Emotional Cutoff In Women Who Abuse Substances

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ABSTRACT

This exploratory study was based upon Bowen Family Systems theory and investigated emotional cutoff in women (n = 168) who entered a substance abuse treatment program. Three questions were explored: First, the degree of emotional cutoff in this sample was compared to a non-clinical sample of women. Secondly, the relationship was explored between the variable of emotional cutoff and the following variables: substance abuse variables, individual psychological functioning variables, and marital and family relationship variables. Finally, the relationship was explored between dropout from substance abuse treatment and emotional cutoff.

Results indicate that the degree of emotional cutoff was significantly higher in this clinical sample of women who abused substances than in two comparison samples—one was a non-clinical sample of women balancing multiple roles and responsibilities and one mixed sample of divorced men and women. Emotional cutoff was found to have a significant positive relationship with the following variables: behaviors characteristic of substance abusers, behaviors of a highly defensive person, symptoms of depression, anxiety, hostility, psychoticism, somatization, obsessive compulsive disorder, interpersonal sensitivity, and a global assessment of psychological dysfunction. Emotional cutoff was found to have a significant negative relationship with denial of substance abuse. No significant relationship was found between emotional cutoff and marital satisfaction, health or distress in family functioning, dropout from treatment, severity of substance abuse, and symptoms of paranoia or phobia. These results have implications for further research based on Bowen theory and the understanding of the emotional process of addicted family systems.
DEDICATION

To my husband, Raymond, whose love and humor sustains me.
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CHAPTER ONE – INTRODUCTION

Statement of the Problem

There is growing evidence that actively treating people for addictions problems in their social context makes sense (Johnson & Lebow, 2000). Fifteen years ago, Kaufman (1985) noted a shift in the treatment community towards the assessment of the three generational system of the substance abuser as well as inclusion of that entire system in family therapy. Theorists and researchers have long recognized the family as a major influence in the development and maintenance of substance abuse (Waldron & Slesnick, 1998). Furthermore, studies are beginning to show the effectiveness of couples therapy for addictions treatment. In fact, the involvement of partners has emerged as essential in the treatment of alcoholism and drug dependence (Baucom, Shoham, Mueser, Daiuto, & Stickle, 1998; Lebow & Gurman, 1995, as cited in Johnson & Lebow, 2000).

Evidence from research affirming the importance of the social context in addictions treatment is a relatively new phenomenon. Historically, there has been a controversy between addictions counselors and Family Systems counselors over how one conceptualizes, defines and treats alcoholism. Alcoholics Anonymous was established in the 1930's and proposed a view of alcoholism as a disease. This view was generally adopted and in the early 1960's Jelinek (1960) defined Alcoholism as a disease. The "disease model" tends to view the individual and factors within the individual as the focus of treatment and excludes the influence of the family (Stevens-Smith, 1994; Bepko & Krestan, 1985). The term alcoholism is often used by adherents of the disease model (Baucom, Shoham, Mueser, Daiuto, & Stickle, 1998). While alcoholism has disease-like effects and damages the healthy biological and neurological integration of the individual, other treatment professionals take a psychological or sociological orientation (Lewis, 1994; Stevens-Smith, 1994). The term problem drinking often reflects a psychosocial approach to treatment (Baucom, Shoham, Mueser, Daiuto, & Stickle, 1998). Family Systems counselors tend to view alcohol addiction from an interpersonal context that points to dysfunctional behaviors being passed from parents to children (Stevens-Smith, 1994; Bepko & Krestan, 1985). There is a growing recognition that treatment needs to integrate individual biological and
psychological components with family and social components (Lewis, 1994; Stevens-Smith, 1994).

Bepko and Krestan (1985) in their book The Responsibility Trap attempt to bridge the gap between the individual and the psychosocial approach by integrating the positions of both therapeutic communities in their Bowen-based treatment approach. They provide a rich, theoretical treatment perspective that consciously integrates an individual approach (focusing on genetic, physiological, psychological, and spiritual factors), including attendance at Alcoholics Anonymous meetings, with an interpersonal Bowen based treatment approach. They consciously integrate systemic and structural interventions to achieve Bowen goals. Another similarly integrated approach is used by Brown and Lewis (1999) who define alcoholism as a physical, psychological, social, emotional, and spiritual disease.

Within the field of family therapy there are three general approaches which are used to treat substance abuse and other addictive behaviors in men and women. These treatment approaches are behavioral, integrative, and family systems models (Waldron & Slesnick, 1998). The Behavioral family therapy model relies primarily on operant and social learning theories to understand the behavior of an individual in the context of the family. Substance use behaviors are viewed as a pattern of responses learned in the context of social interactions and established as a result of family-related and other environmental contingencies. Behavioral family treatment emphasizes skill building and contingency management with the intent of reinforcing behaviors incompatible with substance use, while decreasing substance use and related negative behaviors (Waldron & Slesnick, 1998).

Integrative family therapy models view substance use in the context of multiple systems and sources of influence. Treatment interventions may be drawn from across a variety of therapeutic models to facilitate the improvement of intrapersonal factors and processes which may be influencing substance use, to modify behavioral exchanges in the family and to intervene in the larger context at the level of the schools or legal system. Treatment models commonly drawn upon include Structural, Strategic, Functional, and Behavioral family therapies (Waldron & Slesnick, 1998).
Family Systems models views the family as a basic emotional unit or system. Dysfunction in the system as a whole accounts for the presence of maladaptive behaviors expressed by one or more family members. While there are internal differences among family systems professionals on how to view the family or social context within which substance abuse behaviors take place, all agree that the focus of treatment is relational and needs to address interpersonal relationships and processes, rather than the individual (Waldron & Slesnick, 1998).

Within the family systems models, the Bowen Family Systems approach connects substance abuse and the use of distancing postures in the context of an intergenerational family system. Bowen (1974; 1978) contends that alcoholism develops within an imbalance in functioning in the total family system; and each family member plays a part in this system. Emotional distancing is a relationship posture and may be used in this type of family system to manage anxiety (Bowen, 1978; Gilbert, 1992). The core anxiety being distanced from is the anxiety generated by one's unresolved emotional attachment to one's parents—which is denied. This denial of the need for emotional closeness is automatically and unconsciously taken into adult relationships and can, Bowen (1978) says, be expressed by a super-independent posture which affirms, "I do not need you. I can do it myself." Thus, as isolation increases, anxiety intensifies and relief is sought in substance abuse. However, the original attachment issues are not addressed or resolved in a functional way (Bowen, 1978; Gilbert, 1992). A high percentage of adult alcoholism occurs in people who have the same kind of emotional attachment in marriage that they had in their parental families. They are emotionally isolated from their spouses, just as they were from their parents (Bowen, 1974).

An extreme form of distancing is emotional cutoff. Cutoff is the distancing posture carried to an extreme, resulting in a nonfunctioning relationship (Gilbert, 1992). Bowen says emotional cutoff is manifested in the denial of an unresolved emotional attachment to one's parents, acting independent, and achieving emotional distance through internal psychological mechanisms or by physical distance (Bowen, 1978). Gilbert (1992) says cutoff develops as an attempt to adapt to intense chronic and acute anxiety in the family of origin. The rub is that except for a brief period of calm following the cutoff, intensity actually increases and people involved in cutoff relationships experience an intensification of depression and anxiety. They
may find themselves unable to cope and may suffer from addictions. Relationships in the workplace, with friends or romantic partners will be more intense because they are cutoff from their families of origin (Gilbert, 1992).

After reviewing the Bowen-based research (see chapter two) looking at emotional cutoff and substance abuse, it seems substantial work remains to be done. While studies exist that look at emotional cutoff, there are only two case studies which evaluate emotional cutoff and treatment for substance abuse (Erkenbeck, 1995; McKnight, 1998). Substantial questions remain. This study will examine emotional cutoff in the lives of women who entered a treatment program for substance abuse. I am interested in addressing three questions.

• What is the degree of emotional cutoff in a clinical population of women who present for substance abuse treatment—and how does that differ from a non-clinical population?
• Will a significant relationship be found between emotional cutoff and other variables of interest (i.e., the severity of the addiction, the presence of chemical dependency, the presence of psychological symptoms and distress, family functioning, and partner satisfaction)?
• What relationship exists between emotional cutoff and dropout from treatment?

Rationale

The Bowen Family System's approach to conceptualizing family systems and substance abuse is the therapeutic model upon which my own therapeutic model is based. When I first read Bowen theory four years ago, it made intuitive sense and I used it to begin working on my self in the context of my family-of-origin. Professionally, Bowen theory proves valuable as I meet with clients—some of whom are dealing with issues arising from life in an addicted family system. I have attended Alcoholics Anonymous and Codependents Anonymous meetings and find that integrating many of their ideas and readings into a Bowen approach is productive for my clients. I am personally and professionally interested in relating theory to clinical practice and research.

Bowen family systems theory is based on clinical observation and work. It is an approach to working with substance abusers which has standing in the family systems field. Bowen theory asserts that emotional cutoff increases anxiety; and it will likely be expressed by
increased severity of psychological symptoms, employment or work-related problems, and in family or other social relationship problems (Bowen, 1978). However, no research has actually been done to verify the presence of emotional cutoff in the lives of substance abusers nor has emotional cutoff been linked to other symptoms or signs of increased anxiety or depression substance abusers may show.

This study has clinical relevance to the field. Should this study demonstrate the presence of emotional cutoff in the relationships of substance abusing women, it may help to validate Bowen's underlying theoretical assumptions about the substance abuser's family system. This validation, should it occur, will provide additional certainty to clinicians as they consider their therapeutic approach to treatment of an addicted family system. It stands to reason therapeutically that if you can reduce the anxiety underlying the cutoff you can also reduce other symptoms of dysfunction and increase healthy functioning. This research may help to support this therapeutic judgement and approach.

The field of family therapy has respected the need to integrate theory, research and practice, beginning with Olson's (1976) seminal paper on the subject. However, a recent review of articles published in two major Marriage and Family Therapy journals found that the link between research and theory in practice needs strengthening. While a majority of research studies showed an explicit or implicit link to theory, 42% did not. Furthermore, only 19% of the research articles sought to build theory through a process of basing the study on a theoretical foundation and then applying the findings as a means of extending the theory (Hawley & Geske, 2000). This study will answer the call to validate theory by using the theory in an explicit way, both as the basis for the study and in discussing the findings.

This research used quantitative methods to investigate the systemic presence and effects of emotional cutoff in women who entered a substance abuse treatment program. It assessed the degree of emotional cutoff present; and investigated the relationship between cutoff and substance abuse variables, individual functioning variables, and family/marital relationship variables. Finally, the researcher investigated differences in measures of emotional cutoff
between women who completed a 12 week treatment program for substance abuse and those who
did not complete treatment.

Theoretical Framework

I am using Bowen Family Systems theory on emotional cutoff and addicted family
systems to guide this study. Daniel Papero (1995) offers a particularly clear and concise
description of Bowen Family Systems theory. Papero (1995) addresses the appearance of
anxiety, distancing, emotional cutoff and the effects of emotional cutoff in a relationship system.
Papero (1995) says anxiety, distancing, and emotional cutoff are normal emotional processes
experienced by all human beings. Anxiety is a natural response to real or imagined threat. As a
person responds to the perception of real or imagined threat, physiological and psychological
changes occur in a person's emotional system. Acute anxiety describes a person's response to a
real and current danger. Once the danger passes, so does the anxiety. Chronic anxiety describes a
person's response to a future threat, to what might occur, and can be held long term. Chronic
anxiety can be manifested in many ways—to include fears about what might be, irritability,
fatigue, physical symptoms, and sustained wariness. The presence of anxiety, whether acute or
chronic, impedes a person's ability to use their intellect to guide themselves through life (Papero,
1995; Bowen 1978).

An early symptom of relationship anxiety is emotional distance. It may manifest in
silence, physical avoidance, disinterest in what another says or does, being preoccupied and even
in clinical symptoms, like depression. Each person can become distant from the other, or one
can pull back from a puzzled other. If the distance is uncomfortable enough, the less distant one
will make efforts to reengage the more distant person. If this effort is not successful, the person
who distances will tend to distance more and the other may pursue the distancer more
vigorously. These symptoms may appear whenever anxiety surpasses the particular tolerance of
the people involved (Papero, 1995; Bowen 1978).

Emotional cutoff refers to extreme emotional distancing. When anxiety is high people
who live together may become more reserved and isolated from each other to maintain the
emotional equilibrium in the family. The distance can be internal, with one or more persons in a family system employing internal psychological or physiological mechanisms to avoid contact with others in the same household. Others, who are sensitive to the physical presence of significant others, may resort to physical distancing to find emotional equilibrium. Emotional Cutoff is an adaptive mechanism to achieve emotional distance and equilibrium. It is a way of adapting to intense, chronic and acute anxiety in the family system. While it may provide an immediate sense of comfort, intensity actually increases in subsequent marital and parent-child relationships. Thus the use of emotional cutoff is not functional in the long run. Therefore, emotional cutoff develops as a way to manage unresolved emotional attachment to parents (Bowen, 1978; Papero, 1995)

Unresolved emotional attachment refers to the concept that from conception forward human beings begin to physically separate from their parents in a developmental sequence. Emotional separation is the ability to emotionally separate from one's parents and define a separate self from one's parents. To the degree that emotional separation is incomplete, the parents and child remain attached emotionally. The attachment can be symbiotic, in which parents and child can not survive apart, or degrees of separation beyond that. Emotional separation is the ability to follow one's own intellectual and emotional guidance while maintaining the ability to relate to one's parents (Papero, 1995). The attachment that remains Bowen identifies as unresolved emotional attachment (Bowen, 1978; Papero, 1995).

A common pattern in our society, Bowen (1978) notes is the emotionally distant relationship pattern, with brief superficial visits to the family of origin out of a sense of duty. Partners marry in an attempt to resolve issues they had in their families of origin with their parents; however, all they succeed in doing is reproducing the quality of the relationship they had with their parents with their partners. Bowen affirms that the more a nuclear family is emotionally cutoff from parental families, the higher the incidence of problems and symptoms.

Bowen (1978) notes that the person who "runs away" from home is as emotionally attached as the person who stays but uses internal mechanisms to achieve distance. The person who runs away needs emotional closeness but is allergic to it. In fact, the more intense the cutoff
with parents, the more vulnerable a person is to repeating the same pattern of cutoff in future
relationships (Papero, 1995; Bowen, 1978).

Papero (1995) discusses emotional cutoff and marital relationships. He says it has
particularly important consequences for marriage. Each partner must manage his or her own
unresolved emotional attachment to parents and cutoff is frequently used. The more distant each
partner is from his or her own family, the more intense the emotional process within the
marriage. The person who has used cutoff to manage
their feelings of attachment to their parents is also more likely to employ distance and cutoff with
their spouse. McKnight (1998) notes that when a person is distant they often are thought by
others to be not emotional or not involved. However, distancing is an indicator of just how
cought the person is in the emotional life of the family. The desire to distance confirms just how
important the others are in the emotional life of the individual. People can distance through
work, other relationships, and mood-altering substances (McKnight, 1998).

Alcohol and other substances that are abused often serve the role of emotional "buffers"
in the family (McKnight, 1998). During marriage spouses often look to the other for closeness
and to meet needs that were not met or resolved in their own family of origin. Yet the more one
seeks emotional gratification from the other who is also needy, the less one receives. Each
submerges "self" in the other, and the partners become fused, with little space for their own
identities. In this context, drinking becomes a buffer to over closeness. It provides the drinker
with a sense of escape from the relationship and a sense of emotional space. So the drinking or
abuse of other substances provides a degree of distance which helps the couple maintain a sense
of their own individual identity and relief from the fear of being swallowed up by the other
(McKnight, 1998).

In some marriages, the alcoholic partner goes through periods of drinking and non
drinking. This can parallel the regulation of distance and closeness in the relationship. The brief
period of closeness during the period of non drinking often acts to keep the spouse in the
relationship. This is the period when the alcoholic spouse is eager to please, loving and may be
contrite about the problems caused by drinking. These periods of closeness and non drinking are
often in sharp contrast to the drinkers mood, which may be angry and violent, when they are
drinking. For other couples periods of non drinking are times of conflict when the non drinking
spouse communicates the problems that have accumulated during episodic drinking. Thus
drinking becomes part of the cycle of distance and closeness in the relationship (McKnight,
1998).

Bowen (1978) affirms that a high percentage of adult alcoholics have the same kind of
emotional attachment in marriage that they had in their parental families. Thus, they bring to
their marriage the same quality and degree of emotional contact that they had with their parents.
This emotional contact is expressed in the quality of the contact, and in the degree to which a
sense of emotional connection to, or isolation from, their partner is felt.

When a person becomes aware of their tendency to cutoff from significant others and can
moderate or decrease its use, then the marital partnership benefits with a decrease in emotional
intensity. If a person is able to gain more emotional objectivity about their family of origin and
work towards maintaining meaningful contact with the family rather than cutoff from it, the
amount of anxiety and emotional distance in relationships with spouse, children, and important
others will decrease.

More emotional objectivity means being able to see the way a person influences the
emotional functioning of others and the way others influences their own emotional functioning.
If a person does this then they will be able to be more of an individual within the family system
without disrupting their relationship to others. This calming of internal anxiety and increased
ability to remain emotionally connected to significant others in one's family of origin and one's
family of choice leads to greater differentiation of self (Bowen, 1978; Kerr & Bowen, 1988;
Papero, 1995).

In this sense differentiation of self can be understood as a deliberate effort to understand
the emotional reactivity that influences a person to flee from a relationship. Those who work at
maintaining a separate identity while remaining connected to important others have an increased
ability to direct their lives. The boundaries of self are defined by decisions and choices based on
their values and beliefs rather than upon reactions to their relationship system (McKnight, 1998).

Purpose of the Study

The purpose of this study is to conduct a quantitative investigation based upon Bowen theory into the presence and effects of emotional cutoff in women who entered a substance abuse treatment program. The level of analysis is the individual. The research data will be used to assess the degree of emotional cutoff present and to compare it with a non-clinical population. Next, the researcher will assess whether there is a significant relationship between emotional cutoff and substance abuse variables, individual psychological functioning variables, and family/marital relationship variables. Finally, the researcher will investigate differences between women who completed a 12 week treatment program for substance abuse and those who did not complete treatment by comparing the degree of emotional cutoff present in both populations.

Bowen theory would predict that with increased chronic anxiety a higher degree of emotional cutoff could also exist leading to increased dysfunction at the level of the individual, family and couple. Therefore, I tested the following three hypotheses.

Hypothesis One: The degree of emotional cutoff in this clinical population is significantly above that found in a non-clinical population.

Hypothesis Two: There is a significant relationship between emotional cutoff and substance abuse variables, individual functioning variables, and family/marital relationship variables.

Bowen theory would predict that the more intense the emotional cutoff with parents, the more vulnerable a person is to repeating the same pattern of cutoff in future relationships (Papero, 1995; Bowen, 1978). This includes significant adult relationships with friends, family, employers or co-workers and therapists. This may be the result of being too reactive or
vulnerable to emotional closeness with others (Bowen, 1974, 1978; Bepko & Krestan, 1985; Erkenbeck, 1995).

**Hypothesis Three:** Those clients who drop out of treatment will have significantly higher scores on the Emotional Cutoff Scale than those who complete treatment.
CHAPTER TWO: LITERATURE REVIEW

The purpose of this study is to conduct a quantitative investigation based upon Bowen theory into the presence and effects of emotional cutoff in women who entered a substance abuse treatment program. The level of analysis is the individual. The research data will be used to assess the degree of emotional cutoff present and to compare it with a non-clinical population. Next, I assessed whether there is a significant relationship between emotional cutoff and other variables—specifically, the severity of the addiction, the presence of chemical dependency, the presence of psychological symptoms which may meet the criteria for psychiatric diagnosis, family functioning distress, and marital/partner relationship satisfaction. Finally, I investigated differences between women who completed a 12 week treatment program for substance abuse and those who did not complete treatment by comparing the degree of emotional cutoff present in both populations.

In chapter one I described how Bowen Family Systems theory addresses the addicted family system and emotional cutoff. In this chapter, I describe research which has investigated important concepts in Bowen theory. Next, I describe in greater detail Bowen’s theory of the addicted family system and studies into the treatment of substance abuse based on Bowen theory. Then, I describe studies relating specifically to emotional cutoff.

General Review of Bowen Research

There has been little substantive research done to test Bowen Intergenerational Theory, although it is widely drawn upon as a model for a treatment approach or as a component of integrated models of treatment. However, there has been some recent progress towards conducting Bowen-based research. For example, recent studies have inquired into differentiation and the intergenerational transmission of the emotional process as it pertains to following issues:

- the interplay of intimacy, individuation and health (Harvey & Bray, 1991; Harvey, Curry, Bray, 1991);
- elderly life review therapy (DeGenova, 1991);
late adolescent romantic relationships, individuation and sex roles, and family of origin dynamics (Benson, Larson, Wilson, Demo, 1993; Bartle-Haring, 1997; Bartle-Haring and Sabatelli, 1998)

- emotional reactivity towards one's parents and psychological distress (Bartle-Haring, Rosen & Stith, in press);
- two multicultural samples tested the universality of Bowen concepts on differentiation. A Philippine sample (n=306) was tested to see if parental levels of differentiation would predict children's level of differentiation (Tuason and Friedlander, 2000). Murphy (1999) examined marital adjustment in a sample of 32 married Asian Americans.
- Marital therapy utilizing Bowen therapeutic approaches has also been recently addressed (Hare, Canada, & Lim, 1998; and Cox, 1996; Skowron, 2000).
- Additionally, Skowron and Friedlander (1998) created a differentiation of self inventory (DSI) that focuses on adults, their significant relationships, and current relations with family of origin.
- Other Bowen-based studies have inquired into triangulation, including a study of nurse manager job stress responses (Hanson, 1998), and the process observed in family care between the individual, the family, and the service delivery system. A Menninger study (Davis, 1987) proposed a functional use of Bowen's theory on triangles as an approach to guiding patients, host families, and social workers through a program for placing adult psychiatric patients in family settings. Davis' study is illustrated with two case examples showing how Bowen concepts facilitate the program.

The findings of many of these studies support Bowen theory concerning the intergenerational transmission of family-of-origin patterns and differentiation of self (Harvey, Curry, and Bray, 1991; Skowron and Friedlander, 1998; Bartle-Haring, Rosen & Stith, in press; Rosen, Bartle-Haring, Stith, In Press; Bartle-Haring and Sabatelli, 1998). For example, Harvey, Curry, and Bray's (1991) study provided support for the intergenerational transmission pattern. They found that parents' relational patterns of individuation and intimacy directly and indirectly influenced their offspring's patterns. However, there are also exceptions. Murphy's (1999) study did not find a statistically significant relationship between differentiation and marital
adjustment.; and, Benson, Larson, Wilson, Demo, (1993) did not find anxiety related to triangulation in a study of romantic relationships of late adolescents; but they did find anxiety related to other aspects of Bowen theory. Thus, there is certainly room for more research based on Bowen theory.

Bowen Theory and Studies on Addicted Family Systems

I found one article by Bowen addressing alcoholism (Bowen, 1974), one doctoral dissertation by Erkenbeck (1995) and an article by McKnight (1998). The article by Bowen describes the functioning of alcoholic families from his viewpoint. Erkenbeck and McKnight apply Bowen theory to the treatment of an addicted family system; and they both provide case study data but no quantitative measures. Erkenbeck describes the use of Bowen theory to treat couples with chemical dependency problems.

Bowen theory of addicted family systems

I will describe Bowen's theory of the treatment of alcoholic family systems (Bowen, 1974) and add clarifying information from his article on theory (Bowen, 1978). Bowen (1974) describes Family Systems theory and says alcoholism exists in the context of an imbalance in functioning in the total family system. Every important family member plays a part in the dysfunction of the dysfunctional member. Therapy is directed at helping the family to modify its patterns of functioning. Bowen then discusses his theoretical concepts, particularly differentiation of self, which is the cornerstone of his theory (Bowen, 1974; 1978).

Bowen asserts there are two main variables in his theory: the degree of anxiety and the degree of integration of self. Bowen says all living things are reasonably adaptable to acute threats, having built in mechanisms to deal with short bursts of anxiety. It is sustained or chronic anxiety that is useful in determining differentiation of self. If anxiety is low, almost anyone can remain symptom free. When anxiety increases and remains chronic, persons can develop tension, either within him or her self or in the relationship system. This tension results in symptoms or dysfunction or sickness. The tension may result in physiological symptoms or physical illness, in
emotional dysfunction, in social illness characterized by impulsive behavior or withdrawal, or by social misbehavior. Anxiety is infectious and can spread rapidly through the family (Bowen, 1978).

Bowen (1974; 1978) believes differentiation of self is the degree to which the person has a "solid self" or solidly held principles by which he lives his life. The solid self is made up of clearly defined beliefs, opinions, convictions, and life principles. This is in contrast to a "pseudo self" created by emotional pressure, which can be modified by emotional pressure. The pseudo-self is made up of inconsistent life principles that can be corrupted by coercion for the gain of the moment.

Bowen (1978) said differentiation of self defines people according to the degree of fusion, or differentiation, between emotional and intellectual functioning. At the low extreme of differentiation of self are people whose emotions and intellect are so fused that their lives are dominated by the automatic emotional system. What ever intellect they have is dominated by the emotional system. These are the people who are less flexible, less adaptable, and more emotionally dependent on those about them. They are easily stressed into dysfunction, and it is difficult for them to recover from dysfunction. It is the pseudo-self that is involved in fusion and the many ways of giving, receiving, borrowing, lending, trading, and exchanging of self. This is the process involved in a love relationship when each is trying to be the way the other wants self to be, and each in turn makes demands on the other to be different. This is trading in pseudo-self (Bowen, 1978).

At the other extreme are those who are more differentiated. It is impossible for there to be more than relative separation between emotional and intellectual functioning, but those whose intellectual functioning can retain relative autonomy in periods of stress are more flexible, more adaptable, and more independent of the emotionality about them. They cope better with life stresses, their life courses are more orderly and successful, and they are remarkably free of human problems (Bowen, 1978).
Bowen (1978) asserts differentiation of self is roughly equivalent to the concept of emotional maturity. The level of differentiation or emotional maturity of a person is determined by the level of differentiation of one's parents, by the type of relationship the child has with the parents and the way one's unresolved emotional attachment to his parents is handled in young adulthood (Bowen, 1974). Bowen asserts all persons have some degree of unresolved emotional attachment to their parents. The lower the level of differentiation, the more intense the unresolved attachment. Unresolved emotional attachment is expressed in the way an individual separates from their parent. It is shown in how the individual separates; and may involve a process of isolation, withdrawal, running away, or denying the importance of the parental family (Bowen, 1978).

Bowen (1974) explains that some persons distance themselves emotionally while living close by; others maintain emotional closeness while living far apart. Emotional distance or closeness to parental families is determined by a combination of physical distance and quality of relationship. The one who remains in the parental home and handles the attachment by intrapsychic mechanisms, tends to have a less intense overall process, and to develop more internalized symptoms under stress, such as physical illness and depression. The one who runs away geographically is more inclined to impulsive behavior. He tends to see the problem as being in the parents and running away as a method of gaining independence from the parents. The more intense the cutoff, the more vulnerable to duplicating the pattern in marriage. When problems develop in marriage, he tends also to run away from that.

The more a nuclear family is emotionally cutoff from parental families, the higher its incidence of problems and symptoms. Since people marry spouses who have equal levels of differentiation of self, this predicts the degree of immaturity to be absorbed in the new nuclear family (father, mother, and children).

Bowen (1974) affirms that young people commonly blame their parents for past unhappiness and expect to find perfect harmony in marriage. However, young people commonly approach marriage by fusing their pseudo-selfs into the emotional we-ness of marriage, which sets the conditions for impairment in the functioning of one spouse. The discomfort of fusion is
generally handled in several ways. Fusion can be handled by emotional distance in the marriage, which helps each partner have a more definite self. Fusion can be handled by having a conflictual marriage which helps them maintain emotional distance, except for brief "make-up" periods which provides intervals of intense closeness. Fusion can also be handled by one spouse becoming the dominant decision-maker. In this instance, the adaptive spouse becomes a functional "no self." Allowed to continue, the "no self" spouse becomes vulnerable to chronic dysfunction of some kind, such as physical or emotional illness, drinking, drugs, or irresponsible behavior. Another pattern is one in which parents project their immaturity to one or more of their children.

Bowen (1974) says that, in general, the person who later becomes an alcoholic is one who handles the emotional attachment to parents and especially to his/her mother, by denial of the attachment and by a super-independent posture which says, "I do not need you. I can do it myself." The level of emotional attachment is fairly intense. However, the level of intensity is not as important as the way the attachment is handled. The person may over-function at work, become emotionally isolated from spouse and children, and when the isolation is most intense initiate drinking.

Another way an alcoholic may handle attachment, Bowen (1974) says, is to fuse with his/her mother and become "de-selfed." However, the alcoholic denies this need for closeness to his mother which permits him to keep his distance from the realization of this need for emotional closeness and all subsequent relationships. This alcoholic collapses into drinking early in life, while loudly affirming his/her independence.

Bowen (1974) hypothesizes that a high percentage of adult alcoholism is in people who are married, and who have the same kind of emotional attachment in marriage that they had in their parental families. They are emotionally isolated from their spouses. People marry spouses with equal levels of differentiation of self, although they usually have opposite ways of dealing with stress. They commonly have a combination of three patterns for dealing with marital fusion. They have some degree of marital disharmony, some degree of the adaptive spouse being "de-selfed," in the marital fusion, and some degree of projection of the problem to their children.
Bowen provides case examples of these patterns and then describes therapeutic principles for treatment.

**Bowen case studies of addicted family systems**

Erkenbeck (1995) for his doctoral dissertation conducted a case study using Bowen therapy to treat a couple struggling with chemical dependency and the emotional distance in their relationship. Erkenbeck contends that chemical dependency assisted this couple in regulating the amount of intimacy and emotional distance that existed between them. The husband relapsed after five years of recovery from drug use and at the time therapy began, was not working. The wife took a motherly overfunctioning position toward her husband and her husband accepted this. Erkenbeck describes how Bowen coaching techniques helped this couple learn new ways to manage their anxiety around changes in emotional distance and closeness.

McKnight (1998) provides a case study of couples therapy in the treatment of addiction using Bowen theory. In the first part of the article, she describes Bowen theory and the addicted family system and then applies Bowen theory to a case involving a couple. In some marriages, the alcoholic partner goes through periods of drinking and nondrinking. This can parallel the regulation of distance and closeness in the relationship. The brief period of closeness during the period of nondrinking often acts to keep the nondrinking spouse in the relationship. This is the period when the alcoholic spouse is eager to please, loving, and may be contrite about the problems caused by drinking. These periods of closeness and nondrinking are often in sharp contrast to the drinker's mood, which may be angry and violent during times of alcohol consumption. For other couples, periods of nondrinking are times of conflict when the nondrinking spouse communicates the problems that have accumulated during episodic drinking. Thus drinking becomes part of the cycle of distance and closeness in the relationship (McKnight, 1998).

McKnight (1998) contends that alcohol and other substance abuse often serve as emotional buffers in the family. During marriage, spouses often look to the other for closeness and to meet needs that were not met or resolved in their family of origin. Yet, the more one
partner seeks emotional gratification from the other partner, who is also needy, the less the seeking partner receives. Each submerges "self" in the other, and the partners become fused, with little space for their own identities. In this context, drinking becomes a buffer to overcloseness. This buffer provides the drinker with a sense of escape from the relationship and a sense of emotional space. So drinking or abuse of other substances provides a degree of distance which helps the couple maintain a sense of their own individual identity and relief from the fear of being swallowed up by the other (McKnight, 1998).

Bowen-integrated treatment approaches

Bowen systems thinking has also been integrated with other treatment approaches for substance abuse. I will briefly describe three examples. First, Bepko and Krestan (1985), describe how they integrated Structural and Strategic techniques along with 12 step group approaches to achieve Bowen goals in the treatment of addicted family systems. They focus on the dynamics surrounding over and underfunctioning in the area of personal responsibility by all family members to include the abuser. Another integrated model proposed a Bowen-based approach to co-dependency treatment (Gibson and Donigian, 1993). They discuss how the dynamics surrounding co-dependency are similar to the dynamics of having a low level of differentiation of self. Finally, Systemic Couples therapy utilizes a Bowen intergenerational component along with Structural, Strategic and Behavioral techniques as an approach to couples therapy for women being treated for substance abuse (Wetchler, McCollum, Nelson, Trepper, & Lewis, 1993; Wetchler & DelVecchio, 1995).

Bowen-based Research into Emotional Cutoff

I found 14 studies that study distancing and emotional cutoff directly; or, in their findings, have conclusions concerning emotional cutoff. I will begin by discussing earlier studies and coming forward in time to more current studies.

Dillard and Protinsky (1985) investigated whether a difference in unresolved emotional attachment and emotional cutoff existed in a comparison study of a sample of 11 couples in
therapy for marital difficulties and a sample of 11 nonclinical couples who had been recent
volunteers for a marital enrichment group. It was hypothesized that the greater the emotional
cutoff between the nuclear family and the family of origin, the greater the amount of marital
conflict in the nuclear family. Subjects were administered measures of marital communication,
marital adjustment, and a questionnaire to assess the degree of physical and/or emotional
distance between generations. The results indicated that approximately 25% of each sample was
classified as cutoff. This result does not support Dillard and Protinsky's (1985) hypothesis that
the clinical population would reflect a higher percentage of emotional cutoff than the nonclinical
sample. A second analysis of the data compared the cutoff group with the non-cutoff group.
The results showed that the emotionally cutoff individuals had lower scores on marital
communication than the non-cutoff group. Dillard and Protinsky concluded this supports
Bowen's theory that emotionally cutoff individuals are less well adjusted in their marital
relationships and are lower functioning—as shown by their lower scores on marital
communication. However, Dillard and Protinsky concluded that since approximately 25% of the
clinical and non-clinical samples were cutoff, this suggests symptoms of emotional cutoff may
be endemic to the general population.

A study by Lartin (1986) inquired into the relationship between emotional cutoff and
symptoms in the nuclear family. She explored the concept of adults' unresolved emotional
attachment to their parents, and the process of emotional cutoff used to deal with this attachment
in two groups of families. Married couples were screened and placed in the emotionally
symptomatic group (n=48) or the asymptomatic group (n=39). Three dimensions of cutoff were
studied: the frequency of intergenerational contact, geographic distance between subjects and
parents, and the quality of the relationship between subjects and parents. There were no
significant differences for the first two dimensions (frequency of contact and geographic
distance). However there were significant differences between the two groups concerning the
quality of relationships between subjects and parents. The husbands from symptomatic families
tended to be in relatively less contact with their parents and the wives from symptomatic families
reported the least personal closeness and the most reactivity to their parents. The symptomatic
wives also reported the highest number of relatives having moderate to severe emotional
problems. The husbands and wives from asymptomatic families tended to live farther away from their parents.

A study by McCollum (1986) tested a model proposed by Michael Kerr based on Murray Bowen's concept of family systems. Kerr felt that high stress, in combination with a distant or emotionally cutoff relationship with family members, provides a situation of great risk for the development of various physical or psychological symptoms. McCollum hypothesized that there would be a significant interaction effect between a measure of stress and measures of spousal and intergenerational intimacy in the prediction of serious illnesses and psychological distress reported by subjects. He predicted that subjects who score low in intimacy will score significantly higher on measures of seriousness of illness and psychological distress than subjects who report highly intimate relationships. The sample was comprised of 106 males and 76 females ranging in age from 22 to 77 years old. The mean age was 49.96. The sample was chosen from a group of spouses and parents listed as the nearest relative by Kansas State University graduates. Two scales of the Personal Authority in the Family System Questionnaire (PAFS-Q) were used to measure family intimacy variables. The result of the PAFS-Q was correlated with a new measure McCollum created for this study, the Emotional Cutoff Scale. The Emotional Cutoff Scale was developed to study the cognitive component of Bowen's concept of emotional cutoff. McCollum found evidence for an interaction effect between stress and spousal and intergenerational intimacy in the prediction of serious illness and psychological stress. That is to say, the highly cutoff group changed in the presence of stress, reporting more symptoms as stress increased. Whereas the less cutoff group did not change in the presence of stress, and the number of their symptoms did not increase. Additionally, a strong negative correlation was reported between the Intergenerational Intimacy subscale of the PAFS-Q and the Emotional Cutoff Scale (r=-.82, n = 134, p=.000). That is, people with higher emotional cutoff scores reported less intimacy with their parents.

A study by Reifman (1986) measured the relationship between the degree of emotional cutoff and the quality of marital adjustment and intimacy. He sampled 107 married adults residing in San Diego county. A correlational design was used to determine if differences existed in the quality of intimacy between married adults that cut themselves off and adults that
did not cutoff from members of their family-of-origin. Differences were measured in terms of
dyadic adjustment, marital intimacy, and degree of cutoff from members of the family of origin.
There was a significant correlation between the level of emotional cutoff that exists between
individuals and their families of origin and the establishment and maintenance of intimacy in
their marriages. Reifman found that the more intensely cutoff individuals were the greater
difficulty they had in close intimate relationships. Reifman concluded his study supported
Bowen's theory of emotional cutoff and multigenerational transmission.

An exploratory study into intergenerational distancing and its relationship to individual,
family and occupational functioning was conducted by Day (1988). This study tested the
assumption that problems in daily living are greater for persons lower in differentiation than
persons with a higher level of differentiation of self. The variables of emotional and physical
distance were hypothesized to represent the level of differentiation with subjects living further
away being less differentiated. A convenience sample of 102 employed women between the ages
of 25-70 with at least one living parent was obtained. The women in this study were a non-
clinical population and were experiencing the normal chronic stress due to their handling of
multiple responsibilities and roles as child, wife, mother, and worker. The mean age of the
subjects studied was 41.5 years. Emotional distance was measured by the Emotional Cutoff
Scale (McCollum, 1986) and by the Intergenerational Intimacy subscale of the Personal
Authority in the Family System Questionnaire (PAFS). Day used a 4 item scale she wrote for the
study to assess subject's attitudes towards relocating to be closer to their parents.

Day's scale and the Emotional Cutoff Scale were positively correlated ($r = .61$, $n = 74$, $p$
$.000$ one-tailed) where higher scores suggested less willingness to be geographically closer to
parents. Data analyses revealed little support for the assertion that physical distance from parents
is directly related to increased problems in living. However, the influence of emotional intimacy
between generations on functioning in one's current relationships was supported in limited ways.
Data from interviews with respondents demonstrated a greater reliance on an
over/underfunctioning reciprocity in relationships, as opposed to distancing, as the primary
mechanism of managing anxiety. Day concluded by noting that there are problems inherent in
investigating patterns of reactivity since each person constructs his/her own reality.
Mackelburg (1988) investigated the effect of depression upon marital intimacy in persons emotionally cutoff from their families of origin. He hypothesized that the presence of depression and emotional cutoff from one's family of origin results in decreased levels of marital intimacy. The sample for the study included 149 married graduate students from southern California university campuses. A 2 x 2 factorial design and ANOVA were utilized to determine whether emotional cutoff, depression, or an interaction between emotional cutoff and depression resulted in decreased levels of marital intimacy. The results showed a significant effect ($p<.001$) for depression and decreased marital intimacy. However, Mackelburg found no relationship between levels of marital intimacy and emotional cutoff.

Weiner (1990) investigated Intergenerational distancing, emotional cutoff, and emotional connectedness between former spouses. Weiner obtained a mixed clinical and non-clinical sample of 114 Midwestern divorced volunteers recruited from churches and therapists in rural and metropolitan settings. 40 subjects were male and 74 were female. All had been divorced once or twice. Ages ranged from 20 to 63 years of age. These subjects were well-educated. Only 14 subjects reported not going to college (12.3%), and 30.7% had graduate degrees. Except for two subjects, all were employed either full or part-time with incomes ranging from less than $10,000 to over $75,000. The median income was reported in the $10,000 to $25,000 category. Weiner utilized the intergenerational intimacy subscale of the Personal Authority in the Family System Questionnaire (PAFS) and correlated the results of the PAFS with the Emotional Cutoff Scale. Weiner found that subjects with higher emotional cutoff scores reported less intimacy with their parents. Weiner also found that subjects who were more cutoff from the parental generation were more likely to report health problems. Weiner also found subjects reporting more cutoff were also more likely to make the decision to separate. Weiner concludes these results confirm Bowen's assertion that subjects who use cutoff in parental relationships will also use cutoff in future relationships when emotional intensity rises. Overall, Weiner found a significant relationship between measures of intergenerational emotional cutoff from subject's parents, measures of emotional connectedness to former spouses and physical illness reported by divorced subjects.
Guentherman and Hampton (1992) investigated female differentiation and divorce in a sample of 50 females from divorced families and 50 females from intact families. Females in the divorced group had to be 12 years of age or younger at the time of their parent's divorce. Guentherman and Hampton found that young women from divorced families experienced significantly more emotional cutoff than did young women from intact families (Chi-square = 7.051, df=98, p < .008). The findings revealed that 5 (10%) of females from intact families and 17 (34%) from divorced families met the criteria for cutoff. The researchers also found that subjects who were aged 3-5 when the divorce occurred showed the least chronic anxiety, while subjects who were aged 9-12 when the divorce occurred showed the greatest chronic anxiety. The subjects completed the Personal Authority in the Family Questionnaire—College Version and the State Trait Anxiety Inventory. Females from the divorced group (m=40.06, SD=8.22) had higher levels of chronic anxiety than did females from the intact group (m=36.66, SD=6.99). Additionally they found that females from divorced families had less intergenerational intimacy (T test =3.38, p<.001) and less intergenerational individuation (T test=3.23, p<.002) from their family of origin. They also found an inverse relationship in females from divorced families between levels of chronic anxiety and differentiation r= -.5107, p< .001) from the family of origin. The results supported the hypothesis that females from divorced families are less differentiated and experience higher levels of chronic anxiety than do females from intact families.

Gere (1995) studied perceptions of emotional cutoff in a convenience sample of married parents of elementary students at a school in San Diego. The parents voluntarily completed measures designed to evaluate these adult parent's perceptions of the intergenerational transmission through an evaluation of past and present family dynamics. Gere found that family of origin health (identified as autonomy and intimacy) and emotional cutoff predicted both marital and parent/child individuation. Regressions showed that family of origin health was positively related to individuation; and emotional cutoff was negatively related to individuation.

Harrison (1997) conducted an innovative study which integrated neuroendocrine research into reproduction with a study of the effects of family emotional process on human reproduction. Harrison studied patterns of ovulation, hormonal levels, physiological reactivity, and family
emotional process in 10 women. Reactivity was measured through physiological and hormonal measures. Skeletal muscle activity and digital skin temperature were measured while taking a family history followed by 5 minutes of rest. Hormonal assays of androgens and prolactin were obtained during three menstrual cycles. Patterns of ovulation were measured for three cycles through daily basal body temperatures. Family emotional process was studied through observations about the level and source of stress on a daily basis, completion of a three generation genogram, and counting the number of contacts these women had with members of their family of origin.

Harrison found that three of the 10 subjects were anovulatory and they had higher levels of sustained reactivity. These subjects reported either constant or frequent "high" levels of daily stress. The anovulatory women in this study had contact with their mother and no other family members. Their mothers also had contact with very few or no other family members. The women with ovulatory cycles had contact with more members of their family—as did their mothers (Harrison, private communication, 2000). Harrison concluded that higher and lower levels of reactivity trigger different patterns of response that appear to delay, interrupt, or in other ways regulate hormonal interactions that govern ovulation. This result is all the more interesting since Harrison did not intend to study the theory of emotional cutoff in relation to human reproduction. She did not draw the connection until others pointed it out to her (Harrison, private communication to McKnight, 2000).

Ring (1998) conducted a qualitative study into the meaning of emotional cutoff and subsequent reconnection to test Bowen's assumption that that there are benefits to be derived from reconnecting. She studied the experiences of 15 parents and adult children who perceived they had been emotionally cutoff and had accomplished a reconnection. She conducted audiotaped interviews which were transcribed and analyzed for themes. The themes for cutoff and reconnection were identified. Ring found that the subjects accomplished reconnection by engaging in "personal growth." Personal growth involved the following three broadly stated abilities: first, they needed to see each other as peers and have respect for the other. Second, these parents and adult children said they needed to feel separate, yet connected. Third, the subjects said they needed to be able to hear the other's views and feelings with less emotional
reactivity. Ring found there are benefits to reconnecting. Benefits included increased personal contentment and improved relationships not only with the cutoff family member but with partners, children, grandchildren, friends and co-workers.

Baker and Gippenreiter (1998) investigated emotional cutoff and basic functioning in the lives of 50 grandchildren whose grandparents survived Stalin's purge in Russia. This purge occurred in 1937-1939 during a time of nationwide hysteria, paranoia, and denunciations. Millions were arrested as enemies of the people, tortured, sent to concentration camps, or shot. The purge slowed with World War II but in fact only ended with the death of Stalin in 1953. The researchers were interested in determining the emotional impact on families who survived this trauma and the influence this trauma had on their own development and functioning. The researchers were also interested in studying the implications such findings would have for society, families, and individuals surviving similar trauma. The researchers initially obtained a convenience sample from Memorial, a Russian organization dedicated to researching the events surrounding the purge, and reuniting survivors. The total membership list was made available and a stratified random sample was selected. The researchers identified 25 men and 25 women (n=50) who lived in Moscow and were between the ages of 35 and 45. Five interviewers carefully gathered information using a 58 item Russian language interview questionnaire which included open and closed questions to obtain both objective and subjective information. The principle variables analyzed were cutoff and basic functioning in the grandchild generation. The major finding of the study is a strong negative correlation between emotional cutoff (for both the maternal and paternal lines) and basic functioning in the grandchild generation. Basic functioning was evaluated by assessing the number of marriages, divorces, general health, and physical and psychological symptoms. Baker and Gippenreiter (1998) contend that this finding validates the hypothesis that emotional cutoff is a relationship phenomenon transmitted from one generation to the next. Another hypothesis that was not validated was a correlation between emotional cutoff and the experience of the Purge itself. Baker and Gippenreiter did a second analysis of the information and concluded that the experience of the Purge itself did not lead to the use of Cutoff. Instead, they speculated that families that already had emotional cutoff in their repertoire resorted to it at the time of the Purge to manage the intense stress and anxiety of losing a family member under violent circumstances. Other families may not have used cutoff as a way
to manage their anxiety because they used other relationship postures and family resources—
Cutoff was not in their emotional response repertoire. Additionally, Baker and Gippenreiter
found that higher functioning grandparents apparently survived the tragedy of the Purge by
finding a positive frame for the experience and transmitting this positive frame to their
grandchildren. This frame included the use of family resources like courage, firmness in critical
situations, the ability to actively protest against social coercion, and a commitment to high moral
values and ideals.

Skowron (2000) also investigated Bowen's theoretical propositions which posits a
relationship between differentiation of self and the quality of marital relationships. The sample
consisted of 39 heterosexual married couples living in a large metropolitan area. The mean age
for women was 46.72 years and for men 48.56. Nearly one half of the sample reported they were
both in their first marriage (49%) and less than one half (46%) reported this was a second
marriage for one or both spouses. The ethnic background consisted of 77% European American,
5% African American, and 18% mixed ethnicity (i.e., dyads consisting of mixed Latino, Native
American, African American and European American descent). The sample was highly educated
with 79% were college graduates and only 3% reported high school as their highest level. Two
measures were used—the Differentiation of Self Inventory (Skowron & Friedlander, 1998) and
the Dyadic Adjustment Scale (Spanier, 1976). Couples' levels of differentiation explained
substantial variance in marital adjustment: 74% in husband marital adjustment scores and 61% in
wife adjustment scores.

Skowron (2000) found that a greater degree of husband emotional cutoff from the spouse
uniquely accounted for husband and wife marital discord. Thus when marital partners,
particularly a male partner, remains emotionally present and available, both partners are likely to
experience the marriage as satisfactory. Emotional withdrawal on the part of husbands harms the
life of the marriage. Other results show that greater husband emotional cutoff and increased wife
emotional reactivity, was found more often among couples experiencing greater marital discord.
This pattern resulted in the husband distancing and the wife pursuing the husband.
Summary of Studies on Emotional Cutoff

Research into emotional cutoff based on Bowen theory has found:

- that chemical dependency regulates distance (Erkenbeck, 1999; McKnight, 1998).
- that there is a relationship between intergenerational cutoff and decreased intimacy, communication, and individuation at the marital level. Specifically, individuals with higher cutoff report less intimacy with their parents (McCollum, 1986 Weiner, 1990); and have lower marital communication scores and more trouble with marital intimacy (Dillard and Protinsky, 1985; Reifman, 1986); cutoff is negatively related to individuation in marital and parent–child relationships (Gere, 1995). However, one study (Mackelberg, 1988) found no relationship between marital intimacy and emotional cutoff.
- that an individual who is emotionally cutoff from parents is more likely to make the decision to separate from a marital partner (Weiner, 1990); and that women who grew up in a divorced family have a higher level of emotional cutoff than women from intact families (Guentherman and Hampton, 1992).
- that there may be a gendered approach to the use of emotional cutoff: a non clinical population of stressed women used over/underfunctioning more than distancing or cutoff as the primary means for managing anxiety (Day, 1988). Additionally, women who are cutoff tend to become more reactive towards their parents, while men who are cutoff tend to distance more from their parents (Lartin, 1986).
- that there is a relationship between stress and the appearance of physical and psychological symptoms (McCollum, 1986; Weiner, 1990); including the inability to ovulate (Harrison, 1995).
- that emotional cutoff may be used by as much as 25% of the general population (Dillard and Protinsky, 1985).
- and that there are benefits when adult children and their parents reconnect with each other—including improved marital, peer, and work relationships (Ring, 1998).
Conclusion

Promising steps have been taken in recent years to begin to investigate Bowen's concepts of differentiation of self and emotional cutoff. The majority of studies have focused on the intergenerational transmission of the emotional process relating to differentiation of self and family of origin dynamics. A few clinical case studies address how to treat addicted family systems and these studies note the presence of emotional cutoff as a commonly observed dynamic. No quantitative studies address the dynamics of substance abuse in women and the relationship to emotional cutoff. This study inquires into the degree of emotional cutoff present, how emotional cutoff may correlate with other variables at the individual, marital and family level, and how cutoff may relate to dropout from treatment.
CHAPTER III – METHODS

The purpose of this study is to investigate emotional cutoff in the lives of substance abusing women who entered a 12 week treatment program. The level of analysis is individual. First, I determined to what degree Emotional Cutoff is present in women who participated in this study and compared it to a non-clinical population. Second, I investigated how emotional cutoff may relate to substance abuse variables, individual functioning variables, and family/marital relationship variables. Finally, I analyzed the relationship between emotional cutoff and dropout from a treatment program. My questions were formulated into the following three hypotheses:

HYPOTHESIS ONE: The degree of emotional cutoff in this clinical population will be significantly above that found in a non-clinical population.

HYPOTHESIS TWO: A significant relationship will be found between emotional cutoff and substance abuse variables, individual psychological functioning variables, and family/marital relationship variables. These relationships are, as follows:

Substance Abuse Variables

a) a significant positive relationship will be found between emotional cutoff and the severity of medical condition

b) a significant positive relationship will be found between emotional cutoff and severity of employment/support

c) a significant positive relationship will be found between emotional cutoff and severity of drug use

d) a significant positive relationship will be found between emotional cutoff and severity of alcohol use

e) a significant positive relationship will be found between emotional cutoff and severity of legal status

f) a significant positive relationship will be found between emotional cutoff and severity of distress in family/social relationships
g) a significant positive relationship will be found between emotional cutoff and severity of psychological status
h) a significant positive relationship will be found between emotional cutoff and personality attributes of an abuser
i) a significant positive relationship will be found between emotional cutoff and abuser's conscious concealment of abuse
j) a significant positive relationship will be found between emotional cutoff and abuser's denial of substance abuse
k) a significant positive relationship will be found between emotional cutoff and alcohol or drug abuse preferences
l) a significant positive relationship will be found between emotional cutoff and identification as a defensive person
m) a significant positive relationship will be found between emotional cutoff and identification of a co-dependent family member

**Individual Psychological Functioning Variables**

n) a significant positive relationship will be found between emotional cutoff and depression
o) a significant positive relationship will be found between emotional cutoff and anxiety
p) a significant positive relationship will be found between emotional cutoff and hostility
q) a significant positive relationship will be found between emotional cutoff and phobia
r) a significant positive relationship will be found between emotional cutoff and psychotic symptoms
s) a significant positive relationship will be found between emotional cutoff and paranoia
t) a significant positive relationship will be found between emotional cutoff and somatization

u) a significant positive relationship will be found between emotional cutoff and obsessive compulsive disorder
v) a significant positive relationship will be found between emotional cutoff and interpersonal sensitivity
w) a significant positive relationship will be found between emotional cutoff and global severity of psychological distress
Family/Marital Relationship Variables

x) a significant positive relationship will be found between emotional cutoff and unhealthy family problem solving
y) a significant positive relationship will be found between emotional cutoff and unhealthy family communication
z) a significant positive relationship will be found between emotional cutoff and unhealthy family roles
   aa) a significant positive relationship will be found between emotional cutoff and unhealthy family affective responsiveness
   bb) a significant positive relationship will be found between emotional cutoff and unhealthy family affective involvement
   cc) a significant positive relationship will be found between emotional cutoff and distress concerning behavior control in the family
dd) a significant positive relationship will be found between emotional cutoff and general distress in family functioning
e) a significant negative relationship will be found between emotional cutoff and marital/partner relationship satisfaction

HYPOTHESIS THREE: Those clients who drop out of treatment will have significantly higher scores on the Emotional Cutoff Scale than those who complete treatment.

Subjects for This Study

The subjects for this study were 172 women who were part of a National Institute on Drug Abuse (NIDA) project entitled "Couple-focused Therapy for Substance Abusing Women." I describe the NIDA project first and then how my study fits in. The project was conducted by a team of researchers at Purdue University. The Principal Investigator for the NIDA project was Robert A. Lewis.
The purpose of the NIDA funded project was to evaluate the effectiveness of adding couples therapy to a traditional program of drug treatment for women. The premise underlying this approach to treatment is that family and other relationship contexts play an important role in maintaining alcohol and other substance abuse—especially for women (Wetchler, McCollum, Nelson, Trepper, & Lewis, 1995; & Wetchler, et al, 1996).

When they come to treatment, women have needs that may differ from those of men. McCollum & Trepper (1995), for example, found in a qualitative study that issues such as a non-supportive partner, lack of adequate childcare, lack of transportation, and scarce financial resources were all reported as barriers for women who desired to come to substance abuse treatment. Additionally, the relationship context women are in often influences their introduction to drug use, their entry into treatment and the durability of their recovery (Williams & Klerman, 1984; McCollum & Trepper, 1995). Attending to those relationships in treatment was cited by a number of women in the McCollum and Trepper (1995) study as a major reason for the success of their drug treatment program. This reinforces the findings of Williams and Klerman's study (1984) which noted that women relate their problem drinking and also the desire to seek treatment to family instability and family problems. A third study noted that women opiate addicts are commonly introduced to narcotics when involved in an intimate relationship with men (Anglin, Kao, Harlow & Peters, 1987). While individual factors are important and need treatment, the relational context of alcohol abuse merits special attention and adds particular power to an overall treatment program for women (Wetchler, McCollum, Nelson, Trepper, & Lewis, 1993).

The project was conducted in two outpatient host agencies offering a 12 week treatment program. One agency offers intensive outpatient drug treatment with abstinence as the goal while the other offers methadone maintenance with a strong psychosocial treatment component. Within each agency subjects were randomly assigned to one of three treatment conditions. The first treatment condition was a "12 step friendly" group therapy model. It was a coeducational group for substance abusers that utilizes 12-step ideas without taking a strict 12 step stance. Partners are minimally involved in this group. This 12 step group approach was termed the treatment as usual condition (Wetchler, et al, 1993).
The second treatment condition was Systemic Couples Therapy added to the 12-step treatment as usual condition. Systemic Couples Therapy uses an integrated approach utilizing ideas and interventions from Structural, Strategic, and Bowen Intergenerational therapy. Adding this component allows the researchers to compare couples treatment to group therapy treatment and to assess if the addition of couples treatment is superior to group treatment alone (Wetchler, et al, 1993). The third treatment condition was termed Systemic Individual Therapy added to the 12-step treatment as usual condition. The therapist utilized the Integrated model of Systemic Couples Therapy with the individual woman alone. Her partner was not present. Comparing Systemic Individual Therapy with Couples treatment and treatment as usual enabled the researchers to discover if the couple-focused individual treatment interventions were enough to produce change or if the actual presence of both partners was needed (Wetchler, et al, 1993).

Data were collected for the NIDA project over a four and a half year period from 1990 to 1994. Data were collected in six phases using a repeated measures approach, which included an agency intake process, a pre-test prior to treatment, a post-test after treatment and further administration of the same measures at three, six and twelve months respectively.

**Procedures**

Although a measure of Emotional Cutoff was administered, Emotional cutoff was not a specific focus of the NIDA research project. My study utilized the NIDA data and investigated the variable of Emotional Cutoff and how it relates to other variables of interest. Specifically, I examined only the data collected during the pre-test to test the three hypotheses. Since 12 weeks of treatment followed the pre-test, I decided to avoid having to account for treatment effects, and investigated emotional cutoff prior to treatment. A total of 168 women completed the pre-test measures. The 12 week treatment condition followed. At the conclusion of treatment there were 99 women who completed the post-test measures.

The data were gathered through the use of six measures which were as follows: the Emotional cutoff Scale, The Addiction Severity Index, the Substance Abuse Subtle Screening
Inventory/Risk Prediction Scales, the Symptom Checklist 90 Revised, the McMaster Family Assessment Device, and the Kansas Marital Satisfaction scale.

**Instruments**

**Emotional Cutoff Scale**

The Emotional cutoff Scale (ECS) (McCollum, 1991) measures the sense of cognitive connection to mother and father. It was academically developed as a research tool to study the cognitive component of Bowen's concept of emotional cutoff. The ECS was designed to provide a means to empirically investigate Bowen theoretical concepts. Studies show that if emotional cutoff is used with parents it is more likely to be used in subsequent relationships. This scale consists of 10 items, five items about the subject's relationship with her father and repeating the same five items about the subject's relationship with her mother. Subjects respond to items on a five-point scale (1 = strongly agree; 5 – strongly disagree). Scores range on a continuum between 10 – 50. Lower scores mean a greater degree of connection to parents, higher scores mean a lesser degree of connection (i.e. higher levels of cutoff) to parents. Sample items from the scale are: I would prefer not to have much contact with my MOTHER (FATHER) if I could avoid it; I sometimes discuss my personal problems with my MOTHER (FATHER). The internal consistency and reliability of the ECS is high, with Cronbach's alpha ranging from .82 to .90. (McCollum, 1991). Concurrent validity was found since the ECS was significantly correlated with other instruments theoretically compatible with Bowen's theory, with a significance level ranging from p = .016 to p = .000. For example a subscale of the Personal Authority in the Family System Questionnaire (PAFS-Q) (Bray, Williamson & Malone, 1984) which assesses intergenerational intimacy, was significantly correlated with the Emotional Cutoff Scale. A strong negative correlation was reported in three separate studies: r = -.82 (McCollum, 1986); r = -.85 (Day, 1986); and Weiner (1990) reported r = -.86. This means that people with higher cutoff scores reported less intimacy with their parents. This relationship with the PAFS-Q, an instrument thought to be theoretically consistent, supports a finding of construct validity for the Emotional Cutoff Scale.
Addiction Severity Index

The Addiction Severity Index (ASI) is a structured, 40 minute interview designed to assess the multiple problems seen in alcohol and drug-dependent persons seeking treatment. The instrument was designed to produce information that would be relevant for both clinical and research evaluations. It is designed to be administered by a trained technician to assess the severity of alcohol and drug use, medical conditions, employment/support, illegal activity, family/social relations, and psychiatric conditions. Severity is defined as the need for additional treatment. The data collected includes objective information about the intensity, duration and number of problem symptoms; and, the client's subjective rating of problem severity in each area, as well as the interviewer's independent rating of the severity of each problem area. Thus two types of measures result from the collected data in each problem area: severity ratings for each problem area and composite scores (developed from sets of interrelated items within each problem area). Higher composite scores indicate increased problem severity and the increased need for treatment. The composite scores are well related to the severity ratings (average correlation = .88). Concurrent reliability studies indicated that trained technicians can estimate the severity of patient's treatment problems with an average reliability of .89. Test-retest studies show that the information obtained from the ASI is consistent over a 3-day interval, even with different interviewers. Comparisons of the ASI severity ratings and composite measures with a battery of previously validated tests indicate evidence of concurrent (p <.05 to .01 across the seven subscales) and discriminant validity (p<.05 to .01). (McLellan, Luborsky, Cacciola, Griffith, Evans, Barr, & O'Brien, 1985).

Substance Abuse Subtle Screening Inventory

The Substance Abuse Subtle Screening Inventory (SASSI) is designed to assess chemical dependency regardless of level of honesty, denial, or concealment. The instrument was designed to produce information that would be relevant for both clinical and research evaluations. The SASSI consists of 52 true-false items that generates five scales: obvious attributes(OAT), subtle abuse(SAT), denial(DEN), defensive attributes (DAN), personal/family co-dependency (FAM), alcohol/drug preferences (ALD). The OAT subscale measures behaviors commonly associated
with a substance abuser, such as impulsiveness, low frustration tolerance, impatience, resentment, and self-pity. The higher the score on this subscale, the more readily the subject will identify self with substance abusers, but may not be willing to initiate with change. The SAT subscale measures concealment of abuse and a predisposition to develop dependency. The DEN subscale measures abusers who are in unconscious denial or are attempting to deny their pattern of abuse. The DAN subscale measures defensiveness. The FAM subscale is a measure to identify co-dependency. The ALD subscale measures abuser's preferences for drugs and/or alcohol. The SASSI is scored by matching respondent's answers to the SASSI test template subscale responses; and counting the number of the respondent's answers which match the template responses for each subscale. The number of matches are summed up and become the subscale score. After the subscale score is determined, they may be plotted on the male or female profile form which transforms the scores into standard T-scores. After modifications in the mid-1980's, the SASSI correctly classified 88% in a detoxification sample, 68% of primary and family member abusers, and 92% of family nonabusers. The SASSI has a concurrent validity of .62 with the MacAndrews Alcoholism Scale (MAC), a 49-item subscale from the Minnesota Multiphasic Personality Inventory (MMPI) (MacAndrew, 1965; Miller, 1985; Cooper & Robinson, 1987).

Symptom Checklist-90-Revised

The Symptom Checklist-90-Revised (SCL-90-R) measures psychological symptom patterns of psychiatric and medical patients. This instrument was designed to produce information that would be relevant for both clinical and research evaluations. It is a 90 item self-report symptom inventory. Answers range on a five point scale of distress (0-4) ranging from "not at all" on one pole to "extremely" on the other. Scoring is a simple arithmetic procedure involving addition and division to two decimal places. It is scored and interpreted by gender in terms of nine primary symptom dimensions and three global indices of distress. The nine symptoms are: somatization, obsessive-compulsive, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation, and psychoticism. The three global indices of distress are: the Global Severity Index (GSI), the Positive Symptom Distress Index (PSDI), and the Positive Symptom Total (PST). Sample items are: How much are you distressed by headaches? How much are you distressed by repeated unpleasant thoughts that won't leave you?
Reliability measures of internal consistency using coefficient alpha ranged between .77 for psychoticism to a high of .90 for depression. Test-retest coefficients ranged from a low of .80 to a high of .90. Construct and concurrent validity was supported by a comparison of the SCL-90-R dimension scores with scores from the MMPI. This comparison showed a correlation ranging from .40 to .68 (Derogatis, Rickels, and Rock, 1976).

**Family Assessment Device**

The McMaster Family Assessment Device (FAD) (Epstein, Baldwin, & Bishop, 1983) was designed to be a research and clinically-relevant screening instrument designed to evaluate family functioning on a wide variety of clinically relevant dimensions. It describes structural and organizational properties of the family group and the patterns of transactions among family members which have been found to distinguish between healthy and unhealthy families. It also distinguishes between clinical and non-clinical families. The FAD uses seven subscales: problem solving, communication, roles, affective responsiveness, affective involvement, behavior control, and general functioning. Problem solving assesses a family’s ability to resolve problems in a way that maintains effective family functioning. Communication refers to whether communication within family is clear and direct or indirect and vague. Roles assesses if there are established patterns of behavior to handle important family tasks. Affective responsiveness assesses whether family members respond to situations with the appropriate quality and quantity of emotion; affective involvement explores the degree to which family members are involved and interested in activities of other family members. Behavior control evaluates whether a family expresses and maintains standards of behavior for all members of the family. The FAD is a 53 item questionnaire to which one of four answers may be given by each family member who rates his or her agreement or disagreement with the questionnaire item. The answer choices are Strongly Agree, Agree, Disagree, or Strongly Disagree. The items are statements about families. Sample items are: In times of crisis we can turn to each other for support; we are reluctant to show our affection for each other. It generally takes family members 15 to 20 minutes to complete. Scores range from 1 to 4 with 1 reflecting healthy functioning and 4 unhealthy functioning. Reliability was measured by checking the internal consistency of the seven subscales which was shown to range from .72 to .92 using Chronbach’s alpha. Discriminant validity was supported by
comparing the results of FADs taken by clinical and non-clinical families. For each of the subscales, the non-clinical group mean was significantly lower, meaning healthier, than the clinical group ($p < .001$). Suggested cutoff scores are Problem Solving 2.2, Communication 2.2, Roles 2.3, Affective Responsiveness 2.2, Affective Involvement 2.1, Behavior Control 1.9, General Functioning 2.0 (Epstein, Baldwin, & Bishop, 1983).

Kansas Marital Satisfaction Scale

The Kansas Marital Satisfaction (KMS) Scale (Schumm, Paff-Bergen, Hatch, Obiorah, Copeland, Meens, & Bugaighis, 1986) was academically designed to be a research instrument. The KMS consists of just 3 questions. Each of the items begins with "how satisfied are you with..." husband (wife) as a spouse, with your marriage, and with your relationship with your husband (or wife). The instrument is used as a seven point scale with response categories ranging from extremely dissatisfied to extremely satisfied (on a numeric scale of 1 to 7 points). The score is obtained by summing scores for the three individual items. Scores may range between 3 and 21, with a lower score indicating more dissatisfaction and a higher score greater satisfaction. The KMS appears to be reliable since it has high internal consistency, with alphas ranging from .89 to .98. Intercorrelations among items ranged from .93 to .95. The KMS was significantly correlated with the Dyadic Adjustment Scale with an alpha of .94 ($p < .001$) meaning it has concurrent validity (Schumm, Paff-Bergen, Hatch, Obiorah, Copeland, Meens, & Bugaighis, 1986). This result supports a finding of construct validity for the KMS.

Design and Analysis

For Hypothesis One, the researcher ran a frequency test on the variable of emotional cutoff on the 168 women in this sample to examine the degree of emotional cutoff present. Then the researcher ran an independent T test to compare the Emotional cutoff group mean of the 168 women taken during the pre-test of the NIDA Project with those of two non-clinical populations (Day, 1988; Weiner, 1990).
For Hypothesis Two the researcher correlated the phase two Emotional Cutoff Scale (ECS) scores with the phase two scores from the 31 below identified variables using a Pearson R correlation. Specifically, the researcher correlated the ECS mean with the:

- Addiction Severity Index scale (ASI), which measures the severity of the addiction and associated systemic variables using six subscales (alcohol and drug use, medical conditions, employment/support, illegal activity, family/social relations, and psychiatric conditions). The researcher correlated the ECS with the six subscales of the ASI.

- Substance Abuse Subtle Screening Inventory (SASSI), which measures the presence of chemical dependency regardless of the level of honesty, denial, or faking. The SASSI generates six subscales: obvious attributes, subtle abuse, denial, defensiveness, personal/family co-dependent, and alcohol/drug preferences. The researcher correlated the ECS with the six subscales of the SASSI.

- Symptom Checklist 90 Revised (SCL90-R), which measures nine psychological symptom patterns of psychiatric and medical patients and three global indices of distress. The nine symptoms are: somatization, obsessive-compulsive, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation, and psychoticism. The three global indices of distress are: the Global Severity Index (GSI), the Positive Symptom Distress Index (PSDI), and the Positive Symptom Total (PST). The researcher correlated the ECS with the SCL-90-R nine symptoms and one global indice (the Global Severity Indice). The researcher decided to use just one global indice since the other two are mathematically based off of the Global Severity Indice and would not provide substantive information for analysis.

- McMaster Family Assessment Device (FAD), which measures family functioning using seven subscales: problem solving, communication, roles, affective responsiveness, affective involvement, behavior control, and general functioning. The researcher correlated the ECS with the seven subscales of the FAD.
• Kansas Marital Satisfaction (KMS) scale, which measures marital/partner relationship satisfaction. The researcher correlated ECS with the KMS.

For Hypothesis Three the researcher created two groups from the 168 women who took the pre-test measures—those women who subsequently completed treatment and those who never began treatment or dropped out during treatment. A one way analysis of variance (ANOVA) was run on the pre-test emotional cutoff scores of those who completed treatment (n = 93) and the Cutoff scores of the dropout group category (n = 75).
CHAPTER FOUR: RESULTS

The purpose of this study is to investigate the presence of emotional cutoff in the lives of substance abusing women who entered a 12 week treatment program. The level of analysis is the individual. First, I studied to what degree Emotional Cutoff is present in the lives of women who abused substances and compared it to a non-clinical population. Second, I investigated how emotional cutoff in the individual may relate to substance abuse variables, individual functioning variables, and family/marital relationship variables. Finally, I studied the relationship between emotional cutoff and dropout from a treatment program.

Description of Research Participants

There were 168 women in the NIDA sample used for this study. Their mean age was 32.6 and ranged from 18-48, with only two outliers: one was age 55, and one was age 73. This was a relatively poor population, with 18% reporting no income. The median income was $8000 per year and the mean income $11,281.26. Only four incomes ranged between $72,000 – $132,000 per year. The median years of school is 12. For 64% of the participants this was their first entry into a drug treatment program and 81% were either on probation or parole. In terms of ethnicity, 81% were Caucasian, 5% African American, 4.5% Native American, and 9.7% Hispanic. In terms of marriage, 40.8% were married, 25.6% divorced, 24.4% were never married, 6.8% were separated and 2.4% were widowed. The median number of partners was 2, and the median number of children was 2. In this sample 89% reported they were heterosexual.

The women in this study's sample was significantly less satisfied with their spouses, marriages, and relationships than two comparison samples. Using a one sample T Test I compared this sample's mean on the Kansas Marital Satisfaction scale with a non-clinical sample of 61 mid-western urban wives whose ages ranged from 30-64, with an average age of 44.51, and who averaged 1.66 children (Schumm, Paff-Bergen, Hatch, Obiorah, Copeland, Meens, Bugaighis, 1986). (NIDA, M = 14.30, Schumm, M = 18.28, t = -11.371, n = 172, p<.001). A second comparison was made to a non-clinical sample of 84 married women from three midwestern cities. The average age was 34.7, with an age range of 19-52 years of age. The
average number of children was 2.76 years (Schumn, Nichols, Schectman, & Grigsby, 1983). Using a one sample T Test I compared this study's sample mean on the Kansas Marital Satisfaction scale with the non-clinical sample of 84 women. The results show the NIDA sample was significantly less satisfied with their relationships, spouses, and marriages (NIDA, M = 14.30, Schumn, M = 17.81, t = -10.029, n= 172, p = .001).

This sample was also significantly less healthy in terms of general family functioning as assessed using the Family General Functioning subscale of the McMaster Family Assessment Device (FAD) (Epstein, Baldwin, Bishop, 1985). A lower score indicates healthy functioning and a higher score indicates unhealthy functioning (scale of 1-4). A one sample T Test was used to compare the mean of this study's sample with the suggested cutoff score (Epstein, Baldwin, Bishop, 1985) for Family General Functioning on the FAD. Women in this study's sample scored significantly higher than the suggested cutoff, meaning their general family functioning is significantly less healthy (NIDA, M = 2.25, Epstein, m= 2.0, t = 5.941, n = 172, p <.001).

Reliability of Variables

Reliability was tested on the Emotional Cutoff Scale and the Kansas Marital Satisfaction scale. The reliability for the Emotional Cutoff Scale was calculated using Chronbach's alpha (a = .85, n=168). This value is consistent with those values found on previous studies with Cronbach alpha's ranging from .82 to .90 (McCollum, 1991).

The reliability for the Kansas Marital Satisfaction Scale was calculated using Chronbach's alpha (a = .92, n = 172). This is consistent with other studies which show high internal consistency, with alphas ranging from .89 to .98.

Testing Hypothesis One

*Hypothesis One: the degree of emotional cutoff in this clinical population will be significantly above that found in a non-clinical population.*
The Emotional Cutoff Scale was used to gather the data. Using a one-sample T-Test, the mean of the NIDA sample was compared to the mean found by Day (1988) in her study of a non-clinical sample of 102 stressed women from the Midwest (See figure 4.1). The Day sample of women ranged in ages between 25-70; and they were handling normal levels of chronic stress due to their management of multiple responsibilities and roles as a daughter, wife, mother, and worker. Women in the NIDA sample scored significantly higher on the Emotional Cutoff Scale (NIDA M = 26.89, Day M = 24.67, t = 3.043, n = 168, p = .003). This result confirms the hypothesis that the mean for emotional cutoff will be higher in a clinical sample than in a non-clinical sample.

Next, the mean for emotional cutoff found in the current sample (NIDA n=168) was compared to the mean for emotional cutoff found in a mixed clinical and non-clinical sample studied by Weiner (1990) (see figure 4.1). Weiner obtained a sample of 114 Midwestern divorced volunteers drawn from non-clinical and clinical sources recruited from rural and metropolitan settings. Forty subjects were male and 74 were female. All had been divorced at least one time, with some being divorced twice. Women in the NIDA sample scored significantly higher on the Emotional Cutoff Scale (NIDA M = 26.89, Weiner M = 25.15, t = 2.386, n = 168, p = .018).

<table>
<thead>
<tr>
<th>MEAN</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>SAMPLES</td>
<td>DAY</td>
</tr>
<tr>
<td></td>
<td>24.67</td>
</tr>
<tr>
<td></td>
<td>WEINER</td>
</tr>
<tr>
<td></td>
<td>25.25</td>
</tr>
<tr>
<td></td>
<td>NIDA</td>
</tr>
<tr>
<td></td>
<td>26.89</td>
</tr>
</tbody>
</table>

**Figure 4.1 Comparison of Emotional Cutoff Means**

Next, I divided the ECS 40 point scale into four ranges of scores from 10-19, 20-29, 30-39, and 40-50. Then I recorded the percentage of the population present in each quarter (See figure 4.2). I discovered that those who scored between 10-19 were 21.4% of the NIDA population. This means 21.4% of the population ranged between no cutoff from their parents to a low degree of cutoff. Those who scored 20-29 comprised 38.7% of the NIDA population. This
means 38.7% had a low to moderate degree of cutoff from their parents. Those who scored 30-39 were 29.2% of the population. This means 29.2% had a moderate to moderately high degree of cutoff from their parents. Finally, those who scored 40-50 were 10.7% of the population. This means 10.7% of the NIDA population had a moderately high to high degree of emotional cutoff from their parents.

<table>
<thead>
<tr>
<th>Score</th>
<th>Sample %</th>
</tr>
</thead>
<tbody>
<tr>
<td>10-19</td>
<td>21.4%</td>
</tr>
<tr>
<td>20-29</td>
<td>38.7%</td>
</tr>
<tr>
<td>30-39</td>
<td>29.2%</td>
</tr>
<tr>
<td>40-50</td>
<td>10.7%</td>
</tr>
</tbody>
</table>

**Figure 4.2—Range of Scores Determine Sample Percentage**

Finally, I divided the population into 25% increments to see what the range of scores would be. I found that 25% scored between 10-20 on the Emotional Cutoff Scale. Fully 50% of the sample scored between 21-27 on the Emotional Cutoff Scale and 75% scored up to and including 32. The last 25% ranged in scores between 33-50.

<table>
<thead>
<tr>
<th>Score</th>
<th>Pop %</th>
</tr>
</thead>
<tbody>
<tr>
<td>10-20</td>
<td>25%</td>
</tr>
<tr>
<td>21-27</td>
<td>50%</td>
</tr>
<tr>
<td>28-32</td>
<td>75%</td>
</tr>
<tr>
<td>33-50</td>
<td>100%</td>
</tr>
</tbody>
</table>

**Figure 4.3 Population Percentage Used to Determine Cutoff Range**
Testing Hypothesis Two

_Hypothesis Two: A significant relationship will be found between emotional cutoff and substance abuse variables, individual functioning variables, and family/marital relationship variables._

Using a Pearson Correlation the variable of emotional cutoff was correlated with the variables used in the study (see Table 4.1). Of the 31 variables correlated with the emotional cutoff variable, eleven were significant; eight at the p = .05 level and three at the p = .001 level. See Tables 4.1-3 and the discussion of each below.

Substance abuse variables.

Table 4.1

<table>
<thead>
<tr>
<th>Correlations of Cutoff with Substance Abuse Variables</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CUTOFF</strong></td>
</tr>
<tr>
<td>-------------------------------------------------------</td>
</tr>
<tr>
<td>Severity of Medical</td>
</tr>
<tr>
<td>Severity of Employment/Support</td>
</tr>
<tr>
<td>Severity of Drug Use</td>
</tr>
<tr>
<td>Severity of Alcohol Use</td>
</tr>
<tr>
<td>Severity of Legal Status</td>
</tr>
<tr>
<td>Severity of Family Social Relationships</td>
</tr>
<tr>
<td>Severity of Psychological Status</td>
</tr>
<tr>
<td>Behavioral Characteristics of Abuser</td>
</tr>
<tr>
<td>Concealment of Abuse</td>
</tr>
<tr>
<td>Abuser Denial of Substance Abuse</td>
</tr>
<tr>
<td>Highly Defensive Person</td>
</tr>
<tr>
<td>Alcohol vs. Poly drug Abuser</td>
</tr>
<tr>
<td>Differentiate Abuser from Family MBR</td>
</tr>
</tbody>
</table>

** Correlation is significant at the .001 level (one tailed)
The Addiction Severity Index was used to gather the severity variables and the SASSI to gather related abuser variables displayed in Table 4.1. Emotional Cutoff correlated significantly with three Substance Abuse variables at the $p = .001$ level. Emotional Cutoff correlates in a positive direction with the Behavioral Characteristics of an Abuser ($n = 168, r = .229, p = .001$ (one tailed). This relationship indicates that as emotional cutoff increases so do the behaviors commonly associated with an abuser.

Emotional Cutoff also correlated in a positive direction with the presence of traits indicative of a highly defensive person ($n = 168, r = .238, p = .001$ (one tailed). This relationship indicates that as emotional cutoff increases so does defensiveness.

There was a significant negative relationship between emotional cutoff and the denial of abuse ($n = 168, r = -.296, p = .001$ (one tailed). This relationship indicates that as emotional cutoff increases denial decreases.

There was no significant relationship between emotional cutoff and the remaining 10 substance abuse variables. These 10 are divided into two categories: severity and characteristics of abusers. Severity means the need for treatment. The severity variables are: medical condition, employment/support, drug use, alcohol use, legal status, family/social relationships, and psychological status. Emotional Cutoff did not significantly correlate with the abuser's concealment of abuse, preference for abusing drugs or alcohol, or the identification as a Family Member with Co-Dependent behaviors.

**Individual psychological functioning variables.**

The SCL-90-R was used to gather these variables. Emotional Cutoff significantly correlates at the $p = .05$ level with eight individual psychological functioning variables, and did not correlate significantly with two others (See Table 4.2). Emotional Cutoff correlates positively with Depression, Anxiety, Hostility, Psychoticism, Somatization, Obsessive Compulsive symptoms, Interpersonal Sensitivity, and Global Severity of
### Table 4.2

**Testing Hypothesis Two**

**Correlations of Cutoff with Individual Functioning Variables**

<table>
<thead>
<tr>
<th>Variable</th>
<th>Correlation (r)</th>
<th>Sample Size (n)</th>
<th>Significance (p)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression</td>
<td>r = .138, n = 168, p = .037*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anxiety</td>
<td>r = .154, n = 168, p = .023*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hostility</td>
<td>r = .136, n = 168, p = .039*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Phobia</td>
<td>r = .106, n = 168, p = .086</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Paranoia</td>
<td>r = .116, n = 168, p = .068</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychoticism</td>
<td>r = .172, n = 168, p = .013*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Somatization</td>
<td>r = .128, n = 168, p = .049*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Obsessive Compulsive</td>
<td>r = .162, n = 168, p = .018*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interpersonal Sensitivity</td>
<td>r = .165, n = 168, p = .016*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Global Severity of Symptoms</td>
<td>r = .177, n = 168, p = .011*</td>
<td></td>
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</tr>
</tbody>
</table>

* Correlation is significant at the .05 level (one tailed)

Symptoms. This indicates that as Emotional Cutoff increases so does the severity of psychological symptoms.

Interpersonal Sensitivity refers to symptoms of being highly critical of others or being highly sensitive to how others feel or think about you. For example, being very self-conscious in the presence of others, feeling inferior to others, feeling others do not understand you. This variable was significantly correlated with emotional cutoff (r = .165, n = 168, p = .016 (one-tailed).

There was a significant positive relationship between emotional cutoff and the assessment of global severity of psychological symptoms (n=168, r= .177, p=.011(one tailed). This relationship indicates that as emotional cutoff increases so does the assessment of psychological distress.
There was no significant relationship between emotional cutoff and two individual psychological symptom areas: phobia and paranoia.

Marital and Family Functioning Variables

Table 4.3
Testing Hypothesis Two

Correlations of Emotional Cutoff with Marital and Family Variables

<table>
<thead>
<tr>
<th>CUTOFF</th>
<th></th>
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<tbody>
<tr>
<td>Marital Satisfaction</td>
<td>r = .029, n = 168, p = .355</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family Problem Solving Distress</td>
<td>r = -.062, n = 168, p = .213</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family Communication Distress</td>
<td>r = -.002, n = 168, p = .491</td>
<td></td>
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</tr>
<tr>
<td>Family Roles Distress</td>
<td>r = -.009, n = 168, p = .455</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family Affective Responsiveness Dis.</td>
<td>r = -.016, n = 168, p = .418</td>
<td></td>
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</tr>
<tr>
<td>Family Affective Involvement Distress</td>
<td>r = .076, n = 168, p = .163</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family Distress re:Behavior Control</td>
<td>r = .024, n = 168, p = .377</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family Distress re:General Functioning</td>
<td>r = -.044, n = 168, p = .288</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

No significant correlations

The Kansas Marital Satisfaction scale was used to gather the marital satisfaction variable. The Family Assessment Device was used to gather the family functioning variables. Table 4.3 shows there is no significant relationship between emotional cutoff and marital satisfaction. There is no significant relationship between emotional cutoff and variables measuring distress in family functioning.

Testing Hypothesis Three

Hypothesis Three: Those clients who drop out of treatment will have significantly higher scores on the Emotional Cutoff Scale than those who complete treatment.
I created a new variable for attrition to code two groups—those who started and those who completed. Those who took the pre-test and did not complete treatment were coded into group 1 (n = 74). Those who completed treatment and took the post-test emotional cutoff scale were coded into group 2 (n=93). I ran an Independent Samples T-Test with emotional cutoff as the dependent variable and the dropout status as the grouping variable. I found no significant differences (Group 1, M=25.97, Group 2 M=27.78, n=165, t= -1.236, p=.218).

As a Post Hoc test I ran a Chi Square analysis on four demographic questions, concerning marital status, children, probation/parole and prior drug treatment to see if there were differences among those who dropped out of treatment and those who completed treatment.

Marital status

There were no significant differences between groups on marital status (unmarried or married), (x²=.005, df = 1, p=.942). Of the 74 who started but did not complete treatment, 41 were not married and 33 were married. Of the 93 who completed treatment, 51 were not married and 42 were married.

Children

There were no significant differences between groups on children (those who had no children and those who did have children), (x²=.1380, df = 1, p=.240). Of the 74 who started but did not complete treatment, 20 had no children and 54 did have children. Of the 93 who completed, 18 had no children and 75 did have children.

Probation/Parole

There were no significant differences between groups on probation/parole (those not on probation/parole and those on probation/parole), (x²=.292, df = 1, p = .589). Data were missing for five. Of the 71 who started but did not complete treatment, 58 were on probation/parole and
13 were not on probation/parole. Of the 92 who completed treatment, 72 were on
probation/parole, and 20 were not on probation or parole.

Prior Drug Treatment

There were no significant differences between groups on prior drug treatment (those who
had no prior drug treatment and those who had prior drug treatment), ($x^2 = .224, df = 1, p =
.636$). There was missing data on three cases. Of the 74 who started but did not complete
treatment, 27 had no prior drug treatment and 47 had prior drug treatment. Of the 91 who
completed, 30 had no prior drug treatment and 61 had prior drug treatment.

Summary

Hypothesis one was confirmed. The mean for emotional cutoff was higher in a clinical
sample of women, who just entered treatment for substance abuse, than in two comparison
samples. A comparison of the means of these three groups (stressed women, divorced men and
women, women who abused substances) shows an increasing degree of emotional cutoff from
parents.

The portion of Hypothesis Two which posited a relationship between Emotional Cutoff
and Substance Abuse Variables was only partially confirmed. A significant relationship was
found between Emotional Cutoff and three Substance Abuse variables at the $p = .001$ level.

Hypothesis two was not confirmed in positing a relationship between Emotional Cutoff
and three other Substance Abuse Variables. These variables are the abuser's intentional
concealment of abuse and predisposition towards dependency, preference for abusing drugs or
alcohol, and the differentiation of an abuser from a non-abusing member of an addicted family
system. Hypothesis two was not confirmed in positing a relationship between emotional cutoff
and seven individual substance abuse variables related to severity. "Severity" means increasing
dysfunction in each area requiring "the need for treatment." These severity variables are: medical
condition, employment/support, drug use, alcohol use, legal status, family/social relationships, and psychological status.

The portion of Hypothesis two which posited a relationship between emotional cutoff and individual psychological functioning was partially confirmed. Emotional cutoff significantly correlated at the \( p = .05 \) level with eight individual psychological functioning variables (Depression, Anxiety, Hostility, Psychoticism, Somatization, Obsessive Compulsive symptoms, Interpersonal Sensitivity, and Global Severity of Symptoms). This merits additional investigation. However, Hypothesis two was not confirmed in that a relationship was not found between Emotional Cutoff and two other individual psychological functioning variables: the presence of phobia or paranoia. This result is interesting.

The portion of Hypothesis Two which posited a relationship between Emotional Cutoff and marital satisfaction or distress in family functioning was not confirmed. This result contradicts clinical and other research experience, and merits further investigation.

Hypothesis Three was not confirmed. Hypothesis three posited a significant relationship between emotional cutoff and dropout from a substance abuse treatment program. No relationship was found between the use of emotional cutoff and dropout.
CHAPTER FIVE: DISCUSSION

Purpose of Study

The purpose of this study is to investigate emotional cutoff in substance abusing women who entered a 12 week treatment program. The level of analysis is the individual. First, I studied the degree of Emotional Cutoff in this sample and compared it to two other samples. Second, I investigated how emotional cutoff in the individual may relate to substance abuse variables, individual psychological functioning variables, and family/marital relationship variables. Finally, I studied the relationship between emotional cutoff and dropout from a treatment program.

The Three Hypotheses Explored in This Study

Three Hypotheses were explored. They are as follows:

Hypothesis One: The degree of emotional cutoff in this clinical population will be significantly above that found in a non-clinical population.

Hypothesis Two: A significant relationship will be found between emotional cutoff and substance abuse variables, individual psychological functioning variables, and family/marital relationship variables.

Hypothesis Three: Those clients who drop out of treatment will have significantly higher scores on the Emotional Cutoff Scale than those who complete treatment.

The next three sections of this chapter will discuss the results by hypothesis.

Discussion of Results for Hypothesis One

The first hypothesis was: the degree of emotional cutoff in this clinical population will be significantly above that found in a non-clinical population.
I found that the degree of emotional cutoff was higher in this study's (n=168) clinical sample of women who entered treatment for substance abuse than was found in Day's (1988) non-clinical sample of 102 women balancing multiple roles and responsibilities. This result confirms the hypothesis. This result is in accordance with Bowen theory which predicts that when anxiety increases and remains chronic, individuals may develop tension, either within self or in the relationship system, and this tension may become manifested in physical, psychological or social symptoms (Bowen, 1978).

Since Bowen (1978) asserts that emotional cutoff is a relationship posture which may be used to manage intense, chronic, and/or acute anxiety in a family system, I expected to find a higher degree of cutoff in the NIDA sample of Substance Abusers. Emotional Cutoff is just one posture which may be used to manage intense relationship anxiety. Following Bowen's theory, there are other relationship postures which may be used to manage anxiety—including conflict, distance and pursuit, over and under functioning, triangles, and parental projection to child (Bowen, 1978).

A visual inspection of the three sample means (NIDA, Day, Weiner) reveals an increasing degree of emotional cutoff. See figure 4.1. This may mean that the use of Emotional Cutoff increases as the level of chronic anxiety increases. This makes sense from a Bowen perspective given Day's non-clinical sample was of 102 women managing multiple roles and tasks, Weiner's sample was of 140 divorced men and women. The current sample drawn from the NIDA study was of 168 women who were entering treatment for substance abuse.

In comparing the results of this study with others on Emotional Cutoff, I noticed that the results of this study differs in one respect from Dillard and Protinsky's (1985) study. Dillard and Protinsky suggested that approximately 25% of the population, both clinical and non-clinical, may use emotional cutoff. Dillard and Protinsky used a self-report scale which they developed to measure emotional cutoff. The use of a different scale and unknown criteria for deciding who falls into the cutoff category makes a comparison difficult.
However, using the Emotional Cutoff Scale (McCollum, 1986) I found that 10.7% were the most cutoff in this sample (see figure 4.2). No independent criteria or cutoff scores were supplied for the Emotional Cutoff Scale, which is a 40 point scale with scores ranging from 10 – 50 points. So, given that higher scores mean a higher degree of cutoff, I decided that those who scored between x=40 - 50 on the Cutoff Scale were arguably the most cutoff. I chose this range since x=40-50 represents the upper 25% of the Scale, the range arguably representing the highest degree of cutoff. However, Dillard and Protinsky found that 25% of the population they studied (n=44) were highly cutoff. Not knowing their criteria for determining the most cutoff makes it hard to compare—which also supports the need for the development of standard scales for Bowen research.

Additionally, I found that 25% of the NIDA sample scored between x=33-50 on the Cutoff scale (See figure 4.3). This is above the mean score for the NIDA sample ( M = 26.89); but it is not that far from the beginning range of the upper 25% of the population. Therefore, I am not comfortable with designating this range of scores as the most Emotionally Cutoff. Unquestionably, on the McCollum Emotional Cutoff Scale the most cutoff are those who scored between x = 40-50 and this represents just 10.7% of the population. Accepting this range as the "most cutoff" means that the results of my study differ from Dillard and Protinsky's (1985) finding that 25% of the clinical population were the most cutoff.

Still, caution must be used in attempting comparisons between these samples. The NIDA sample (n=168) is comprised of women only. The Dillard and Protinsky sample (n=44) was comprised of 11 clinical couples and 11 non-clinical couples. Gender effects and sample size alone might account for the differences noted in the percentage of population assessed as "most" cutoff. This points to the need to develop standard measures which researchers can use to test different aspects of Bowen theory so that researchers can adequately compare results or conduct replication studies.

While the difference between means is statistically significant, there may be little clinical significance. The greatest difference in means is between the NIDA sample (NIDA M=26.89) and Day's sample (Day M=24.67). However, the Means are just over 2.22 points different from
each other on a 40 point scale (scores range between 10 to 50), and they are on the less cutoff end of the scale. This result surprised me since I expected the mean for emotional cutoff to be much higher in the NIDA sample—somewhere in the 30's. This may mean that clinical and non-clinical populations of women may be more alike than different in terms of cutoff.

Nonetheless, this study supports the use of emotional cutoff to a widely varying degree in a clinical population of women who abuse substances. While 21.4% of the population (see figure 4.2) reported a low degree of cutoff, 78.6% reported a moderately low to high degree of cutoff from their parents.

Still, given the low percentage of participants (10.7%) in the highest quarter of the scale (figure 4.2), and the relatively low mean (NIDA M = 26.89) in this sample, I believe that other methods are being used to manage anxiety. Notably, substance abuse itself is recognized in Bowen theory as one way to manage anxiety, as are other automatic relationship postures. Presumably, this sample has been accustomed to calling upon addictive substances and have longstanding interpersonal relationship patterns to deal with anxiety within themselves and within their family systems. McKnight (1998), Erkenbeck (1994), and Bepko and Krestan (1985) all comment on the presence of over and underfunctioning in the dynamics of an addicted family system.

Bowen affirms that emotional cutoff is just one way of managing anxiety in an addicted family system. For a population of women who abused substances and are just entering treatment, substance abuse itself is the most obvious response. Bowen asserts that substance abuse provides relief from anxiety stemming from the sense of increasing isolation which comes from living with cutoff (Bowen, 1974). This sample was tested prior to the initiation of 12 weeks of treatment. Presuming that the sample was no longer abusing drugs, they still had available to them the interpersonal dynamics which were already in place in their respective family systems.

Additionally, it is likely that this study's sample continued to do what they already knew to do in their interpersonal relationship patterns. For about 21.4% this included no or little use of emotional cutoff. Baker and Gippenreiter's (1998) study on the use of emotional cutoff during
the Soviet Purge suggested that families that already used cutoff, automatically resorted to cutoff at the time of the Soviet Purge. Baker and Gippenreiter speculated that other families did not respond this way for two reasons: First, because they had other family resources available. Second, because the use of cutoff was not in their emotional response repertoire. This concept of an emotional response repertoire may be applicable to a finding from Day's (1988) study.

Day's (1988) study of 102 women found that over and under functioning was used more often than emotional cutoff to manage anxiety. What this means for this study is that if emotional cutoff is in the emotional response repertoire of a family system, a substance abuser is more likely to draw upon cutoff as a solution to increased anxiety. However, if emotional cutoff is not already used within the family system, then it is less likely to be drawn on if at all. Rather, substance abusing women may draw upon other postures familiar to clinicians, like over and underfunctioning or a pursuit-distancing pattern.

Currently, scales are available to measure Bowen's concepts of differentiation of self in the family (Anderson & Sabatelli, 1992) and emotional cutoff (McCollum, 1986). It would be a great advantage to the investigation of Bowen theory if additional research instruments were developed to assess the presence and use of different relationship postures—like over/underfunctioning reciprocity, conflict, distance, triangling, and parental projection of anxiety to a child. Such instruments would be invaluable to investigating Bowen theory—particularly in conducting replication studies using equivalent samples and control groups.

Discussion of Results for Hypothesis Two

Hypothesis Two: A significant relationship will be found between emotional cutoff and substance abuse variables, individual psychological functioning variables, and family/marital relationship variables.

In response to the second hypothesis, I found that emotional cutoff has a significant positive relationship with ten variables; and emotional cutoff has a significant negative
Emotional Cutoff correlated significantly with three substance abuse variables at the p = .001 level. Emotional Cutoff did not correlate significantly with 10 other substance abuse variables (see Table 4.1). Emotional Cutoff related significantly in a positive direction with the behavioral characteristics of an abuser and with defensiveness. Emotional Cutoff related significantly in a negative direction with denial of abuse.

Emotional Cutoff correlated in a positive direction with the Behavioral Characteristics of an Abuser (n = 168, r = .229, p = .001 (one tailed). This relationship indicates that as emotional cutoff increases so do the behaviors commonly associated with an abuser who is not willing to change. These behaviors are impulsiveness, low frustration tolerance, impatience, resentment, and self-pity. The higher the score on this subscale, the more readily the subject will identify with substance abusers, but may not be willing to initiate change (Miller, 1985). From a Bowen standpoint, this may mean that as a substance abuser becomes more emotionally cutoff from parents intensity increases within them and may also find expression in behaviors characteristic of an abuser.

Emotional Cutoff correlated in a positive direction with the presence of traits indicative of a highly defensive person (n = 168, r = .238, p = .001(one tailed). This relationship indicates that as emotional cutoff increases so does defensiveness in a person. According to Miller (1985) elevated scores on defensiveness reflect a tendency to avoid acknowledging any signs of personal limitations and faults. Instead, the person may blame others and external circumstances for their problems. Defensiveness often is characteristic of an abuser or a co-dependent in an addicted family system (Miller, 1985). What this result means is that a person who is increasingly emotionally cutoff from one or both parents may also have an increased tendency towards defensiveness. They may blame others for their problems, like their parents, and they may not be in touch with their own inner reality—to include their own limits, faults, or strengths.
What this may mean from a Bowen standpoint is that as a substance abuser faces what they perceive to be criticism or blaming, they distance from the enormous anxiety this generates in their emotional self, by attacking the other or external circumstances.

There was a significant negative relationship between emotional cutoff and the denial of abuse \((n = 168, r = -0.296, p = .001\text{ (one tailed)})\). This relationship indicates that as emotional cutoff increases denial decreases. This result surprised me since I predicted a positive relationship between these two variables. I thought that as a substance abuser increases their degree of cutoff from others so would the level of denial about substance abuse. However, this result shows that as a person increases the degree of their emotional cutoff from parents, their denial that they abuse substances actually decreases. The SASSI manual (Miller, 1985) indicates that substance abuse clients with low scores on the denial sub-scale tend to recognize they have a substance abuse problem and that something needs to be done about it. However, not all will admit the primary problem is chemical dependency, nor be willing to enter treatment. From this I conclude that a substance abuser who is emotionally cutoff from the parental subsystem may possibly decide to blame their parents for being a substance abuser and also may decide not to seek treatment.

This is an exploratory study and these results need further evaluation and study. The strength of the three correlations, while statistically significant, were still relatively low (see Table 4.1). If other studies bear out these conclusions, it would be clinically relevant since it points to the need to assess and treat the degree of emotional isolation or emotional cutoff from the family of origin in a substance abuse population of women.

There was no significant relationship between emotional cutoff and the remaining 10 substance abuse variables (see Table 4.1). The lack of a relationship between emotional cutoff and increasing problems in the areas of medical condition, employment/support, drug use, alcohol use, legal status, family/social relationships, and psychological status is not consistent with Bowen theory or research.
Bowen asserts that the use of emotional cutoff increases anxiety; and this anxiety creates tension in the individual or in the family system and will likely be expressed by increased severity of psychological symptoms, employment or work-related problems, and in family or other social relationship problems (Bowen, 1978). Bowen research has demonstrated a relationship between emotional cutoff and the presence of psychological distress and medical conditions (McCollum, 1986; Harrison (1997)). McCollum found that subjects who score low in intimacy will score significantly higher on measures of seriousness of illness and psychological distress than subjects who report highly intimate relationships. Harrison (1997) found that the presence of a high degree of emotional cutoff in the family system significantly related to the lack of ovulation in otherwise healthy women. These studies point directly to the importance of the family emotional process upon individual biology.

The lack of a relationship between Emotional Cutoff and increasing problems in family/social relationships is puzzling. However, a population of women who abuse substances may be in denial about many things to include the status of their family and social relationships. Additionally, 81% of this population were on probation or parole. They had already experienced significant legal involvement. They were under pressure by their probation or parole officers and may simply have been eager to deny problems so that their probation and parole would go more smoothly. This result may also be an artifact of when this data was collected. The data may have been collected prior to the point in time when this sample of substance abusers were ready to acknowledge they truly had a problem. The data was collected prior to the initiation of 12 weeks of treatment and the establishment of a relationship with a therapist. This means they may not have developed a level of trust sufficient to risk disclosure of their problems and their need for treatment.

Emotional Cutoff did not significantly relate to psychological symptoms on a substance abuse scale (the Addiction Severity Index). This seemingly contradicts subsequent findings in this study in which significant relationships were found (on the SCL-90-R). The instrument used, the Addiction Severity Index, assesses the lifetime incidence and presence within the last 30 days of the experience of depression, anxiety, hallucinations, memory problems, violent behavior, and suicidal ideation. It asks for the patient's assessment of their need for treatment. It
may be that this result is an artifact of the abuser's denial and defensiveness about problems. Or, the participants may simply have not been at a point where they were ready to admit to a treatment professional that they need help. The SCL-90-R which I discuss more fully in the next section was also used to assess psychological functioning. It is a more sensitive instrument than the Addiction Severity Index since it more subtly assesses the presence of symptoms indicative of a psychiatric diagnosis without naming the diagnosis to the participant. The Addiction Severity Index in essence names the diagnosis to the client and then asks if the client thinks they need treatment. A substance abuser who already has a significant adversive relationship to the legal system and who may also be a reluctant participant in drug treatment, may choose to deny their need for psychological treatment.

This lack of candor points to a question about the accuracy of a substance abuser's self-report on the Addiction Severity Index, which was the instrument used to measure the severity variables. The SASSI instrument itself was designed on purpose to identify an abuser regardless of the abuser's level of honesty about their abuse (Miller, 1985). This is also why SASSI subscales determine the degree of defensiveness and denial of abuse. As mentioned in the preceding paragraph, the Addiction Severity Index in effect asks the abuser about problem areas commonly noted in abusers and how often that area has been a problem in their life and during the last 30 days. Then, it asks if the abuser thinks they need treatment in that area. If the abuser is reluctant to participate in treatment or is not yet ready to acknowledge the need for treatment, they are not likely to request help. This may help to explain the lack of significant correlations for the other variables related to substance abuse.

Initially, I was surprised that Emotional Cutoff did not correlate with a measure of codependent behaviors (e.g., problems with setting limits, a lack of a sense of personal power, and over focusing on others needs) (Miller, 1985). However, as I consider the result in light of Bowen theory, it seems to me that such behaviors are characteristic of someone who is fused emotionally with significant others in the family system, and who lacks an adequate sense of self as a whole person. This makes sense in a woman substance abuser, in particular, since women typically are more likely to make decisions based on their relationships (McCollum and Trepper, 1995). It may be that their desire to stay connected, regardless of the emotional cost to self,
means they are not likely to resort to cutoff. This is also supported by Lartin’s (1986) study which noted that highly cutoff women tend to become highly reactive to their parents, while highly cutoff men simply distanced and cutoff contact. I believe that what these studies show, taken together with the results from my study, is that there may be a gender effect to the use of cutoff. Therefore, there is a need for therapy and research which is gender sensitive on the use of relational postures like emotional cutoff. There is likewise a need for research instruments which are gender sensitive and can be used in Bowen investigative research to measure relationship postures—like distance and cutoff, over/underfunctioning, conflict, and triangling.

Correlations of emotional cutoff with individual psychological variables

Emotional Cutoff significantly correlates at the p = .01 to .05 level with eight individual psychological functioning variables; and did not correlate significantly with two others. If this result is valid, this may mean there is an interactional factor in specific psychological disorders. This result indicates emotional isolation may contribute to the rise of depression, anxiety, and other psychological symptoms. This result is supported by Bowen theory and research. This result, if valid, clinically very significant.

Bowen asserts that emotional cutoff increases anxiety; and this creates tension within the individual and family system and may be expressed by increased severity of psychological symptoms (Bowen, 1978). McCollum's (1986) study which was based in large part upon this assertion by Bowen, found that subjects who score low in intimacy will score significantly higher on measures of psychological distress than subjects who report highly intimate relationships. Research by Kung (2000) supports a link between depression and the interactions involved in marital relationships. Gilbert (1992) notes in her explanation of Bowen theory that people involved in cutoff relationships experience an intensification of depression and anxiety (Gilbert, 1992).

I found that Emotional Cutoff is significantly and positively related at the p = .05 level with depression (p=.04), anxiety (p = .02), hostility (p = .03), psychoticism (p = .01), somatic symptoms (p = .05), obsessive compulsive symptoms (p=.02), and a measure of Global Severity
of symptoms (p = .01). Interpersonal Sensitivity refers to symptoms of being highly critical of others or being highly sensitive to how others feel or think about you. I believe that such sensitivity points to an emotional disconnection from others and from self. Therefore, it makes clinical sense that there is a relationship between interpersonal sensitivity and emotional cutoff. It also makes clinical sense—at least from a Bowen viewpoint—that there is a relationship between emotional cutoff and anxiety, depression, and the other psychological dimensions named above. Bowen theory predicts that people involved in cutoff relationships from their parents experience an intensification of depression and anxiety (Gilbert, 1992).

Global Severity is a measure of the total sum of the distress scores in each symptom dimension, divided by 90. The relationship between Global Severity and emotional cutoff indicates that as emotional cutoff increases so does the assessment of overall psychological distress. This result is predictable given that so many of the individual psychological subscales correlated with the emotional cutoff scale.

While there is statistical significance, it is valid to wonder if Type I error operating. The strength of the correlations is low. Type I error means that there is a danger of falsely concluding that these correlations are significant, when they may not be (Sprenkle & Moon, 1996). It may be by chance that these particular correlations reached significance due to sampling a large number of variables (31) and chance.

There was no significant relationship between emotional cutoff and two individual psychological symptom areas: phobia and paranoia. The lack of a relationship with phobia and paranoia is just as interesting as those that did show a relationship. Assuming there is statistical and clinical significance to the other psychological dimensions, this result may indicate something about the nature and etiology of phobia and paranoia. The implication of this finding is that emotional isolation may be related to the etiology of certain psychological disorders and not to others. This result is really interesting and worth follow up.
Correlations of Emotional Cutoff with Marital and Family Variables

There was no significant relationship between emotional cutoff and marital satisfaction. Nor was a significant relationship found between emotional cutoff and distress in family functioning (See Table 4.3). This result suggests Bowen theory is wrong to draw a connection between the use of Emotional Cutoff to manage anxiety in marital and/or family interactions.

This result is not supported by clinical experience of Bowen therapists. Case studies of couples in addicted family systems affirm emotional cutoff is a factor (Erkenbeck, 1995; McKnight, 1998). Other related research (Kaufman, 1985; Crnkovic & DelCampo, 1998; Skowron, 2000) and the clinical experience of substance abuse clinicians who use an integrated approach to treatment (Bepko & Krestan, 1985) supports distress in family systems which is related to cutoff. For example, Reifman's (1986) study found a significant relationship between emotional cutoff from families of origin and difficulties with the establishment and maintenance of intimacy in marriage. Reifman found that the more intensely cutoff individuals were from their family's of origin, the greater difficulty they had in close intimate relationships. This was echoed in Dillard and Protinsky's (1985) study on couples which found that emotional cutoff from family of origin has a significant negative impact on couple functioning. Furthermore, Lartin's (1986) study found a significant relationship between emotional cutoff and the quality of marital and parent-child relationships between generations. McCollum's (1986) study found a significant relationship between emotional cutoff from parents, stress, and the development of physical or psychological symptoms. Harrison's (2000) study found a significant relationship between a high degree of emotional cutoff within the family of origin and the lack of ovulation in women.

Weiner's (1990) study found that subjects who used cutoff in parental relationships are significantly more likely to make the decision to divorce their spouses. Guentherman and Hampton (1992) found that young women from divorced families experienced significantly more emotional cutoff than do young women from intact families.
Furthermore, Ring (1998) found there are systemic benefits to reducing cutoff from parents by reconnecting. Benefits included increased personal contentment and a generalizing effect across the social context. Ring found other relationships automatically improved after an adult child reconnected with their parents. This benefit was found with partners, children, grandchildren, friends and co-workers.

The above studies significantly contradict these findings. Overall, the lack of support for Bowen theory on emotional cutoff in the above findings is fascinating, challenging, and perplexing. No measure of social desirability was used to check for possible skewing of answers in response to questions about marital satisfaction or family functioning.

However, given that a large number (81%) were on probation or parole, it may be that they minimized their family or marital concerns. This is the weakness of using self-report instruments. The researcher does not know what was in their minds when they responded as they did. Not knowing what the consequences of answering the question might be, they may have wished to avoid the unknown—to include the possibility of entangling members of their family system in treatment. Substance abuser’s in particular may attempt to deny abuse. Miller (1985) created the SASSI instrument to detect denial in substance abusers, regardless of their level of honesty. Members of the sample may not yet have been ready to acknowledge their problems and seek help. Thus, I wonder about the accuracy of their self-report. Given that the participants were members of an addicted family system, their perspective may have been somewhat skewed as to what is normal and what is problematic.

Finally, another possibility is that they may have used other relationship postures more often than cutoff to manage their anxiety in their couple and family relationships. Day (1988) found that a non-clinical population of women tend to use over and underfunctioning more than emotional cutoff to manage their anxiety. It may be that this may also be true for a population of women who abuse substances.
Discussion of Results for Hypothesis Three

Hypothesis three: Those clients who drop out of treatment will have significantly higher scores on the Emotional Cutoff Scale than those who complete treatment.

In response to the third hypothesis, I found no significant relationship between emotional cutoff and dropout from treatment. This result is not consistent with Bowen theory which suggests that relationship patterns learned in the family of origin are taken into subsequent significant adult relationships—which includes relationships with substance abuse professionals (McKnight, 1998; Erkenbeck 1995; Treadway, 1989).

The results appear on their face to be valid since those who completed 12 weeks of treatment established a relationship with a treatment professional. The data were analyzed by comparing the pre-test emotional cutoff scores of those who completed treatment and the pre-test emotional cutoff scores of those who dropped out. There were no significant differences between groups on this variable, emotional cutoff. Therefore, I believe the results are valid and need further exploration to discover the variables which influence attrition.

A review of four demographic questions using a Chi Square analysis also found no significant relationship between these questions and the phenomenon of dropout. There were no significant differences between those who started treatment and those who actually completed treatment on the following four demographic questions: marital status (married versus unmarried); children (those with no children, and those with children); probation and/or parole (those not on probation/parole versus those on); and prior drug treatment (those who had no prior drug treatment/ and those who had prior treatment).

Still, this was an exploratory study. The researcher is not aware of other Bowen studies into dropout from a substance abuse treatment program. Of course there has been other research into attrition; and a recent study inquired into the problems of bias for researchers introduced by non-cooperation by providers and problems in the retention of patients (Gerstein & Johnson, 2000).
My research has been valuable if only to affirm the complexity of the issues involved in dropout from substance abuse treatment. The researcher noted that just in this sample alone 45% dropped out prior to completion—meaning that 55% completed (NIDA sample n=168, completers n = 93). This dropout rate represents a substantial threat to the internal and external validity of this research. Such threats to internal and external validity have long been studied and commented on in research reviewing the phenomenon of attrition from substance abuse treatment (Hansen, Tobler, & Graham, 1990).

Hansen et al (1990) suggest that researchers should more explicitly address processes within treatment programs that may account for subject retention and attrition. Certainly, we should examine what we do in treatment programs that may influence retention and attrition. McCollum and Trepper (1995) found in a qualitative study on women that issues such as a non-supportive partner, lack of adequate childcare and transportation and scarce financial resources were reported as barriers facing women coming to treatment.

I reflected on what variables may from a Bowen stand point influence attrition from a substance abuse treatment program, if only to help researchers who may inquire into this phenomenon. Many variables may influence attrition from substance abuse treatment. Emotional cutoff is just one relationship posture. Other postures consistently noted in the research literature on addicted family systems, besides distancing and cutoff, is the presence of over and underfunctioning between spouses, and dynamics around closeness and distance (Erkenbeck, 1995; McKnight, 1998; Bepko & Krestan, 1985). Further research is needed to discover what variables influence dropout from treatment. Day's (1988) study, which I commented on earlier, found that a non-clinical population of women relied more on the use of over and underfunctioning in relationships as opposed to distancing and emotional cutoff. It may be useful to compare a non-clinical population of women, such as was used in Day's study, with a population of women undergoing treatment for substance abuse. This would permit a comparison of similarities and differences in the strategies used in interpersonal functioning; and it could lead to a discovery about how these strategies may influence or be involved in dropout from substance abuse treatment.
Triangling during therapy itself may also be involved in attrition. McKnight (1998) and Erkenbeck (1995) utilize Bowen therapy in helping couples manage their anxiety around changes in distance and closeness. McKnight talks about substance abuse acting like a buffer in a couple relationship. In effect, the substance abuse functions as the third point of a triangle, stabilizing the couple in their stuck positions. They both blame substance abuse for their problems and avoid addressing the interpersonal dynamics that underlie their problems. If therapy does not address this anxiety surrounding changes in distance and closeness with significant others, it may be that a substance abuser will elect to drop out from treatment.

Which brings us to the variables the professional clinician brings to treatment. McKnight (1998) suggests that if a treatment professional does not address the interpersonal dynamics of closeness and distance, the couple may withdraw from treatment. Brown and Lewis (1994), in discussing the recovery process of alcoholic families, also explicitly refer to the need to take a process approach to treatment. Process refers to the communication and interaction patterns that are part of the family system (Watzlawick, Weakland, & Fisch, 1974; Ackerman, Papp, & Prosky, 1970; Ackerman, 1958; as cited in Brown & Lewis, 1994). Brown and Lewis note that families often want to start their treatment by focusing on communication, bypassing changes in structure. However, treatment professionals need to focus on process which includes addressing the interactional dynamics as well as communication.

McKnight and Bowen (1978) also assert the importance of the therapist maintaining neutrality in their relationship with spouses. Other substance abuse professionals who follow an integrated approach, (balancing and utilizing individual and family systems goals), support the importance of treatment professionals addressing interpersonal dynamics and maintaining therapeutic neutrality, that is not aligning with one spouse against the other (Bepko & Krestan, 1985).

Overall, the lack of support for a relationship between emotional cutoff and dropout from a substance abuse program is fascinating and challenging. It may be that overall the lack of differences between groups could be attributed to the Emotional Cutoff measure used. It may not
be sensitive enough. Or, it could be that this was a relatively impoverished population and many may have stayed in due to being paid for their participation. If so, this may have skewed the pattern of dropout.

**Limitations**

Caution must be used in interpreting the results from this study. It may be that the Emotional Cutoff Scale (McCollum, 1986) is not sensitive enough in the measurement of emotional cutoff; and the scale may need some refinement. It is true to Bowen theory in that it specifically addresses forms of cutoff between the participant and the participant's parents. Bowen theory affirms that if you find cutoff from parents, the participant is likely to use cutoff in other significant adult relationships. A clinician can make the association and ask further questions to assess replication in other adult relationships. A researcher who desires to do quantitative research and use standardized instruments theoretically compatible with Bowen theory is limited to inferring the existence of a cutoff relationship or adding on a qualitative component.

Thus, one limitation I found in this study is there is no scale available that directly measures participant's replication of the cutoff posture with their partner or spouse. It seems to me one way this could be remedied on the Emotional Cutoff Scale is to substitute the appropriate indicators for other adult relationships (like spouse, partner, boss, or close friend) in place of the words mother or father on the Emotional Cutoff Scale. Naturally, this modification needs to be submitted for competent psychometric review.

Bias may have been inadvertently introduced into this study since the sample was paid for their participation. Given that this was a relatively impoverished population, the participants may have skewed their responses to gain the approval of the administrators. This payment may have unwittingly biased responses to questions concerning partner satisfaction or family functioning.
Responses may have also been skewed by social desirability. This factor could have skewed responses on the Emotional Cutoff Scale, and the family, marital scales. Some subjects may have been too embarrassed to respond accurately and, instead, responded that they were more connected to their parents than they actually were—or responded that their families were better functioning than they actually were. Social desirability may have skewed the results and needs to be controlled in future studies.

Scales are available to measure Bowen's concepts of differentiation of self in the family (Anderson & Sabatelli, 1992) and emotional cutoff (McCollum, 1986). It would be a great advantage to the investigation of Bowen theory if additional research instruments were developed to assess the presence and use of different relationship postures—like over/underfunctioning reciprocity, conflict, distance, triangling, and parental projection of anxiety to a child. Such instruments would be invaluable to investigating Bowen theory—particularly in conducting replication studies using equivalent samples and control groups.

All instruments were self-report in nature. The Addiction Severity Index is administered in an interview format; but otherwise the result is the same. These findings should be interpreted cautiously in light of using just one method to collect data. Future research would benefit by introducing more than one method of data collection and analysis.

The Challenge of Research based on Bowen Theory

The purpose of this study was to inquire into the variable of emotional cutoff in a population of women who abused substances. However, limiting this study to just this one relational posture may have narrowed the focus too far. The result may not do justice to either the theory or to the emotional process of an addicted family system.

This result points to the challenge of conducting Bowen-based research. Bowen theory is broadly stated. In a clinical session, the actual therapeutic interventions used may be focused on an extremely small piece of the overall process. Its analogous to discussing the human circulatory system and then using a microscope to look at a red blood cell under glass to find
evidence that the system exists. The reality is that you have confirmed a red blood cell exists; the rest must be inferred.

Bowen researchers need to find a way to do justice to the theory while adhering to research protocol. I found it extremely challenging to link the theory to the research paradigm. Given the broadness of Bowen theory itself and the complex interpersonal dynamics that exist within an addicted family system, it is a very large challenge. Operationalizing research questions into terms that withstand the rigors of research and statistical analysis means I may have inadvertently lost focus on the rest of the emotional process which exists in an addicted family system. Ring (1985) commented on the challenges of doing this type of research.

This concern leads me to recommend the development of instruments which can capture the broader reality while remaining specific in focus. Scales are available to measure Bowen's concepts of differentiation of self in the family (Anderson & Sabatelli, 1992) and emotional cutoff (McCollum, 1986). Such instruments would be invaluable to investigating Bowen theory—particularly in conducting replication studies using equivalent samples and control groups.

It would be a great advantage to substance abuse researchers who desire to investigate Bowen theory if additional research instruments were developed to assess the existence and function of different relationship postures in significant dyads and triads. For example, dyadic scales could assess parent-child, spouse/partner interactions. Triadic scales are also needed which inquire into dyadic relationships but add on substance abuse as the third point in the triangle- the first two points being parent-child or two partners/spouses.

The development of such instruments would be invaluable to investigating Bowen's theory on substance abuse in an addicted family system. Such measures would be invaluable to the conduct of replication studies, providing researchers the ability to compare outcome using equivalent samples and control groups. I discuss this issue of measures in the next section which provides suggestions for future research.
Suggestions for Future Research

Further research is warranted into the area of emotional cutoff and the complex individual and interpersonal family system dynamics associated with substance abuse. This study was exploratory in nature and it raises more questions than it answers. For example, this study confirms the presence of emotional cutoff towards parents in clinical and non-clinical populations, with a higher degree of cutoff in a population of women who abuse substances. However, it raises many new questions about the possibility of a relationship emotional cutoff and substance abusers, psychological disorders, and attrition.

This study confirmed an association between emotional cutoff and the behaviors associated with a substance abuser. Erkenbeck (1995) and McKnight (1998) both state that chemical dependency regulates the amount of intimacy and emotional distance between couples in addicted family systems. It may be that two future measures could be developed. One measure is needed which investigates the dynamics surrounding changes in emotional distance and closeness between couples. Another measure could examine how substance abuse may act as a buffer in the relationship. Finally, a study is needed to more fully explore the nature of the relationship between emotional cutoff and behaviors of a substance abuser.

Given the confirmation of a relationship between emotional cutoff and the appearance of psychological symptoms, additional research is warranted into this area to discover how cutoff relates to the appearance of symptoms. A biopsychosocial approach to research combined with a Bowen theoretical approach to interpersonal process may help to identify the variables involved and to describe their relationships more fully.

Exploratory studies from a Bowen Family systems perspective are needed to discover what variables influence dropout from substance abuse treatment. This study did not support a connection between emotional cutoff and dropout. However, this result is puzzling from the standpoint of theory.
Future studies may attempt the comparison of an emotionally cutoff group with a non-cutoff group in a population of substance abusers. The McCollum (1986) Emotional Cutoff Scale could be used to define a cutoff group from a non-cutoff group. A companion study could be conducted simultaneously into the partners/spouses of substance abusing women which looks at the same factors and makes comparisons to spouses/partners in a non-clinical population. The researcher might compare groups in terms of the degree of emotional closeness to parents and spouses; the use of various relationship postures, including cutoff; and, the function of substance abuse as a "buffer" in interpersonal dynamics in the family system.

Finally, the dynamics between the substance abuser and the therapist also merit review. Bowen theory and Bowen-based research supports the importance of therapist neutrality to all members of the client's family system. If a therapist aligns with any family member clinical experience says treatment tends to go no where. A worthwhile Bowen study could inquire into the effects of therapists maintaining neutrality towards a client and members of the client's family system; and then compare this with the treatment effects flowing from a loss of neutrality by the same therapist towards the client. My experience of Bowen therapists and therapy is that the therapist is always working towards maintaining neutrality. Erkenbeck (1995) courageously describes the ebb and flow of therapy when neutrality is maintained and when it is lost with a couple in recovery from substance abuse. These concerns are echoed by Bepko and Krestan (1985) and, of course, Bowen (1978).

Clinical Importance

A varying degree of emotional cutoff is present in a population of women who abuse substances, but not in all. The mean for emotional cutoff was statistically significantly higher in this sample than in two comparison samples—one non-clinical, one mixed (clinical and non-clinical). Just as many participants in this study were emotionally connected to their parents as were highly cutoff. Therefore, it is important not to impose a simplistic therapeutic frame upon substance abusing clients which presumes all women with substance abuse problems are cutoff. The clinician needs to maintain an open mind and assess the degree of cutoff present, if any. The
Emotional Cutoff Scale is a clinician friendly scale that is easily administered and can be used as a therapeutic tool (Crnkovic & DelCampo, 1998).

Individual psychological problems show an association with emotional cutoff from one's parents. This means successful treatment will attend to the dynamics of interpersonal isolation as well as the underlying biology of psychological disorders. This association confirms Bowen's theory that chronic anxiety can be manifested through cutoff and the appearance of psychological symptoms. It would be easy for the clinician to become distracted by the symptoms and fail to focus on the interpersonal process which maintains the symptoms (Brown & Lewis, 1999).

It is important to remember that treatment of an addicted population involves understanding the presence of complex interpersonal as well as individual biology and individual psychological symptoms. Thus, all relational postures used in an addicted family system need assessment and attention at both the individual and family systems level. A treatment plan that attends to this complexity is required.

There may be a gender effect to functioning in an addicted family system. Fusion and an over/underfunctioning posture may be used more often by women who abuse substances—more so than cutoff. Gender specific dynamics need to be assessed and treatment tailored to fit. Bepko and Krestan (1985) describe these differences clearly.

Summary

Notwithstanding the significant challenge of conducting Bowen research, due to the complexity of Bowen theory, the present study has shown that it is useful and possible to conduct theoretical research into the presence and effects of emotional cutoff in a clinical sample of women who abused substances. I found the mean for emotional cutoff was higher in this studies sample of women, who just entered treatment for substance abuse, than in two comparison samples. A comparison of Emotional Cutoff between these three samples (stressed women, divorced men and women, and women who abused substances) shows an increasing
degree of cutoff. This may mean that as the level of chronic anxiety increases, so does the level of symptoms expressed in a cutoff population.

I also found that emotional cutoff has a significant positive relationship with substance abuse behaviors and a highly defensive person. Emotional cutoff has a significant negative relationship with denial of substance of abuse.

Furthermore, a relationship was established between emotional cutoff and individual symptoms of seven psychological disorders and a measure of global psychological dysfunction. The disorders are Depression, Anxiety, Hostility, Psychoticism, Somatization, Obsessive Compulsive symptoms, and Interpersonal Sensitivity. These results are preliminary and are worth follow up in future studies.

This research did not confirm a relationship between emotional cutoff and couple satisfaction or family functioning distress variables. These results are perplexing, not consistent with Bowen or other substance abuse research, and merits additional investigation. This result may mean that as distress increases in family/social relationships, other relationship postures may be drawn upon more often than cutoff to deal with the increased tension and anxiety.

Finally, this research did not substantiate a relationship between emotional cutoff and dropout from a substance abuse treatment program. This result merits review and careful inquiry into the nature of dropout and the interpersonal dynamics which may be involved.
REFERENCES


VITA FOR FRANCES BELL

ACADEMIC PREPARATION

Master of Science, Marriage and Family Therapy, Virginia Tech. Completed requirements for degree during September 2000. Acquired 62 graduate hours with a 3.92 G.P.A; and 538 direct client clinical hours serving families, couples and individuals. Completed clinical internship at the two following locations:

- Two year clinical internship at the Center for Family Services, Virginia Tech, in Falls Church, Virginia.

- One year internship with the Family Systems Counseling Unit, an entity of the Fairfax County Juvenile and Domestic Relations Court, in Fairfax, Virginia.


RELATED VOLUNTEER ACTIVITIES

Leader in the Stephen Ministry lay counselor program:

Met with individual clients who were struggling with relational conflicts, the effects of alcohol addiction, and issues stemming from serious medical or chronic illness, dying, or grief for five years (1994 to 1999).

- Coordinated efforts of a five-person Leadership Team. Interviewed and assessed candidates for suitability as lay counselors; organized and provided training of new lay counselors; and conducted individual and small group peer supervision of 24 lay counselors.

Organizer and Facilitator of Women’s Support Group. Trained at John Hopkins University as a support group facilitator. Training was provided by the Depression and Affective Disorders Association. I facilitated a weekly Women’s Support Group; and I was supervised by a Licensed Professional Counselor.

RELATED EDUCATION

Army Inspector General Course, 1993. Functioned as a counselor to soldiers and commanders and conducted sensitive investigations for the Secretary of the Army. I practiced active listening, neutrality and the avoidance of bias, employed investigative methods and ethics, and gathered evidence concerning allegations.
Army Special Agent Counterintelligence Investigator’s Course, 1977. Trained in the conduct of counterespionage investigations by interviewing witnesses and suspects using unbiased, open questions, personal observation and listening skills; unbiased and legal collection of evidence; and special surveillance techniques. Also trained in the presentation of clear, comprehensive reports.

RELATED WORK EXPERIENCE

Army Inspector General, 1993 to 1997. Conducted investigations of allegations made against U.S. Intelligence activities and personnel on behalf of the Secretary of the Army. Conducted interviews of witnesses and suspects. Provided counsel, recommendations, and findings to Army Commanders and the Secretary. Conducted systemic inspections of classified Army organizations. Deconflicted organizational and relationship issues within the Army system by walking them from the bottom up through organizational levels to the top of the Army.

Army Counterintelligence Officer, 1977 to 1997. Oversaw sensitive investigations into Army personnel. Ensured the conduct of ethical, impartial interviews with the intent of gathering all available evidence.