the capacity to be in “close emotional contact with significant others without having one’s thinking, emotions, and behavior reactively governed by those relationships or by the accompanying emotional environment” (p. 37). Differentiation is a variable that operates at a system level, referring to the level of fusion or emotional neediness. “The higher the level of differentiation, the less need for family members to continually seek love, approval or affection from one another, the less the need to blame or hold others responsible for not fulfilling these needs, and the more able family members are to engage in adaptive, age-appropriate, goal-directed tasks” (p. 37).

In well-differentiated family systems, age-appropriate individuation occurs, allowing the young adult to engage in both intimate contact with others and autonomous functioning. In contrast, in poorly differentiated family systems, the family members are dependent or disengaged from one another. This leads to age-inappropriate individuation, the emerging of a child without clear identity, boundaries, or ability to set a life direction. As an adult, the child continues a fusion with others, including the child’s parents, or, in an attempt to be separate, they are cut off from important relationships.

Anderson and Sabatelli (1992) examine the areas which are crucial to the present study—enmeshment and cutoff. The less individuated individual has a high level of reactivity which can be expressed as either conformity at the expense of autonomy, or rebellious defiance of parental wishes at the expense of connectedness and intimacy. Those who fuse with their parents avoid conflicts, view themselves in need of others’ assistance, and are highly financially and functionally dependent on the family. Those who react to conflict or tension by rebelling, retreating, or severing the relationship trade a sense of autonomy, being "themselves", for connection to the family. The less individuated person either tips to dependency or denies the importance of their family relationships.

Cutoff and fusion are two faces of emotional intensity in families, which become more pronounced in lower levels of differentiation. Fusion reflects the joining together of two people out of emotional neediness, which compromises the identities and self-direction of each, rather than a productive connection between people. It is a trading and borrowing of ‘selves’, so that the thoughts and feelings of one person are indistinguishable from another’s. Fusion can be expressed in several emotional patterns, including conflict, distance and pursuit, over/underfunctioning, and projection.

In a conflictual relationship, individuals are unable to maintain their identity in a relationship without reacting with emotion or anger to another. Often one or both partners feel that the other one is not hearing their position, so they state it louder or more frequently. Reactions spiral until one or the other backs away to a distant position, which can calm the reactions and allow the partner to approach one another. The conflict then heats up. Conflict, as the other emotional patterns, is one mechanism to attempt to preserve self in the emotional pull from others. It is a common pattern for adolescents
who are attempting to individuate a self from their parents. If they can get their parents into an angry argument, the teenager feels freer to be "different from" the parent. The more fused the parent with the child, the more the child turns to rebellion and reactivity to gain feelings of independence. The dilemma is that this rebellion is not a truly thoughtful position on behavior and goals, but a reactive position to fusion with the parent, and generally leaves the child dependent and in an enmeshed position with their family (Gilbert, 1992).

A second pattern of fusion is distance and pursuit. When two spouses are emotionally needy of one another, without enough of a base of functioning in their own lives or without other relationships to turn to, one or the other can feel overwhelmed or "suffocated". They need some breathing room so they create distance from each other. Then one of the partners pursues the other to maintain the connection. This can become a pattern over time, with one partner appearing cold and removed and the other appearing emotional and needy. It is a common relationship pattern between parents and a distant, non-communicative teenager. If the parents back off from pursuing closeness, the teenager will often become more open (Kerr & Bowen, 1988; Papero, 1990).

A third emotional pattern that reflects fusion is over/underfunctioning. In a marriage, one partner can appear more competent and caretaking, while the other looks dependent and not capable. This pattern is common in families with addiction and depression. From a family systems viewpoint, this relationship pattern has a reciprocity, in which the fusion of the two partners is reflected in a one up/one down position. If the dependent partner becomes more functional, the caretaker can become depressed or anxious (Bowen, 1978). When a parent overfunctions, they can interrupt the developmental stages of the child through overprotective help and intervention. Or conversely, the underfunctioning of a parent, through addiction, distance, or emotional illness, can produce a child who is a caretaker for his/her siblings and the parent (Gilbert, 1992). This overfunctioning child may look capable, but often his/her concerns for others do not allow this child to build a separate and balanced identity. This child can choose a dependent partner as an adult to fit his emotional patterning as a child (Kerr & Bowen, 1988; Papero, 1990).

The last emotional pattern is the projection process. The pertinent example is projection onto a child. The parents' marriage may appear calm, but they are drawn together in agreement that their child is the problem. Projection onto a child is an example of a triangle in which two sides are in an alliance, or togetherness, while the third is in an outside position or is thought of as a problem. The parents are transferring their reactivity to the child, therefore feeling less anxious themselves. The child reacts to this focus, acts less capably or with higher emotional reactivity, and is diagnosed as more of a problem. Sometimes parents are in an endless pursuit of helping their child so that their engagement in the symptoms prevents the teenager from taking responsibility for thinking through his/her choices for functioning better (Bowen, 1978). It is common for many teenagers who are identified and treated for substance abuse to come from multiproblem families, in which emotional reactivity and symptoms are so ingrained that
the teenager has no platform from which to launch their own identity. These children often turn to substance abuse in order to belong to a social group or to a gang, which offers them a fusion, or acceptance, that substitutes for the family.

Families with high levels of fusion can reflect their emotional neediness and reactivity through conflict, dependency and symptoms, distance, and projection onto a child. The members of the family do not maintain self-directed, collaborative functioning nor are they in meaningful communication with one another. Sometimes the reactivity is so high and the ability to stay connected while managing some kind of boundaries in the relationship system is so fragile that the person severs the relationship with the family. This cutoff from the family is an effort to maintain a sense of emotional equilibrium in the face of intense relationships. The individual cannot manage their reactivity nor maintain their sense of identity while in contact with the family. While this cutoff can be explained as self-sufficiency or not needing the family, Bowen (1978) theorized that it reflected neediness among family members that was so intense that one member could not function effectively in contact with it. This concept is generally applied across generations, between parents and children, although it also speaks to marriages in which one partner disappears through divorce, jail, or in other ways.

In 1991, Bartle and Anderson researched a hypothesis that has a direct connection to the present study. Their basic research question touched upon a central aspect of multigenerational process—-is one generation’s level of functioning similar to the next? Their hypothesis was that adolescents have similar levels of differentiation as their parents, which they investigated by looking at levels of individuation in multiple generations. In studying the results of questionnaires returned from 42 families, they found that the mother’s individuation from her parents was more crucial to the functioning of the adolescent than the father’s individuation from his parents. They concluded: "The adolescent’s individuation from both parents appeared to be more related to mother’s individuation from her mother than from her father, and not at all related to father’s individuation from either parent" (p. 921).

Anderson and Sabatelli (1992) continued their research on multigenerational emotional process by developing the Differentiation in Family Scale (DIFS), which consist of 11 items to assess an individual’s perception of various members of a family interact with each other. A sample of 60 college students filled out questionnaires, including the DIFS scale, and data were collected on interactions among family members. The intercorrelations between the subscales indicated that parents were viewed as acting fairly consistently across different relationships.

Ng (1992) used the Personal Authority in Family Systems to measure level of differentiation among married couples, as did McCreanor (1989) in researching the relationship between health and differentiation in 250 married couples. These scales, as described in the literature, are an effort for family members to describe the quality of their relationships, the pull of togetherness, and the ability to remain nonreactive and autonomous.
Other researchers have attempted documenting multigenerational patterns and levels of differentiation through questions about the functioning of the family over time. Schara (1994) developed an AIDS Research Questionnaire to investigate the emotional process, level of cutoff, and differentiation in families with AIDS. Baker and Gippenreiter (1994) published a study of Russian families in which a grandparent had disappeared in the Stalin’s Purge. Caskie (1995) used the Family Stability Index to investigate differentiation and the development of arteriosclerosis in families. Each of these investigators used a record of family events and functioning that could be factually documented, rather than perceptions of relationship process in the family.

One instrument that measures the level of cutoff and degree of self-sufficiency in a family is the Characteristics of Relationship to Nuclear and Extended Family (CRNEF), which was developed and utilized in a Research Survey Project by Murphy, Purkey, Bradley, and Sroka at the Family Crisis Center of Baltimore Co., Md. (Murphy et al, 1994). This tool measures contact and knowledge of family, self-functioning, and incidence of marital violence. The initial hypotheses for that study of families with spousal violence was: does the degree of cutoff from family of origin and/or the dependence on family of origin to maintain self-functioning correlate with the intensity of violence in the spousal unit if intensity is determined by the number of violent incidents and length of marriage?

Participants were randomly selected from the center’s intake process for those families seeking family counseling for physical violence that had occurred in the spousal relationship. Data were gathered by four researchers/therapists during the course of psychotherapy. In the initial report on the data, 52 married couples completed the survey. All data were reported by the clients and interpreted by the family interviewer. Good or personal contact with the extended family was present in only about 14% of either husbands or wives in this sample. Knowledge of extended family relationships was good or detailed for almost 20% of the husbands and 25% of the wives. The data has yet to be correlated with the intensity physical violence in these families (Murphy et al., 1996).

**Instruments to Measure the Variables in the Research Study**

One of the questions raised in this study was how to measure cutoff and self-functioning in families. Many instruments and research designs, some of which have already been cited (Anderson & Sabatelli, 1992; Baker, 1994; Caskie, 1995; Schara, 1994), were reviewed to assess their effectiveness in capturing data that reflects the measurement of cutoff in a family. Of particular importance was the simplicity and ease of administering the instrument, as well as its ability to capture the complexity of the connection between generations.

The researcher looked for several instruments that would corroborate and validate the measurements of cutoff and self-sufficiency in a family, while recording the factual
information about the family as accurately as possible. In addition, the data forms of the mental health center where the research is to be conducted were examined.

Descriptive data will also be recorded on intake forms provided by the mental health center, which records the same factual material in written form. These intake forms include demographic information, as well as a more in-depth description of presenting problem, family history, health, legal, employment, psychiatric, substance abuse, and self-functioning data.

As a measurement of self-sufficiency, the Global Assessment of Functioning (GAF) was administered to each parent. This measurement scale is published in the Diagnostic Criteria from Diagnostic and Statistical Manual for Mental Disorders IV by the American Psychiatric Association (1994), and is widely used in mental health clinics and hospitals to assess individual functioning. A assessment is made by the interviewer, based on descriptors on a scale of functioning. The clinician is instructed to consider psychological, social, and occupational functioning on a hypothetical continuum of mental health—illness, when the impairment is not due to physical or environmental limitations. The scale ranges from 10 (persistent danger of severely hurting self or others), to 50 (serious symptoms), to 90 (absent or minimal symptoms). The GAF is Axis V in the criteria for diagnosis as outlined in DSM-IV.

The rating of overall psychological functioning on a scale of 0-100 was first developed and operationalized in the Health Sickness Rating Scale (Luborsky, 1962). Spitzer and colleagues revised this scale into the Global Assessment Scale (GAS) which was included first in the DSM III-R and then in DSM-IV (APA, 1994) as the Global Assessment of Functioning (GAF) (Goldman, Skodol & Lave, 1992). The purpose was to provide a measure of overall social functioning, while Axes I-IV measured emotional, personality, and physical disorders and stressors specific to the individual.

In the Emotional Cutoff Scale (ECS), McCollum (1991) generated instrument items measuring cutoff based on a definition by Kerr (1981): “Emotional cutoff describes the way one generation cuts off emotional contact with the previous generation in order to avoid potential relationship problems.” Cutoff represents one of the most common ways that unresolved emotional issues are dealt with and thus is a cornerstone in Bowen’s understanding of the genesis of emotional problem. “The importance of this concept to Bowen’s theory and the lack of empirical measures constitute the rationale for attempting to develop an emotional cutoff scale” (McCollum, 1991, p. 248).

McCollum (1991) developed 10 items, which were reviewed by a panel of judges familiar with Bowen’s ideas, that he used to assess the cognitive component of emotional cutoff in his research study. They included desire for contact, mood during contact, time in contact, and personal quality of relationship with each parent. Items were generated that assessed the cognitive component of emotional contact, implying the meaningful relationship between attitude and behavior. The items were given to a panel of six judges familiar with Bowen’s Theory who rated each item on a scale of 1 to 5 scale based on
how well the item fit the concept of emotional cutoff. The five highest rated items were used to construct the scale.

The instrument was first administered to 48 members of an undergraduate class in family studies. The internal consistency of the scale was high with an alpha of .90. McCollum (1986) administered the Kansas Family Life Satisfaction Scale (McCollum, Schumm, & Russell, 1988), which is a measure of satisfaction with nuclear family relationships. An inverse relationship was found between scores on the ECS and the KFLSS (r = -.35, n = 128, p = .001, one-tailed). This finding fits with Bowen’s Theory that those who are cutoff from the parental generation experience difficulties in their marital and parent-child relationships.

Weiner (1990) used two measures in his work that linked cutoff to physical well-being. He found a low, but significant correlation between the ECS and a measurement of the seriousness of illness (r = -.21, n = 104, p = .016, one-tailed). The finding was consistent with Kerr’s (1981) findings that suggests that those who are more cutoff from the parental generation are more likely to have health problems. In assessing physical well-being, Weiner asked his divorced subjects if they made the decision to separate, and found that the spouse who reported more cutoff were more likely to make the decision to separate. This was consistent with Bowen’s assertion that those who use cutoff in parental relationships will also use it in future relationships (McCollum, 1991).

Day (1987) used a four-item scale written specifically for her study to assess her subject’s attitude toward geographical distance from their parents. Day’s scale, called the Willingness to Relocate Scale, asked questions where higher scores suggested less willingness to be geographically close to parents. Day’s scale and the ECS were positively correlated (r = .61, n = 74, p = .000, one-tailed). Bowen Theory would predict that those who handle their relationships with their parents through cutoff would be less likely to want to move physically closer to them, which was the finding of her study.

For validity, McCollum (1986) factor analyzed (principal components analysis with varimax rotation) the ECS scores in his sample, again with the instruction that two factors be extracted. This analysis confirmed the two factors found in the pilot study. A subscale of the Personal Authority in the Family System Questionnaire, the Intergenerational Intimacy Scale (IIS), was administered in each of these studies (Bray, Williamson, & Malone, 1984). The IIS had a strong correlation with the ECS—those who were more cutoff reported less intimacy with their parents (McCollum (1986), r = -.82, n = 134, p = .000; Day, r = -.85, n = 74, p = .000; Weiner, r = -.86, n =104, p = .000). This result lends credibility to the validity for the ECS.

The reliability or internal consistency of the ECS was similar in all three studies. McCollum found a Cronbach’s alpha of .82 (n=145); Day, an alpha of .88 (n=74); Weiner, an alpha of .86 (n = 104). In McCollum’s study, the distribution of scores did not differ from normal when tested by the Kolmogorov-Smirnov Goodness of Fit Test (z = .902, n = 145, p = .390, two-tailed).
The Child and Adolescent Functional Assessment Scale (CAFAS) is a multidimensional measure of degree of impairment in functioning. The instrument measures eight areas of adolescent and child functioning: Role Performance: School/Work, Role Performance: Home, Role Performance: Community, Behavior toward Others, Moods/Self Harm-Moods/Emotion, Moods/Self Harm—Self Harmful Behavior, Substance Use, and Thinking. In addition, Caregiver Material Support and Family Social Support are measured. Each area is measured on a scale of Minimal (0), Mild (10), Moderate (20), and Severe (30) Impairment. Each area of functioning is measured separately, with the total score reflecting the overall impairment of the adolescent.

Data on the psychometric properties of the CAFAS have been produced from two large evaluations: the Ft. Bragg Evaluation Project (FBEP) (Hodges & Wong, 1996, 1997) and the national evaluation being conducted of the demonstration grants funded by the Center for Mental Health Services (CMHS; Hodges, Doucette-Gates, & Liso, 1996). High inter-rater reliability has been reported for CAFAS across different sites and with both lay and clinician raters (Hodges & Wong, 1997). These studies have used the CAFAS Self-Training Manual (Hodges, 1994) to train raters and demonstrate reliability.

Good test-retest validity was demonstrated in a study in which lay interviewers rated the CAFAS after administering the CAFAS interview via telephone (Hodges, 1995). Contrast group validity has been demonstrated in both evaluations. Inpatients scored as more impaired than youth in alternative care (e.g. home-based services, day treatment), who in turn scored as more impaired that youth in out-patient care (Hodges & Wong, 1996). In the CMHS evaluation, children living in residential placements were more impaired than youth who were in specialized foster care, who in turn were more impaired than youth living in their own home or in regular foster care. In the CMHS study, youth diagnosed with schizophrenia or a pervasive developmental disorder were more impaired than depressed, anxious, and conduct-disordered youth, who in turn scored as more impaired than youth with adjustment disorders.

The CAFAS score at intake was found to be related to services received over the subsequent year. Higher impairment, as measured by the CAFAS, was significantly related to more restrictive care, higher cost of services, more bed days, and more days of service.

**Conclusion**

Many perspectives about teenage alcohol and drug abuse are discussed in the literature. As an individual pathology in a child, researchers propose a number of causes: a genetic predisposition for a primary disease of addiction, an inability to meet the tasks of adolescence, a lack of self-esteem and goal setting, poor role models, impulsiveness and influence of peers, family disruption, and community norms. The research correlates the teenager's substance abuse to other problems that are reported or documented. This
viewpoint that substance abuse is a physiological, psychological, or social pathology in the teenager is a predominate view in treatment programs for adolescents and reflects much of societal thinking about the problem. When doing a study of families of teenage substance abusers, this body of research and literature should be acknowledged.

Family theorists who have studied and written about addiction have a different point of view. The inability of the teenager to function adequately and meet developmental tasks through substance abuse, while present in the teenager, is a reflection of the functioning of the family. The family is unable to provide the structure and support to the teenager to allow them to fulfill their life tasks. Family theorists conceptualize the lack of self-esteem or the turning to a substance-using peer group for acceptance as an inability of the family to emotionally sustain a child’s trajectory to independence.

A third approach, which is the theoretical basis of this study, is that a problem in a child could be several generations in the making. By giving an in-depth survey of BFST as a way to describe multigenerational emotional process, an effort is made to present a theoretical context for the choice of the concepts of cutoff and fusion as variables in studying families with teenage substance abuse. A number of researchers have explored the relationship of the child’s individuation process to the functioning level or differentiation of their family. A central question that results from the literature review on BFST is whether a child is capable of more emotional maturity and direction in their teenage years than that of their parents.

In this chapter, different perspectives toward the problem of teenage substance abuse were reviewed. The substance-abusing teenager frequently experiences psychological, social, school, physical, and legal problems. There is substantial research that disrupted and anxious families produce symptomatic children with substance abuse problems. The literature on Bowen Theory presents a wider view of families over several generations as a context the emotional patterns, such as cutoff, which may contribute to the impairment of a teenager through substance abuse.