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THE EFFECTS OF FAMILY RESPONSIBILITIES AND GENDER ON SEEKING SUBSTANCE-ABUSE TREATMENT

by
Holly Weiss

A Thesis

Submitted to the
Department of Psychology
College of Science and Mathematics
In partial fulfillment of the requirement
For the degree of
Master of Arts in Clinical Mental Health Counseling
at
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Thesis Chair: Matthew Miller, Psy.D.

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Abstract

Holly Weiss
THE EFFECTS OF FAMILY RESPONSIBILITIES AND GENDER
ON SEEKING SUBSTANCE-ABUSE TREATMENT
2015
Matthew Miller, Psy.D.
Master of Arts in Clinical Mental Health Counseling

It is evident in the media, from news reports to published research, that substance use is a serious and extensive problem (SAMHSA, 2012). The problem with drug use is not a new issue, but with a changing society the substance abuse issue is changing as well. With substance abuse at its highest in about ten years, it would be expected that treatment admissions would be at the highest levels as well, yet the numbers have remained constant (SAHMSA, 2012). The changing society has helped foster increased drug use, but it has also assisted in developing new difficulties that those affected must face in order to get help. Currently, many barriers to treatment are faced by individuals (Green, 2006). These barriers included childcare, home responsibility, employment and negative social stigma. The results of these barriers are that they are unable to get the treatment for substance abuse that they need. This study seeks to develop an understanding of which identified barriers are the most serious and detrimental to someone seeking treatment, specifically women. T-Tests and Regression Analyses indicate that women reported higher levels of responsibility, as predicted, with both genders reporting the most frequent responsibilities. Contrary to the study's hypothesis, the most reported family responsibility was not childcare; implications for the findings and directions for future research are discussed.

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Chapter 1

Introduction and Literature Review

Substance Use and Abuse

It is estimated that in 2011, in the United States alone, 22.5 million people have used an illegal drug in the last month. That is 8.7 percent of the population using illicit substances just in a span of 30-days alone (SAMHSA, 2012a). Also, according to 2011 *National Survey on Drug Use and Health*, the rate of current substance use among persons aged 12 or older ranged from 8.7% to 8.9% between the years of 2008-2011 and 8.3% in 2002. However; it was higher than the rates in most years from 2003 through 2008 (7.9% to 8.3%) (SAMHSA, 2012a). These numbers indicated that while the number of individuals using illicit substances has been stable over the last three years, they have increased from previous years. With regards to alcohol, the report states that a little more than half (51.8 percent) of Americans aged 12 or older reported they currently drank alcohol.

Looking at gender, in 2011 adult men reported a higher rate of substance use and abuse than adult women (11.2% vs. 6.5%). Men were also users of several illicit substances at a higher rate than women. Of several illicit substances, marijuana (9.3% vs. 4.9%), nonmedical use of prescription drugs (2.6% vs. 2.2%); cocaine (0.7% vs. 0.4%) and hallucinogens (0.5% vs. 0.3%) were reported to be higher for men (SAMHSA, 2012a). Looking at alcohol use in 2011, adult men represented a higher percentage of current drinkers than adult women (56.8% vs. 47.1%). These numbers show that male rates of substance use/dependence are twice as high as female rates. However; the rate of

substance use for men in 2011 is down 1.3% compared to 2010 but the rate of substance use for women does not show a decrease from 2010 (SAMHSA, 2012a).

With the increase in substance use/abuse over the past ten years, there has also been an increase in health-related issues related to substances. These health-related issues include unpleasant reactions to a substance, taking more than prescribed, drug on drug interactions, drug on alcohol interactions and side effects (SAMSHA, 2010). According to the Drug Abuse Warning Network (DAWN), there were 4.6 million emergency room visits in 2009 related to drug use (NIH, 2011). That number is up 81% from 2004 which had 2.5 million emergency room visits. Of those 4.6 million emergency room visits, 21.2% involved illicit drugs and 14.3% involved alcohol, in combination with other drugs (NIH, 2011).

Additionally, violence and/or sexual assault often coincide with substance use together and affect those involved. According to The National Center on Addiction and Substance Abuse at Columbia University (1999), 37% of victims self-reported that the offender that raped or sexual assaulted them were under the influence of alcohol (alone or with other drugs). It is important to note that, it is likely that drugs play a larger role in rapes and sexual assault then is reported. Often, many assaults by substance using men are against substance using women who may be more disinclined to report the assault. Supplementary information collected from inmates in state prisons for sexual assault show that one in five offenders reported they were under the influence of drugs at the time of their crime. Of those, 5% were under the influence of drugs alone and 15% under the influence of both drugs and alcohol (The National Center on Addiction and Substance Abuse at Columbia University, 1999). Furthermore, victims of sexual assault often turn

to drugs or alcohol to cope with their trauma. According to the Research and Advocacy Digest (2005), rape victims are 5.3 times more likely than those that have not been victimized to have used prescription drugs for a use other than for what they were prescribed. This shows that, disorders that can develop after an assault (i.e. PTSD, depression, anxiety)and increased alcohol and substance use and abuse are well linked, even among those who were not users of these substances prior to their assault (Anderson, 2005).

While it is apparent that substance use and abuse has a large effect on someone physically, the cost to society is even greater. In the U.S., costs related to substance use/abuse total around $600 billion annually (NIH, 2012). These costs include lost work, healthcare and crime. Just to healthcare, the cost of substance abuse is $137 billion (NIH, 2012). Finally, the biggest cost of substance use and abuse is the loss of life. Since the early 1980's, deaths from substance use has nearly doubled. Today, one in four deaths is attributable to alcohol, tobacco, and illicit drug use (Volkow, 2012). Other studies show that drug overdoses over the last twenty years exceeded suicides and motor vehicle deaths (Nauert, 2013).

Characteristics of Female Substance Users

Focusing on gender, research published in The Psychiatric Clinics of North America show that men use substances at a higher rate than women, however most research shows that the diagnosis of a substance abuse disorder is not specific to one gender. With regards to a person's actual substance use, women have many differences over men. Women have a tendency to turn to substances later in life and have different reasons for their use (Brady & Randell, 1999). When looking at women and substance

use, research has shown that women tend to drink less often than men and when they do consume alcohol, it is in smaller amounts (Green, 2006). Additionally, women are less likely to develop problems related to alcohol consumption and are less likely to use illicit drugs and develop drug related problems. However; when women develop substance related problems, they tend to be older in age and progress faster. Also, with women there tends to be shorter periods of time between the onset of the substance problem and negative consequences. Negative consequences for the female substance users include physical problems, poor impulse control, and negative interpersonal changes such as changes to the personality and/or decreased self-esteem. Additional negative consequences include interpersonal difficulties and a decreased ability to maintain social responsibilities. An additional characteristic of the female substance user is the shorter interval between the onset of chronic substance use and help-seeking behavior. Women also tend to experience an increased number of health related issues related to their substance use and have difficulty functioning in more areas of their life (Green, 2006).

Further characteristics of female substance users include women being more susceptible to substance use because of pressure from their significant other (Brady & Randell, 1999). Women also tend to have a more negative view of substance use and this personal view combined with society's stigma of substance abuse may be related to the tendency for women to get medications prescribed to them from a physician as opposed to off the streets (Brady & Randell, 1999). Finally, women tend to enter treatment earlier than man and tend to have a better response to treatment than men (Brady & Randell, 1999). Current numbers in the United States show that women make up about half of

those with drug related problems and one third of those with alcohol problems (Green, 2006).

Co-Occurring Disorders and Substance Abuse

The importance of the relationship between substance abuse and mental health disorders has been has been closely looked at for at least forty years. Between the decades of the 1980's and the 1990's, many researchers and practitioners discovered that many substance abuse issues were associated with numerous mental health disorders, not just depression as previously thought (CSAT, 2005). During this time, it is reported by substance abuse treatment programs that between 50 to 75 percent of clients had co-occurring mental disorders, while clinicians in mental health settings have reported that between 20 and 50 percent of their clients had co-occurring substance use disorder (CSAT, 2005). In 2009 it was shown that, of adults with a documented substance use disorder, 42.8 % (8.9 million) also had a co-occurring mental illness (SAMHSA, 2010). These numbers demonstrate that substance abuse and co-occurring mental illness is becoming increasingly common and the need to cater to this co-morbidity is becoming increasingly necessary. However; despite the seemingly obvious need for treatment of those dually diagnosed, research is showing that there is a gap between those identified with a co-occurring disorder and those actually receiving treatment (CSAT, 2005). The Substance Abuse and Mental Health Service Administration (2010) showed that 62% of those in need of mental health or substance abuse treatment received it, but 38% did not receive any treatment.

The National Institute on Drug Abuse (2007) went on to further say that those that are duel diagnosed have more severe symptoms then those with just one disorder alone.

This institute went into further discussion regarding the lack of treatment received and it was cited that the health care system that is in place currently has a detachment between mental health treatment and substance abuse treatment because of the more severe symptoms exhibited by both disorders instead of by one disorder alone. Also, the detachment comes from mistakenly identifying substance use symptoms (withdrawal, intoxication, etc.) for mental health symptoms and providing ineffective treatment (2007). Also, those that are treating patients are often on different levels, with physicians treating mental illness and a variety of providers and people with different backgrounds treating substance abuse. This also leads to biases and differences of opinion regarding the use of medication which can be at times necessary (National Institute on Drug Abuse, 2007). This is because that while many medications are used for treatment of substance abuse issues and treatment of mental health issues, their effectiveness has not been studied in a co-morbid population (National Institute on Drug Abuse, 2010). Recommendations from researchers at the National Alliance on Mental Health (2013) include detoxification and sobriety from abused and even non-abused substances and then intensive psychiatric treatment. The authors note that treatment for mental health issues will be the most effective when substances are ceased (Duckworth & Freedman, 2013). The National Alliance on Mental Illness (2011) identified the divide, discussed by Duckworth and Freedman, in treatment and went on to further explain that treatment of mental illness in a predominantly substance abuse treatment center can be dangerous. Traditional substance abuse treatment tends to be more confrontational and obligatory, which is not healthy for those with mental health issues because they have a tendency to

be too fragile (NAMI, 2011). This type of coercive treatment may cause those with mental illness to relapse and create auxiliary damage (NAMI, 2011).

Barriers to Treatment

With statistics showing that substance use and abuse has been on the rise over the last ten years, it should be expected that admissions to drug treatment centers would be increasing as well. This however; is not the case. According to the Treatment Episode Date Set (TEDS) presented by the Substance Abuse and Mental Health Service Administration's Center for Behavioral Health Statistics and Quality, "the treatment admission rate in 2010 (691 per 100,000 population aged 12 and older) was about 6 percent lower than the rate in 2000 (738 per 100,000 population)" (SAMSHA, 2012b). These numbers show that while substance use is on the rise, treatment admissions are remaining constant.

Researchers at the Drug Abuse Research Center sum up the problems faced with treating those with substance abuse disorders in the simplest terms, most of those that need substance abuse treatment do not get it (Hser et al.1998). A study by the Center for Interventions, Treatment, and Addiction Research (CITAR) identified barriers to treatment as characteristics of a person or group that form obstacles to receiving care. They further went on to define internal treatment barriers as attitudes or impressions that come from within the person and external barriers as factors outside of the individual, i.e. "healthcare system, structural characteristics of a program, and socio-cultural-environmental factors" (Xu, Wang, Rapp & Carlson, 2007).

Regarding internal barriers, researchers at Griffith University found that that uncertainty toward stopping or cutting down substance use was also a major obstacle of

seeking treatment. The authors also cited a lack of motivation as another key barrier to substance users seeking treatment (Klag, Creed and O'Callahhan, 2010) and other research went on to propose that the motivation to get treatment is unsteady without a significant external force (Hser et al., 1998). Additionally, researchers from The Drug Abuse Research Center found other internal barriers to entering treatment that include a higher level of dysfunctionality, such as higher levels of family and psychological problems (Hser et al., 1998). These findings support the information from CITAR that internal barriers such as individual attitudes and experiences impact receiving substance abuse treatment. Concerning external barriers, results from the 2008 National Survey on Drug Use and Health information found that 32.1% of people did not receive treatment because of inadequate health insurance/lack of ability to pay and 12.3% did not receive treatment because of a negative effect on their job (SAMHSA, 2009). Additional research from the Livestrong Foundation identified difficulties with referrals and locating resources as a dilemma. The author also identified difficulties staying on waiting lists, locations, hours or operations, keeping interview appointments and paying fees and the inability to remain in programs long enough to make progress as barriers to getting help (Earhart, 2010). The Drug Abuse Research Center cited that less treatment history and/or less positive treatment histories also had a negative effect on entering treatment (Hser et al., 1998). Additional research by CITAR combined internal and external barriers and found that that certain facets of the health care system, such as policy issues, finances and program eligibility and admission criteria, can interact with individual variables, such as stagnant personal characteristics and situational needs, and negatively impact the utilization of health care and substance abuse treatment. Difficulties from the health care

system will interact with these personal characteristics and can serve as an obstruction to receiving treatment (Rapp, Xu, Carr, Lane, Wang and Carlson, 2006).

Women's Barriers to Substance Abuse Treatment

Between the years of 2000 and 2010, the number of men entering substance abuse treatment was nearly double that of women entering treatment (around 1,290,000 vs. around 590,000) (SAMSHA 2012b). This is rather concerning and begs the question, what is preventing women from getting treatment? Statistics from the Substance Abuse and Mental Health Service Administration show that the rate of substance abuse/dependency is twice as high for men, which would explain the higher rates of treatment admission (2012b). However; research published in The Psychiatric Clinics of North America show that women tend to go into treatment earlier and have a better response to treatment than men (Brady & Randell, 1999).

Researchers at the Drug Abuse Research Center postulated that help-seeking seems to be mainly influenced by individual characteristics; environmental circumstances and sociocultural context and these appear to be having a larger effect on women (Hser et al., 1998). The numbers detailing less utilization of substance abuse treatment by women is in contrast with other medical treatments in which women have been shown to use and need more than men (Green, Polen, Dickinson, Lynch, Bennett, 2002). Women have a higher probability to face numerous barriers to receiving substance abuse treatment and therefore have a lower chance of seeking treatment (Green, 2006). According to this researcher, women may seek substance abuse treatment less than men because of ongoing barriers to treatment such as childcare, low income and poor insurance coverage, negative stigma regarding women's addiction issues and discrepancies between typical female

gender roles, such as the mother role, and seeking substance abuse treatment (Green, 2006).

Evidence in the literature suggests that women entering treatment are reporting having more family responsibilities and less social support and have more child-care issues then men (Green et al., 2002). Further studies by CITAR reported having to be a caregiver as a major barrier to seeking treatment (Rapp et al., 2006). Furthermore, women have more difficulty attending regular treatment sessions because of family responsibilities (Green, 2006). Additional research conducted by researchers at SAMHSA discussed issues related to pregnancy and childcare and its impact on seeking substance abuse treatment. They report that many women who are pregnant while using fear losing custody of their child along with charges of child abuse or other charges. "For example, 14 states consider substance use during pregnancy to be child abuse under civil child welfare statutes, and 9 states require health care professionals to report suspected prenatal substance abuse" (Brady & Ashley, 2005). These authors go on to further discuss childcare and substance abuse treatment and they report that women are more likely to be more concerned about child care and/or may have more children living in their home or be the sole caretaker of children. Women that are in the role of caretaker to children worry about the care of their children during treatment and this becomes the number one barrier to women entering substance abuse treatment (Brady & Ashley, 2005).

Research published by the American Journal of Drug and Alcohol Abuse took a look at treatment history (2000). The researchers found that women had fewer lifetime admissions to any substance abuse treatment (4.4 admissions for women vs. 5.1

admissions for men) and fewer total days of treatment (91 days for women vs. 122 days for men. For women who had received outpatient or day treatment for addiction, the researchers found that women still had fewer lifetime admission then men (1.6 admissions for women vs. 2.3 admissions for men) (Westermeyer & Boedicker, 2000). A researcher at the Semel Institute for Neuroscience and Human Behavior also looked at the source of payment for treatment and the differences between men and women. She cited that more men self-pay (pay out of pocket) then women (26% vs. 18%) and a larger number of women are reliant on public insurance as a source of payment (26% vs. 12%) (Grella, 2008). These numbers indicate that men appear to have more financial resources (i.e. better job, higher pay, better benefits) and women have a higher need to utilize public assistance. Furthermore, it was noted that with women having a greater dependence on public assistance to pay for substance abuse treatment, the availability of treatment will fluctuate with changes in eligibility in public assistance (Grella, 2008).

Limitations to Previous Research

While previous studies have established clear and consistent barriers to treatment, there are limitations. It became evident that many studies were able to identify multiple barriers to treatment and the identified barriers remained stable and consistent across multiple studies. Statistics performed by the researchers in these studies were often performed to identify which identified barriers were reported more often and how these barriers differed from the barriers faced by men. The identified research was able to provide a comprehensive view of barriers faced by women, but how significant that barrier was in relation to women seeking substance abuse treatment. What was left out of virtually every study was the strength of the relationship between the identified barrier

and a women not entering substance abuse treatment. The most common barrier identified by participants and researchers was family roles and the matter of caring for children and families while receiving substance abuse treatment. Green et al. (2002) referred to this as the "mother role" and how it clashes with the mother seeking help for her addiction problem. The restrictions of studies such as Green et al.'s (2002) is that while it is important to understand how the "mother role" effects a women's ability to get substance abuse treatment, it is equally as important to understand how much of an impact this role has on seeking substance abuse treatment. The process of identifying barriers to treatment is important, but there is a need to identify which barriers are the most strongly related to entering substance abuse treatment so that resources can be developed.

The Present Study

Based on this information, it is very clear that many barriers to substance abuse treatment surround family roles and responsibilities, specifically marriage and childcare. There appears to be a gap in the literature regarding this specific issue and it appears that if family roles and responsibilities are such a large factor in women seeking substance abuse treatment, that there is a need for further research into how much of an effect this issue has on women's substance abuse treatment. Logically, knowing the strength of the relationship of the barrier to the issue would assist in identifying which barriers are the most crippling to women and make obvious to providers what problems are the most important to assist with first. For example, if research shows that childcare, which has been previously identified as a barrier, has a stronger and more significant relationship to women not seeking substance abuse treatment than finances, which has also been shown

to be a barrier, providers could work immediately with women to assist in finding childcare. Once childcare was removed as a problem then further work could be done on getting the women into the treatment they need. What may also come from identifying the strength of the relationship between the barrier and the problem of getting treatment is that once the most significant barrier is removed, all other identified barriers may go away and the women can proceed directly to treatment.

The aim of the present study is to further explore the impact of women's family roles on seeking substance abuse treatment. The first hypothesis is that women will report more family responsibility than men. The second hypothesis proposes that the amount of family responsibility will be negatively correlated with their seeking and receiving substance abuse treatment. Additionally, it is likely that the largest barrier to treatment will be childcare difficulties, particularly for women. By investigating this relationship, this study may provide a further understanding of women's barriers to treatment and support further developments that assist women in getting the help that they need regarding substance abuse such as making childcare while in treatment more readily available and/or less expensive or, providing additional assistance with regards to maintaining a home while away for treatment.

Chapter 2

Method

Participants

Participants included 45 individuals, 29 were male and 16 were female. The mean age of participants was 44.6 (SD= 11, range 26-66). The sample was normally distributed. The majority identified as White/Non-Hispanic (58.3%, n= 28) followed by African American/Black (18.8%, n= 9), other (8.3%, n= 4), Hispanic/Latino (4.2%, n= 2) and Native American (4.2%, n= 2). Regarding relationship status, 39.6% (n= 19) of participants reported being single (never married) and 16.7% (n= 8) reported dating someone (seeing one or more person(s)). The remainder of participants reported they were separated (10.4%, n= 5), divorced (8.3%, n=4), married (8.3%, n=4), in a serious relationship and not living together (4.2%, n=2), in a serious relationship and living together (4.2%, n=2) and other (2.1%, n=1). Table 1 displays our sample demographics.

Materials

Participants were given a demographics questionnaire as part of the study asking questions regarding their age, gender, ethnicity, relationship status, parental roles and caregiving roles (caring for elderly family members, caring for younger family members, etc.). No personal health information (i.e. name, social security number, etc.) was asked for or collected.

Table 1

Sample Demographics

Demographic	*N*	%
Gender		
Male	29	64.4
Female	16	35.6
Relationship		
Single	19	39.6
Dating	8	16.7
Separated	5	10.4
Divorced	4	8.3
Married	4	8.3
Serious not living together	2	4.2
Serious living together	2	4.2
Other	2	2.1
Parental roles		
No children	19	39.6
Children not in the home	10	20.8
Children with visitation	7	14.6
Children in the home	5	10.4
No contact with children	2	4.2
Other	2	4.2
Caretaking roles		
Family care once a week	14	33.3
No caretaking roles	14	29.2
Minimal caretaking (monthly)	5	10.4
Caring for nonfamily members	5	10.4
Other	5	10.4

Further surveys included the Family Responsibility Index (FRI) a 53-item, face valid, self-report survey that measures traditional family role tasks by behaviors (Corcoran & Fischer, 2000). The FRI is broken into 10-subscales: yard work, laundry, house care and upkeep, kitchen clean-up, family business, housecleaning, car care, heavy housecleaning, family care and preparing meals (Alley, 1984). This survey is scored on a scale of 1 (no responsibility) to 5 (full responsibility). There was also the option of 0

(does not apply). Seven items were removed from the survey based on relevance (i.e. yard work questions and preparing meals questions). The language was also altered to include more neutral language (i.e. husband changed to other) to accommodates participants that are not married. Correlations between the 54-items produced moderately high correlations with a mean of r = .82 and r = .79 on a second test (Alley, 1984). Face validity was tested between husbands and wives and measured a mean of r =.88 for wives and r = .86 for husbands (Alley, 1984). To score the FRI, the answers were summed.

The participants were also given a substance abuse treatment questionnaire. It was created based on available information regarding common substance abuse treatment options and a measure used by Green et al. (2002). The authors measured treatment hours by the usual hours spent in each type of treatment identified (2002). For example, individual sessions were measured as 1 hour, partial care or intensive outpatient sessions were measured as about 2.5 hours and inpatient treatment as 7 hours per day (Green et al., 2002). Based on the measurement by Green et al., a 4-item self-report survey was created that involves multiple choice answers in the form of A-E responses, ranging from no level of participation to high levels of participation. For example, "in the past year, how many hours have you spent in individual counseling for substance abuse or issues related to substance use; A. 0-5 hours, B. 6-10 hours, C. 11-15 hours, D. 16-20 hours, E. 20 or more hours". It includes questions about inpatient drug rehabilitation, individual counseling for substance abuse, partial care/intensive outpatient programming as well as pro-social meetings such as AA/NA over the preceding year.

Lastly, in order to assess substance abuse severity the CAGE-AID was utilized. The CAGE-AID a 4-item, face valid, self-report survey that measures severity of

substance abuse (SAMHSA, 2014). The CAGE-AID asks four questions related to amount of substance use such as, “Have you felt you ought to Cut down on your drinking or drug use?” and social views of substance use, “Have people Annoyed you by criticizing your drinking or drug use?” The survey also asks about personal feelings related to substance use, “Have you felt bad or Guilty about your drinking or drug use?” as well as continued substance use to get rid of withdrawal effects, “Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover [Eye-opener]?”. This survey is answered with ‘yes’ or ‘no’ responses with each positive response being assigned one point and negative responses being assigned zero points. The test is regarded as a positive screen if one or more of the answers are positive. Sensitivity reports on the CAGE-AID are 0.79 for one or more “yes” responses and 0.70 for two or more “no” responses. These results show that the CAGE-AID is able to correctly identify addiction 79% of the time with one or more positive responses and 70% of the time with two or more positive responses. Specificity reports for this questionnaire are 0.70 for one or more “yes” responses and 0.85 for two or more “yes” responses. This indicates that 77% of the time this survey is able to correctly identify the absences of addiction with one or more positive responses and 85% of the time with two or more positive responses (SAMHSA, 2014).

Procedure

Approval was obtained from Rowan University International Review Board prior to data collection. Additionally, approval was obtained from a large mental health provider’s MICA (mentally ill and chemically addicted) program. The MICA program is a partial care program that provides group counseling, individual counseling, case

management and medication monitoring to those with dually diagnosed mental health and substance abuse issues. The program is six-hours a day and consumers attend between two and five times a week. Group counseling sessions consist of developing coping skills, social skills, relapse prevention skills, psychoeducation and prevocational training. Consumers enrolled in the MICA program also have access to a psychiatrist for medication needs and monitoring.

Data was collected using paper surveys distributed to participants. Participants were offered to partake in the survey at the start of the morning group session Monday through Friday for five weeks. The participants were informed that involvement in the study was entirely voluntary and that they had the opportunity to decline participation at any time without ramifications or disruption to treatment. An informed consent was distributed first to allow any questions regarding the study to be answered. The informed consent included the purpose and procedures of the research as well as the ethical guidelines. After the informed consent forms were collected, the surveys were handed out to participants and took an average time of twenty minutes to complete.

Power Analysis

Estimated sample size was determined using commercially available software (Effect Size Generator, Devilly, 2004) Effect sized (Cohen's d) were calculated based on available date from Xuet. al (2007). The effect sizes for these studies fell into the large range (d= .48-.90).

According to the power analysis, a minimum of 120 would be necessary to identify a significant relationship between family roles and gender with a large effect size (r=.90), 3 predictors in the model and using the .05 confidence interval to ensure a 90%

likelihood of identifying the relationship. Given the proposed sample size (n=120) and assuming a large effect size, the power of detecting a significant relationship would be .90.

Chapter 3

Results

When asked about their parental roles, 39.6% (n=19) reported that they did not have any children. Additionally, 20.8% (n=10) of participants reported that they had children but they did not live in the home and 14.6% (n=7) of participants reported that they had children and visited with them. The remainder of participants reported they had children that lived in the home (10.4%, n=5), had children but did not have any contact (4.2%, n=2) and other (4.2%, n=2).

In regards to caretaking roles outside of parenthood, 33.3% (n=14) reported caring for family members one time a week and 29.2% (n=14) reported that they had no caretaking roles. The remainder of participants reported minimal (monthly/bimonthly) caretaking responsibilities (10.4%, n=5), caring for nonfamily members once a week (10.4%, n=5) and other (10.4%, n=5).

Due to experimenter error, only 30 of the 45 participants completed the alcohol and drug severity survey (CAGE-AID). Of those 30 participants, 90% (n=27) were in the clinically significant range. When looking at male and female reported substance abuse as measured by the CAGE-AID, it was found that there was not a significant difference between genders ($t=.922$, $df=43$, $p=.362$).

An independent-samples t-test was conducted to compare substance abuse treatment for males and females with their level of family responsibility. There was a significant difference in the scores for males ($M=2.32$, $SD=0.88$) and females ($M=3.15$, $SD=1.02$); $t(43) =-2.87$; $p<.003$. These results suggest that males and females differ in

family responsibilities, with females reporting a higher number of responsibilities. This could be potential evidence for a barrier for females.

When looking at which family roles were reported most, and therefore likely to be a detriment to seeking further treatment, it was found that for both genders, housecleaning (M=29.07, SD=1.004) (e.g. Vacuum rugs, wash floors, change beds) was reported the most frequently followed by family care (M=22.07, SD=1.004) (e.g. buying clothes for self/others, making dental/doctor appointments, arrange for childcare) and heavy housecleaning (M=14.18, SD=1.004) (e.g. wash walls, shampoo rugs/furniture, polish floors). When looking at male scores on the Family Responsibility Index, M=2.315, SD=.881, SEM=.164. Males reported housecleaning (M=25.33) as the primary family role. This was followed by family care (M=17.52) and heavy housecleaning (M=10.79) (e.g. wash clothes, put clothes away, iron clothes). When looking at female scores on the Family Responsibility Index, M=3.147, SD=1.016, SEM=.254. The primary family role reported by females was housecleaning (M=35.38). This was followed by family care (M=30.87) and heavy housecleaning (M=20.31). These results indicate that women report higher family roles of housecleaning and family care then the genders combined and men separately.

Multiple regression analyses were performed to look at the predictive capabilities of gender and individual duties of the Family Responsibility Index (FRI) (day to day housekeeping, household maintenance and meal and care responsibilities). These sub domains were created based off of the duties/subscales of the FRI and grouped together based on tasks that were similar in nature. The day to day housekeeping sub domain is comprised of the FRI duties of washing clothes, putting clothes away, ironing, washing

windows, washing walls, cleaning the refrigerator/stove, shampooing rugs, washing dishes, putting dishes away, cleaning kitchen, cleaning bathroom, vacuuming, washing floors, dusting, changing beds, indoor plants and making beds. The household maintenance sub domain consists of the FRI duties of balancing the checkbook, paying bills, income tax, finance decisions, emptying the garbage, car fluids, car repair, care tires, routine car servicing, indoor painting, outdoor painting, physical upkeep of the house, house repairs and house remodeling. The meal and care responsibilities sub domain is made up of the FRI duties of caretaking, planning meals, preparing meals, buying clothes for oneself, buying clothes for others, doctor appointments, correspondence, caring for preschool children, childcare, family recreation, going to doctor appointments and staying home with sick children.

Inpatient Rehabilitation

Regarding gender, a significant model did not emerge $F(1, 40) = .532$, $p = .47$. When looking at day to day housekeeping in predicting inpatient rehabilitation enrollment, a significant model did emerge $F(20, 21) = 3.644$, $p = .002$. The model explains 56.3% of the variance (adjusted r squared=.563). When looking at predictor variables, wash clothes, put clothes away, clean refrigerator and stove, wash dishes, put dishes away and cleaning the kitchen were significant predictors of inpatient rehabilitation enrollment. (See Appendix E for chart). When looking at household maintenance in predicting inpatient rehabilitation enrollment, a significant model did not emerge $F(15, 25) = .473$, $p = .933$. When looking at meal and care responsibilities in predicting inpatient rehabilitation enrollment, a significant model did not emerge $F(15, 28) = 1.949$, $p = .062$.

MICA Attendance

Concerning gender, a significant model did not emerge F (1, 40) =3.775, p=.059. When looking at day to day housekeeping in predicting MICA attendance, a significant model did not emerge F (20, 21) =.929, p=.564. When looking at household maintenance in predicting MICA attendance, a significant model did not emerge F (15, 25) =1.153, p=.365. When looking at meal and care responsibilities in predicting MICA compliance, a significant model did not emerge F (15, 28) =.578, p=.867.

Individual Counseling

Relating to gender, a significant model did not emerge F (1, 39) =.110, p=.742. When looking at day to day housekeeping in predicting hours in individual counseling, a significant model did not emerge F (20, 21) =1.555, p=.161. When looking at household maintenance in predicting hours in individual counseling, a significant model did not emerge F (15, 25) =1.003, p=.482. When looking at meal and care responsibilities in predicting individual counseling, a significant model did not emerge F (15, 28) =.639, p=.818.

AA/NA Meetings

Regarding gender, a significant model did not emerge F (1, 40) =.165, p=.687. When looking at day to day housekeeping in predicting number of AA/NA meetings, a significant model did not emerge F (20, 21) =.573, p=.891. When looking at household maintenance in predicting number of AA/NA meetings, a significant model did not emerge F (15, 25) =.633, p=.821. When looking at meal and care responsibilities in predicting number of AA/NA meetings, a significant model did not emerge F (15, 28) =.907, p=.566.

Substance Abuse Significance

When looking at gender, a significant model did not emerge F (1, 40) =1.373, p=.248. When looking at day to day housekeeping in predicting substance abuse significance, a significant model did not emerge F (20, 21) =.782, p=.707. When looking at household maintenance in predicting substance abuse significance, a significant model did not emerge F (15, 25) =.702, p=.760. When looking at meal and care responsibilities in predicting substance abuse significance, a significant model did not emerge F (15, 28) =.519, p=.908.

Family Responsibility

As to gender, a significant model did emerge F (1, 40) =6.940, p=.012. The model accounted for 12.7% of the variance (adjusted r squared =. 127). (See Appendix F for chart). When looking at day to day housekeeping in predicting family responsibility, a significant model did emerge F (20, 21) =9.259, p=.000. The model explains 80.1% of the variance (adjusted r squared=.801). When looking at predictor variables, ironing, screens repair and changing the beds were significant predictors of family responsibility. (See Appendix F for chart). When looking at household maintenance in predicting family responsibility, a significant model did emerge F (15, 25) =10.416, p=.000. The model explains 77.9% of the variance (adjusted r squared=.779). When looking at predictor variables, pay bills and inside painting were significant predictors of family responsibility. (See Appendix G for chart). When looking at meal and care responsibilities in predicting family responsibility, a significant model did emerge F (15, 28) =11.149, p=.000. The model explains 78% of the variance (adjusted r squared=.780). When looking at predictor variables, planning meals, buying clothes for self, buying

clothes for others and taking children to the doctor were significant predictors of family responsibility. (See Appendix H for chart).

Chapter 4

Discussion

The purpose of this study was to evaluate whether or not women report more family responsibilities than men and if those responsibilities negatively affect women seeking and entering substance abuse treatment. With the use and abuse of substances at its highest level in ten years (SAMSHA, 2012) and an increase in emergency room visits due to substance misuse (NIH, 2011) as well as men entering treatment twice as much as women (SMAHSA, 2012), this study is important in assisting women in receiving the substance abuse treatment that they need.

In regards to the theories that women report higher levels of family responsibility and that family responsibility for women negatively impacts their ability to seek substance abuse treatment, the treatment population gender difference (males n=29; females n=16) is consistent with family responsibilities being greater for women. The sample size difference is consistent as well with the reported difference in drug usage between men and women as men report almost double the use as women. As reported previously, about 40% of the sample reported that they did not have any children, and this was demonstrated in the spread of family responsibilities by gender. Both women and men reported housecleaning as their primary responsibility and family care as their secondary responsibility. In congruence with the previous statement of women reporting higher responsibilities, the numbers for housecleaning and family care were higher for women than men.

Regression analyses showed that day to day housekeeping responsibilities had an effect on enrollment in inpatient drug rehabilitation. Furthermore, variables that had the

highest effect on enrollment were washing and putting clothes away, cleaning the refrigerator and stove, washing and putting away dishes and cleaning the kitchen. These results show a contrast to previous research that indicated that women have more childcare barriers (Green et al., 2002) and report care giving as a major barrier to treatment (Rapp et al., 2006). Additionally, regression analyses indicated that day to day housekeeping, household maintenance and meal and care responsibilities were closely predictive of family responsibility. In regards to day to day housekeeping, ironing, screen repair and changing the beds were predictive of overall housekeeping responsibilities. These results indicate that if an individual reports engaging in these activities in the home, they are likely engaging in all or most of the household activities. Further research may choose to investigate how day to day responsibilities such as washing clothes, cleaning dishes and cleaning the kitchen predict enrollment in inpatient rehabilitation.

While this study highlights the fact that women have specific needs (i.e. childcare, caregiver to family, low income and/or poor insurance coverage, negative stigma against women receiving treatment) regarding substance abuse treatment over men, one limitation to this study was in regards to its sample. The sample of individuals enrolled in treatment were registered to a program targeted for those dually-diagnosed. The participants were not only diagnosed with substance use and abuse, they also had a range of diagnosed mental disorders. While this sample does not allow for a pure picture of substance misuse disorders, the population used demonstrates what previous research has shown, that a majority of those with a substance abuse diagnosis also have a co-occurring mental illness diagnosis. If a sample of individuals were used that was not receiving

substance abuse treatment, it may not be representative of a co-occurring population which has be shown to be more common.

Another possible limitation of this study could be the economic level of this population. While monetary income and/or occupation was not directly asked as a part of the demographics questionnaire, prior knowledge and experience with the population in regards to occupation/finances indicated that the sample was low income, low education and unemployed. The implications of this could be difficulty generalizing the results to higher income individuals. For example, a family with a higher level of income is more likely to own a home and/or own a vehicle, while many of those participants in the sample were residing in shelters, supportive housing or motels. Additionally, a majority of those in the sample did not have a vehicle or even a driver's license. As a result, those that own a home and/or a vehicle have different levels of responsibilities than those that live in temporary setting such as a motel. In regards to the childcare and/or family care, which was a significant factor in this study, those that have a higher socio-economic status are more likely to be able to afford daycare or nannies for their children as well as home health aides or residential settings for additional family members. Additionally, the small sample size (n=45) makes generalization to the overall population difficult.

These findings support anecdotal evidence regarding the impact of family and home life on getting treatment and also make a significant contribution to understanding the influence of both family and household needs in getting substance abuse treatment. Applications of the results of this study may impact the ability of treatment programs to accommodate those family responsibilities that are reported the most, specifically for women. Women in this study reported difficulty with managing a household and

managing a family as their most pronounced responsibilities and very few substance abuse treatment facilities provide any type of childcare. Facilities that do provide programs for parents with children are at a cost much too high to most that attempt admission. One possible solution could be an increase in programs that provide for children at a cost that is more attainable to parents. For example, one of the very few treatment facilities in the United States that does offer women's services provides an inpatient experience that includes a flexible length of stay for women who are pregnant or have children. This facility also offers different phases of treatment that include individual, group and family counseling. Furthermore, this facility offers medical care for children (pre- and postnatal) as well as therapeutic on-site childcare. The goal of this facility is to keep families together by targeting education deficits, poor work history, parenting issues, relationship problems and criminal backgrounds. This program also seeks to address issues that develop for children of addicted parents such as physical abuse, emotional abuse, neglect, sexual abuse and abandonment. This facility boasts an 80% success rate for families, in that they no longer have legal trouble, involvement with child protective services and are self-sufficient in the community as well as their household. As previously mentioned, the cost is often prohibitive for most families. The facility referenced asks for one hundred dollars per day, per person for a single parent and one child with an average length of stay of about six months. The final cost for this program is around $36,000, for one parent and one child. What drives the cost of this program are the multiple professionals in multiple fields that are needed for the treatment center to function day to day. These professionals include mental health counselors for adults, as well as children and families, addictions counselors for adults and families,

vocational and educational counselors, day care providers, case managers, medical doctors that treat adults as well as the children and physicians that can accommodate pre-natal care, as well as psychiatric providers. In order to meet the needs of women who identify childcare as a barrier to entering treatment, more facilities need to model this program and strive to be made available to all socio-economic statuses. In order to make parent/child programs more economically available, while maintaining the highest levels of care, facilities would benefit from accepting a wider range of insurance plans as well as developing payment options that ease the financial burden.

Additionally, a therapeutic community model has shown to be effective in enhancing personal growth, recovery as well as balancing out cost. A therapeutic community (TC) works on the basic principles of empowerment, safety, belonging, openness and living-learning (Campling, 2001). TCs can be identified as ," 'therapeutic' as denoting the social and psychological goals, namely changing the individual's lifestyle and identity, while 'community' denotes the primary method or approach employed to achieve the goal of individual change" (Gowing, Cooke, Biven, Watts, 2002). The specific component of work activities in the TC help to develop personal change as well as instill the value of work. As a result, the participant in the TC develops workable skills, gains in personal goals as well as material gains (Gowing, Cooke, Biven, Watts, 2002).

In regards to the other primary responsibility reported by this sample of house care, perhaps insurance companies may add a section to their coverage that offers handling of aides that assist in the upkeep of the home while the individual is away at

treatment. While implications of these research findings may be difficult to implement, the discussion of need versus availability is something that must be addressed now.

Further research related to seeking substance abuse treatment may choose to look at finances as a problem area. Previous research indicated that 32.1% of people did not receive treatment because of inadequate health insurance/lack of ability to pay (SAMHSA, 2009). In this research, business/finances were the seventh most reported responsibility (males M=8.90, women M=10.47). Additional research may focus on how money impacts receiving treatment or if money has an effect on the type of treatment received. Additionally, it was found by the Livestrong Foundation that difficulties with referrals and locating resources is a dilemma faced by those attempting to locate substance abuse treatment (Earhart, 2010). Further research may choose to explore how substance abuse facilities are advertising themselves as well as how other treatment providers (i.e. primary care doctors, counselors, emergency rooms, etc.) are spreading information about treatment facilities. Additional research from this study found that for men, car care (M=8.50) and meals (M=6.55) were reported the least and for women, meals (M=9.00) and car care (M=4.06) were reported the least. Ongoing research in the future may choose to examine why these family responsibilities are reported the least.

Despite its limitations, this study was the first to study specific family responsibilities that may affect an individual's ability to enter substance abuse treatment. Despite previous studies that that indicated that women have more childcare barriers (Green et al., 2002) and report care giving as a major barrier to treatment (Rapp et al., 2006), this study indicated that household responsibilities, such as cleaning and maintenance, were the largest factors limiting an individual's ability to get substance

abuse treatment. Because substance addiction places such a burden on society and an individual, it is so important to identify and remove any possible barriers to treatment to help lower wide spread costs. Future research on variables that negatively impact addiction treatment can help inform treatment tactics.

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Appendix A

Demographics

1. What is your age?
2. What is your gender?
    a. Male
    b. Female
3. Please select the response that corresponds to your race or ethnicity
    a. African-American/Black
    b. Hispanic/Latino/Latina
    c. White/Non-Hispanic
    d. Asian/Pacific Islander
    e. Native American
    f. Other
4. Please select the response that is most descriptive of your relationship status over the past year
    a. Single
    b. Dating (seeing one or more person(s))
    c. Involved in a serious relationship, but not living with a significant other
    d. Living with a significant other
    e. Married
    f. Separated
    g. Divorced
    h. Other
5. Please select the response that is most descriptive of your parental role
    a. No Children
    b. Have children and living together
    c. Have children and not living together
    d. Have children, not living together, with visitation
    e. Have children with no contact/visitation
    f. Other
6. Please select the response that is most descriptive of your caretaking role to others over the past year
    a. No caretaking responsibilities
    b. Minimal caretaking responsibilities
    c. Care for elderly family members (i.e. parents, grandparents, aunts/uncles, etc.)
    d. Care for younger family members (i.e. nieces/nephews, siblings, cousins, etc.)
    e. Care for family members not listed

Appendix B

Family Responsibility Index (FRI; Bjorkquist, 1984)

Instructions: During a typical working week, who is responsible for each of the following tasks? Please use the appropriate numbers provided below and enter in the space next to the listed task.

5=Myself always
4= Myself more
3= Self/Other Equally or both
2= Other more
1= Other always
0= Does not apply/Not applicable

Laundry

1. Wash clothes _____
2. Put clean clothes away _____
3. Iron clothes _____

House Care and Upkeep

4. Indoor painting _____
5. Outdoor painting _____
6. Physical upkeep of house exterior _____
7. Household repairs _____
8. Household remodeling _____
9. Put on storm windows and/or screens _____

Kitchen Clean-Up

10. Put dished in dishwasher/wash dishes _____
11. Empty dishwasher/dry dishes and put dishes away _____
12. Clean stove, counters, and table _____

Family Business

13. Balance checkbook _____
14. Pay bills _____
15. Prepare income tax forms _____
16. Make major financial decisions (e.g., buy insurance, select financial investments) _____

Housecleaning

17. Clean bathroom _____
18. Vacuum rugs _____
19. Wash floors _____
20. Dust furniture _____
21. Change beds _____

22. Care for indoor plants _____
23. Make beds _____
24. Empty garbage _____

Car Care

25. Check and add gas, oil, water, battery fluid _____
26. Decide when car needs servicing and take to garage _____
27. Buy and change tires or take to garage to have tires changed _____
28. Perform routine car servicing (e.g., change oil, antifreeze) _____

Heavy Housecleaning

29. Wash windows and drapes/curtains _____
30. Wash walls _____
31. Clean refrigerator and stove _____
32. Shampoo rugs and furniture _____
33. Polish floors _____

Preparing Meals

34. Plan meals/buy food _____
35. Prepare meals _____

Family Care

36. Buy clothes for self _____
37. Buy clothes for other family members _____
38. Make dental and doctor appointments _____
39. Care for family pets _____
40. Keep in touch with relatives and good friends _____
41. Take care of preschool children _____
42. Teach, help, and discipline children _____
43. Arrange for child care _____
44. Organize family recreation and entertainment _____
45. Take children to dentist/doctor _____
46. Stay with children when sick _____

Source: Corcoran, K., & Fischer, J. (2000). *Measures for clinical practice: A sourcebook* (Vol. 1). New York, NY: The Free Press.

Appendix C

Substance Abuse Treatment

Instructions: Please indicate for each question, the time spent receiving the indicated substance abuse treatment.

1. In the past year, how many times have you enrolled in inpatient drug rehabilitation (i.e., Maryville, Sunrise House, Post House)?
A. 0-1 times
B. 2-3 times
C. 3-4 times
D. 5-6 times
E. 7 or more times
2. In the past year, how many hours have you spent in individual counseling for substance abuse or issues related to substance use?
A. 0-5 hours
B. 6-10 hours
C. 11-15 hours
D. 16-20 hours
E. 20 or more hours
3. In the past year, how consistent has your attendance been at your MICA partial care program?
A. Not at all consistent
B. Somewhat consistent
C. Consistent
D. Very consistent
E. 100% consistent
4. In the past year, how many AA/NA or other community meetings have you attended?
A. 0-5 meetings
B. 6-10 meetings
C. 11-15 meetings
D. 16-20 meetings
E. 20 or more meetings

Appendix D

CAGE-AID

Instructions: When thinking about drug use, include illegal drug use and the use of prescription drug use other than prescribed.

Questions:

1. Have you ever felt that you ought to cut down on your drinking or drug use?
2. Have people annoyed you by criticizing your drinking or drug use?
3. Have you ever felt bad or guilty about your drinking or drug use?
4. Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover?

Appendix E

Day to Day Housekeeping and Inpatient Rehabilitation Enrollment

Model		Unstandardized coefficients		Standardized coefficients			95.0% confidence interval for *B*		Correlations			Collinearity statistics	
		B	*SE*	β	*t*	*p*	Lower bound	Upper bound	Zero-order	Partial	Part	Tolerance	VIF
1	(Constant)	1.115	.386		2.890	.006	.335	1.895					
	Gender	.192	.264	.115	.729	.470	-.341	.725	.115	.115	.115	1.000	1.000
2	(Constant)	2.108	.501		4.205	.000*	1.065	3.150					
	Gender	.065	.231	.038	.279	.783	-.416	.545	.115	.061	.029	.562	1.778
	WashClothes	.370	.153	.625	2.424	.024	.053	.688	-.100	.468	.250	.160	6.245
	PutClothesAway	-.629	.133	-1.041	-4.722	.000*	-.905	-.352	-.403	-.718	-.487	.219	4.558
	Iron	-.010	.054	-.030	-.193	.849	-.122	.101	-.105	-.042	-.020	.442	2.260
	WashWindows	-.057	.136	-.157	-.422	.678	-.340	.226	-.022	-.092	-.044	.077	13.036
	WashWalls	.119	.150	.335	.796	.435	-.192	.431	.012	.171	.082	.060	16.565
	CleanFridgeStove	-.451	.167	-.827	-2.708	.013*	-.798	-.105	-.107	-.509	-.280	.114	8.746
	ShampooRugs	.060	.135	.171	.445	.661	-.220	.340	-.065	.097	.046	.072	13.874
	PolishFloors	-.136	.084	-.391	-1.624	.119	-.310	.038	-.089	-.334	-.168	.183	5.455
	Screens	.051	.061	.120	.822	.420	-.077	.178	-.191	.177	.085	.503	1.990
	WashDishes	.519	.151	.885	3.441	.002*	.205	.833	-.057	.600	.355	.161	6.215
	PutDishAway	-.715	.135	-1.581	-5.315	.000*	-.995	-.435	-.354	-.757	-.549	.120	8.301
	CleanKitchen	.770	.191	1.568	4.026	.001*	.372	1.168	-.093	.660	.416	.070	14.229
	CleanBathroom	-.278	.162	-.497	-1.721	.100	-.615	.058	-.003	-.352	-.178	.128	7.819
	Vacuum	-.042	.216	-.080	-.196	.847	-.492	.408	-.170	-.043	-.020	.063	15.759
	WashFloors	-.137	.228	-.303	-.600	.555	-.611	.338	-.072	-.130	-.062	.042	23.900
	Dust	.098	.169	.216	.583	.566	-.252	.449	-.035	.126	.060	.078	12.848
	ChangeBeds	.172	.134	.335	1.283	.213	-.107	.451	-.157	.270	.132	.156	6.392
	IndoorPlants	.028	.068	.079	.405	.689	-.114	.169	.097	.088	.042	.282	3.540
	MakeBeds	.100	.161	.193	.625	.539	-.234	.435	-.173	.135	.065	.112	8.957

[a] Dependent Variable: InptRehab.

*$p < .05$

Appendix F

Gender and Family Responsibility

Model		Unstandardized coefficients		Standardized coefficients			95.0% confidence interval for *B*		Correlations			Collinearity statistics	
		B	*SE*	β	*t*	*p*	Lower bound	Upper bound	Zero-order	Partial	Part	Tolerance	VIF
1	(Constant)	1.591	.432		3.682	.001	.718	2.465					
	Gender	.778	.295	.385	2.634	.012*	.181	1.375	.385	.385	.385	1.000	1.000
2	(Constant)	-.122	.408		-.299	.768	-.970	.726					
	Gender	.040	.188	.020	.213	.834	-.351	.431	.385	.046	.015	.562	1.778
	WashClothes	-.137	.124	-.192	-1.105	.282	-.395	.121	.434	-.234	-.077	.160	6.245
	PutClothesAway	.149	.108	.204	1.373	.184	-.077	.374	.591	.287	.096	.219	4.558
	Iron	.108	.044	.261	2.489	.021*	.018	.199	.498	.477	.173	.442	2.260
	WashWindows	.114	.111	.259	1.029	.315	-.116	.344	.750	.219	.072	.077	13.036
	WashWalls	-.094	.122	-.219	-.772	.449	-.348	.159	.730	-.166	-.054	.060	16.565
	CleanFridgeStove	.057	.136	.087	.421	.678	-.225	.339	.622	.092	.029	.114	8.746
	ShampooRugs	.054	.109	.128	.495	.626	-.173	.282	.709	.107	.034	.072	13.874
	PolishFloors	.054	.068	.129	.795	.435	-.087	.195	.668	.171	.055	.183	5.455
	Screens	.125	.050	.246	2.503	.021*	.021	.229	.447	.479	.174	.503	1.990
	WashDishes	.122	.123	.172	.991	.333	-.134	.377	.580	.211	.069	.161	6.215
	PutDishAway	.027	.109	.050	.247	.807	-.200	.255	.619	.054	.017	.120	8.301
	CleanKitchen	-.232	.156	-.391	-1.490	.151	-.555	.092	.699	-.309	-.104	.070	14.229
	CleanBathroom	.159	.132	.235	1.208	.241	-.115	.433	.515	.255	.084	.128	7.819
	Vacuum	.005	.176	.009	.031	.976	-.361	.371	.580	.007	.002	.063	15.759
	WashFloors	-.062	.185	-.114	-.334	.741	-.448	.324	.625	-.073	-.023	.042	23.900
	Dust	.015	.137	.026	.106	.917	-.271	.300	.608	.023	.007	.078	12.848
	ChangeBeds	.235	.109	.379	2.154	.043*	.008	.462	.544	.425	.150	.156	6.392
	IndoorPlants	.110	.055	.262	2.001	.059	-.004	.225	.657	.400	.139	.282	3.540
	MakeBeds	.046	.131	.073	.352	.729	-.226	.318	.564	.076	.024	.112	8.957

[a] Dependent Variable: FRTOTAL.

*$p < .05$

Appendix G

Household Maintenance and Family Responsibility

Model		Unstandardized coefficients		Standardized coefficients			95.0% confidence interval for *B*		Correlations			Collinearity statistics	
		B	*SE*	β	*t*	*p*	Lower bound	Upper bound	Zero-order	Partial	Part	Tolerance	VIF
1	(Constant)	1.604	.443		3.623	.001	.708	2.500					
	Gender	.770	.306	.374	2.520	.016	.152	1.389	.374	.374	.374	1.000	1.000
2	(Constant)	.402	.373		1.079	.291	-.365	1.170					
	Gender	.477	.198	.232	2.410	.024*	.069	.885	.374	.434	.179	.596	1.678
	BalanceCheckbook	.061	.045	.145	1.360	.186	-.032	.155	.524	.262	.101	.486	2.058
	PayBills	.176	.071	.380	2.475	.020*	.030	.323	.547	.444	.184	.234	4.279
	IncomeTax	.047	.051	.108	.925	.364	-.058	.153	.476	.182	.069	.401	2.491
	FinanceDecisions	.017	.070	.038	.241	.811	-.128	.162	.583	.048	.018	.220	4.552
	EmptyGarbage	.093	.050	.178	1.867	.074	-.010	.196	.382	.350	.139	.608	1.644
	CarFluids	-.013	.082	-.027	-.153	.880	-.181	.156	-.019	-.031	-.011	.179	5.601
	CarRepair	-.011	.109	-.024	-.101	.920	-.235	.213	.129	-.020	-.008	.095	10.473
	CarTires	-.034	.121	-.076	-.281	.781	-.284	.216	.034	-.056	-.021	.075	13.325
	RoutineCarServicing	.136	.104	.295	1.318	.199	-.077	.350	.136	.255	.098	.110	9.084
	IPainting	.225	.077	.484	2.918	.007*	.066	.384	.637	.504	.217	.200	4.988
	OPainting	-.097	.086	-.205	-1.130	.269	-.273	.080	.417	-.220	-.084	.168	5.955
	PhysicalUpkeep	.007	.076	.015	.088	.930	-.149	.163	.560	.018	.007	.197	5.067
	HouseRepairs	-.030	.069	-.061	-.441	.663	-.173	.112	.514	-.088	-.033	.292	3.429

[a] Dependent Variable: FRTOTAL.

*$p < .05$

Appendix H

Meal and Care Responsibilities and Family Responsibility

		Unstandardized coefficients		Standardized coefficients			95.0% confidence interval for *B*		Correlations			Collinearity statistics	
	Model	*B*	*SE*	β	*t*	*p*	Lower bound	Upper bound	Zero-order	Partial	Part	Tolerance	VIF
1	(Constant)	1.373	.408		3.362	.002	.549	2.197					
	Gender	.943	.287	.452	3.284	.002	.363	1.522	.452	.452	.452	1.000	1.000
2	(Constant)	.161	.353		.457	.651	-.562	.885					
	Gender	.110	.212	.053	.519	.608	-.324	.544	.452	.098	.037	.496	2.017
	Caretaking	-.026	.069	-.036	-.385	.703	-.167	.114	.229	-.073	-.028	.595	1.682
	PlanMeals	.241	.104	.447	2.309	.029*	.027	.455	.643	.400	.165	.137	7.308
	PrepareMeals	-.005	.099	-.009	-.048	.962	-.208	.198	.671	-.009	-.003	.151	6.629
	BuyClothesforSelf	.260	.076	.342	3.395	.002*	.103	.416	.439	.540	.243	.504	1.985
	BuyClothesforOthers	.130	.057	.264	2.277	.031	.013	.248	.597	.395	.163	.380	2.632
	DrAppointments	.037	.051	.069	.731	.471	-.067	.141	.437	.137	.052	.570	1.755
	Pets	.080	.047	.180	1.700	.100	-.016	.176	.466	.306	.122	.459	2.177
	Correspondence	-.109	.061	-.204	-1.782	.086	-.234	.016	.391	-.319	-.128	.391	2.555
	CareforPreschoolKids	.200	.100	.305	1.992	.056	-.006	.405	.466	.352	.143	.219	4.562
	TeachKids	.001	.070	.001	.008	.994	-.143	.145	.473	.001	.001	.255	3.920
	ChildCare	-.193	.107	-.272	-1.807	.081	-.412	.026	.510	-.323	-.129	.227	4.408
	FamilyRecreation	.078	.052	.152	1.496	.146	-.029	.185	.505	.272	.107	.499	2.005
	TakeToDr	.240	.102	.467	2.351	.026*	.031	.450	.548	.406	.168	.130	7.710
	StayHomeKidsSick	-.115	.122	-.229	-.941	.355	-.365	.135	.520	-.175	-.067	.087	11.558

[a] Dependent Variable: FRTOTAL.

*$p < .05$