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Stereotypical sex-roles: A barrier to success in addiction treatment?

Paul Walter Sharpe

STEREOTYPICAL SEX-ROLES: A BARRIER TO SUCCESS IN ADDICTION TREATMENT?

A Project

Presented to the

Faculty of

California State University,

San Bernardino

In Partial Fulfillment

of the Requirements for the Degree

Master of Social Work

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Abstract

The hypothesis of this research project was that participants in addiction treatment programs who had the sex-role scores indicating "macho male" or "overly seductive" female would have a lower completion rate than participants who did not receive a test score indicating assumption of these sex-roles. The instrument used was the Bem Sex-Role Inventory, which does not treat sex-role as opposite ends of a continuum, but allows one to measure individuals that possess characteristics of both roles. The project was conducted at American Hospital with participants whose treatment was being funded by the County of Los Angeles. The project found that sex-role was related to completion of an addiction treatment program, but did not support the hypothesis of the researcher. The roles that the researcher predicted would be the lowest were second and third in treatment completion rate. This research had another significant finding in that the number of non-white participants was high, thirty-seven of sixty-two. They were found to possess the same characteristics on sex-roles as the white participants. This project while having too small of a number to be considered definitive points the way for more research in this area on this type of population. It also has implications for Social Work to consider the sex-role of all individuals they are seeing that have chronic drug/alcohol problems.

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CHAPTER ONE

PROBLEM STATEMENT

In the addictions treatment field there are many theories of treatment. Furthermore, some of these theories are in direct contradiction to each other and cause confusion when dealing with individual patients. One reason for this is that most theories are based upon the clinical, and often personal, experience of the individual expounding the theory. This experiential based knowledge in not wrong, in fact it is often correct, but it does present some problems.

The first problem is that the only way to pass this knowledge on to others is by direct training. While this is a plus for those that are trained by a knowledgeable person, it does no good for the person working in the next treatment center. In addition, this type of knowledge is often parochial and is only useful for the type of patients admitted to a particular program.

Another problem is the type of staff usually present in the majority of substance abuse treatment centers. "Traditionally the field of substance abuse treatment has been served more by paraprofessionals than all other classes of trained professionals with the exception of Medical Doctors." (Cook 1985) These paraprofessionals have been well trained in the particulars of addiction treatment in their agency's style, but have little inclination or training to

follow scientific methodology. Therefore, these paraprofessionals base their conclusions, and develop theories, on their own observation and experiences.

This leads to a further problem in the area of effectiveness of treatment. Peter Reuter, a drug expert at the University of Maryland who has advised the federal government states: "The drug treatment infrastructure is very weak. Typically, only 20% of addicts who participate in drug treatment programs are still off drugs a year later, but the rate improves after four or five treatment programs, when you start to see greater effects." (Richter & Delgado 1994)

All of these problems can be linked to the fact that knowledge is not often transferred from treatment center to treatment center and, as discussed above, is not necessarily transferable. One article points out this situation very successfully: "The contradiction characteristic of many present theoretical and practical approaches to drug addiction might be reduced if more well-defined populations were considered." (Phil & Peterson 1992)

This research project attempted to deal with this confusion by trying to discover if there tended to be well defined populations within treatment participants. In addition there is very limited information concerning the characteristics that lead to success in addiction treatment.

This research may discover one characteristic that could lead to success in addiction treatment.

Of particular importance to the profession of Social Work is that "at the present time, fewer than 20% of the nation's addicts can get drug treatment, unless they can afford to pay for private care." (Falco, as quoted in Scott 1993) Part of those that do receive treatment are in publicly funded programs. The majority of those that do not receive treatment would be in publicly supported programs if they were able to gain admission to treatment. This is the population that Social Workers have traditionally served, and for many of us in Social Work, the population we choose to serve. It is a principle of Social Work to examine our population and evaluate our practice skills continually with the goal of enhancing our delivery of service.

PROBLEM FOCUS

The hypotheses of this study was that patients fitting the stereotypical sex-roles of "macho" male and "overly seductive" female tend to have lower completion rates in drug treatment programs than patients not fitting these stereotypical sex-roles. In addition this study attempts to discuss a more "well-defined" population as discussed above by Phil and Peterson (1992).

The client population has been well described by Griffin-Shelley in his study of an addict population. "The male is typically "macho" while the female is viewed as

"seductive". Addicts with an extensive history of addiction adhere to and/or endorse strong stereotypical sex roles, the John Wayne syndrome (macho-male) and the come-on seductive female." (Griffin-Shelley 1986) He further explains: "The male addict wants an angel (female) who acts like a whore, when the lights are off. The female, while actually wanting to be taken care of passively. must act like a whore in order to be treated like an angel. These survival techniques of the drug subculture do not allow either male or female to act out their internal beliefs, which are usually congruent with society." (Griffin-Shelly 1986) This confusion between beliefs and behavior may cause the lower treatment completion rate typical of this population. The first task of this study was to discover if there is a relationship between sex-role and completion of an addiction treatment program.

CHAPTER TWO

LITERATURE REVIEW

A review of the literature found a large number of published material focused on sex roles. However, very limited information on sex-roles in substance abusers, either addicts or alcoholics was found.

The information on sex-roles does point out the importance of the topic. "Sex-roles have long been viewed as an important attribute of the overall psychological and sociological well-being of the individual." (Hane 1986) It is not an overstatement to say the consensus of the literature is that one of the foundations of mental health is the sex-role adopted by the individual. This makes it an excellent area to research.

The Social Work Encyclopedia goes into detail about sex-roles and points out the importance the topic has had to the field of Social Work. "The women's movement gave considerable impetus to research concerning the relative contribution of genetic inheritance and cultural conditioning in producing "typical" masculine or feminine behavior." (Solomon 1987) This is an area the Social Workers have been very interested in.

In addition to being an area of importance to the individual's mental health and a topic of interest to the field of Social Work, it is also an area that is open to intervention. "It is known that many aspects of sex role

behavior are learned." (Angrist 1969, Block 1973, McNeil 1969) If the behavior is learned then an individual can change the behavior given the correct conditions.

The paucity of material dealing with sex-roles and substance abusers is best shown by The Biology of Alcoholism, Volume 6: The Pathogenesis of Alcoholism, Psychosocial Factors. This six hundred and ninety-five page book has one reference that takes up one fourth of a page. "In one study examining the relationship between sex-role conflict and problem drinking, no significant relationship was found." (Barnes 1979) Finding the study was very difficult and its main point was that there was no "addictive personality" and had no more information then the quote above. (Blane & Chafetz 1971)

There was one article that looked at sex-roles in addiction and even used the Bem Sex-Role Inventory. Eric Griffin-Shelley in his article, Sex Roles in Addiction: Defense or Deficit?, noticed the same pattern as this researcher that there were an excess of patients fitting the stereotypical sex-roles. "Exaggerated sex-role behavior and attitudes - that is, "macho" men and "seductive" women - are common in alcoholics and drug addicts." (Griffin-Shelley 1986) He had several questions that he was interested in, but his main interest was to see if the roles contributed to the development of the disease of addiction. Griffin-Shelley also cited the paucity of research in this area; "Theories

and empirical research about sex roles in drinking and drug addiction are limited." (Griffin-Shelley 1986) Going back to 1957 he was able to find only eight studies on sex-roles in substance abusers. Most were involved in looking for clues to the "addictive personality" that was a popular theory in the 1960s. They found no proof for this theory. One common aspect in these few studies was sex-role conflict, found by Wilsnack and Penick. "Women alcoholics exhibit a conscious desire to be feminine while having a masculine sex-role style." (Wilsnack 1973) In a study of male alcoholic veterans the subjects were found "sex-typed more frequently as feminine than masculine." (Penick, Powell and Read 1984) Griffin-Shelley found "Despite the frequent images of "macho" males and "seductive" females presented by this population, when asked to rate themselves on stereotypically masculine and feminine traits and behaviors, addicted clients saw themselves as primarily Undifferentiated or Feminine with few Masculine or Androgynous subjects." (Griffin-Shelley 1986)

The literature suggests a high level of cross sex-role identification in this population. In terms of the present research it is basically silent and therefore we will be looking at a new area for this population.

RESEARCH DESIGN AND METHODS

The tool used to operationalize the independent variable for this project was the Bem Sex-Role Inventory. Developed by Sandra Lipsitz Bem, Ph.D. this inventory is for sale to the public from Consulting Psychologists Press, Inc. of Palo Alto, California. The sale puts this inventory in the public domain and therefore places no restrictions on the use of it for this research project.

In addition to the work of Dr. Bem in testing the reliability and validity of this inventory, others have found it to be acceptable. Factor analysis has confirmed the construct validity of the Bem. (Gadreau 1977) Others prefer to describe the two dimensions that are measured as "instrumentality" and "expressivity," but found the inventory to be reliable and valid. (Kelly & Worrell 1977, Helmriech et al., 1979; Gilbert 1981) One recent look at this inventory, while feeling the sex-roles should be "self-directed" and "other-oriented" rather than masculine and feminine, confirmed the continuing validity and reliability of the Bem Sex Role Inventory. (Ballard-Reisch & Elton 1992)

The Bem Sex Role Inventory was designed to implement research on psychological androgyny. It contains sixty personality characteristics. Twenty of the characteristics are stereotypically feminine (e.g., affectionate, gentle, understanding, sensitive to the needs of others) and twenty are stereotypically masculine (e.g., ambitious, self-

reliant, independent, assertive). The Bem Sex Role inventory also contains twenty characteristics that serve as filler items (e.g., truthful, happy, conceited). When taking the inventory, a person is asked to indicate on a seven point scale how well each of the sixty characteristics describes herself or himself. The scale ranges from one, "Never or almost never true" to seven, "always or almost always true", and is labeled at each point on the scale.

The inventory is essentially self-administering and may be given to large groups as well as to individuals. The test is labeled simply "Bem Inventory" to reduce the possibility that responses might be influenced by a knowledge of the purpose of the inventory. The test can be completed in fifteen minutes or less by most subjects.

Most instruments put masculinity and femininity on different ends of a single bipolar measurement. The Bem Sex Role Inventory treats these traits as two independent measures and an individual can be high on both. The Bem Sex Role Inventory also adds two other possibilities of androgynous, high on both masculinity and femininity, and undifferentiated, low on both sex-roles. This should allow us to pick out those individuals whom clearly adhere to the traditional sex-roles.

The participants in the study were patients in a chemical dependency recovery hospital and therefore the research project was subject to two sets of restrictions.

These were the Federal Confidentially Regulations for Drug and Alcohol patients and American Hospital's internal restrictions.

The Federal regulations require that all patients be voluntary and that they can leave any time they so choose. A treatment program can put restrictions on a person's admission or readmission, but can not force any patient to stay in a program. This requirement holds regardless of any other situation that may exist. For example, many patients have had problems with the criminal justice system and have been ordered by a Judge to enter and complete a treatment program. Even in this situation the Federal requirements state the patient must volunteer for treatment and be allowed to leave whenever he or she wants to.

The Federal regulations also state that no information about the patient can be released without a specific signed release from the patient naming the information to be released and the name of the person or organization the information can be released to. Without the signed release you can not even acknowledge that the person is or is not a patient. This restriction extends to all persons and has resulted in situations where a family member has driven a patient to be admitted to the program and knows the patient was admitted. However, the patient for whatever reason has not given a written signed release and hospital staff have to tell the family member that no information about the

patient's presence, or lack of presence, in the program can be given. For this project all participants were required to sign a release of information concerning the research and the use of the information.

Permission was granted by the Administrator of American Hospital to conduct the research project. Several restriction were placed on the project. First was that all information gathered from any patient be voluntary given. Next that the information to be released could only include results of the Bem Inventory, completion status and demographic information.

Patients were informed that taking the Bem Inventory was voluntary and that they could decline to participate without any effect on their treatment. They were informed that the research was to see if there were common traits in patients. They were informed who the researcher was and that the test itself would remain with their medical records. They were informed of the availability of counselors should any of the material upset them. They were also given a debriefing statement that contained the name, location and phone number of the facility advisor, Dr. Hunt.

Participants were patients at American Hospital, a chemical dependency treatment program. While there are several programs at American, all participants were selected from the six month long residential rehabilitation program. This program is funded by Los Angeles County for legal

residents that lack the ability to pay for their own treatment. All patients in the publicly funded program must have a primary diagnosis of drug abuse which excludes alcoholism. The sixty-two inpatient volunteers did not include any psychotic, organically impaired, illiterate or court ordered patients. The first three types were excluded because their results may have been colored by their conditions. The fourth group, court ordered patients, were excluded so that they could not be perceived as loading the completion percentage.

All patients meeting these qualification entering the program during one six month period were invited to participate in the project. Three patients refused to take the inventory and one left before she had taken the test. This is a sample of convenience in that only subjects entering one program during one six month period have a chance of being involved. This will limit extending the results past this population. However, since all members of the population had an equal chance of being selected we do have a probability sample. Since sixty-two of the sixty-six, 94% of the potential population, were included the probability of representativeness is fairly high.

The inventory was offered during the first week of treatment for all participants. During this period of time the patients are involved in orientation to the program and are providing information to develop a treatment plan. They

do take several tests to discover more information about them. The Bem Inventory was just another test and this procedure should have made it seem rather normal.

The test was given over a six month period from June, 1993 through December, 1993. No scores were assigned to the tests until after a participant had left the treatment program. This was done to insure that there would be no different treatment of individuals based on the score on this inventory. The test was given on Fridays to all qualified new admissions that week at the conclusion of a regular orientation group. The largest number taking it a one time was six and there were two times that only one person took it.

The question of cultural sensitivity is a harder one. The Bem Inventory was developed by using primarily white college students as subjects. One would suspect that it was not culturally sensitive due to the lack of any other racial group. The college students would generally be of a higher socioeconomic group than would be excepted from the group in a publicly funded addiction treatment program. However, a look at the median score for the normative sample and for this sample are so close that there does not appear to lack cultural sensitivity.

CHAPTER THREE

RESULTS

The participant population contained forty-two males and twenty-one females. Twenty-five of the participants were White; twenty-eight were Black; seven were Hispanic; one was Asian and one was Puerto Rican. Twenty-two of the participants were from 18-30 years old; 29 were from 31-43 years old and 11 were from 44-56 years old. Education levels for the sample were, eighteen had completed from the 9th to the 11th grade; twenty-one had completed 12th grade and twenty-three had completed from the 13th to the 17th grade.

The first question on method was a decision to use either the median scores from this sample or from the normative sample. Since the numbers in this sample were small it seemed best to use the larger normative sample. After looking at the median scores the difference was very small. Femininity Raw Scores were 4.93 compared to 4.90 for the normative sample. Masculinity Raw Scores were 5.01 compared to 4.95 for the normative sample. The decision was to use the normative sample as they were from a much larger sample and the difference between the samples was too small to make any difference.

Since the sample did not meet the assumptions for a parametric test and it used using nominal variables it was decided to use the Chi-square to test significance. The hypothesis was that the dependent variable, completion would

have a significant relationship to the independent variable of sex-role. More exactly that the sex-role of macho male and seductive female would have a lower completion rate that other sex roles.

In addition to sex-roles it looked at the variables of gender, ethnicity, age and education level. The results did show there was a relationship between sex-role and completion status of a drug treatment program, but it was not the relationship that was predicted by the hypothesis.

A two way Chi-square test of independence was ran for ethnicity and completion status. They were found to be independent and hence not related. Specifically, those who were classified as white had relatively the same completion rate of the drug treatment program as those who were classified as black. ($p > .05$)

A two way Chi-square test of independence was ran for gender and completion status. They were found to be independent and hence not related. Specifically, those who were classified as male had relatively the same completion rate of the drug treatment program as those who were classified as female. ($p > .05$)

A two way Chi-square test of independence was ran for age and completion status. They were found to be independent and hence not related. Specifically, those who were classified in the following age groups: 18-30, 31-43, and

44-56, had relatively the same completion rate of the drug treatment program. ($p > .05$)

A two way Chi-square test of independence was ran for education level and completion status. They were found to be independent and hence not related. Specifically, those who were classified in the following education levels: "did not complete high school", "completed high school", and "completed high school and attended college" had relatively the same completion rate of the drug treatment program. ($p > .05$)

Another Chi-square test of independence was ran for education and completion status and it was found that, once again they were independent and hence not related. Specifically, those who were classified in the following education levels: "attended 12 years of school or less" and "attended 13 years of school or more", had relatively the same completion rate of the drug treatment program. ($p > .05$)

The final two way Chi-square test of independence was ran for sex-role and completion status. They were found to be dependent and hence, related. Specifically, of those who were classified as androgynous, relatively more completed the drug treatment program. Also, of those who were classified as undifferentiated, relatively less completed the drug treatment program. ($p < .01$)

DISCUSSION

The addiction treatment field has problems that have caused it to be less effective than may be possible. Many theories are in direct contradiction to each other and most are useful only in individual programs dependent upon the training of that particular staff. There is also a lack of well defined populations within the people presenting for treatment. This research was an attempt to discover a more well defined population that will hopefully assist in the development of theories that are more compatible with each other.

The hypothesis of the research was individuals that appear to adhere to strong stereotypical sex roles, i.e. the "macho male" and the "seductive female" would have a lower completion rate in a program. The literature has little information on sex roles in the addicted population. However, most information does confirm the importance of sex role to an individual's mental health. What little information there is one sex roles in the addict population does show agreement with the observation of the presence of endorsement of stereotypical sex roles. It is further observed that there are significant percentages of this population that have adopted the sex role of the opposite gender.

Using the Bem Sex Role Inventory a test of the hypothesis that those having these stereotypical sex roles

would have a lower completion rate than addicts having a different sex role was carried out. The population of one addiction treatment program that was publicly funded was used for this research project. This population is composed of the type of people that Social Work has traditionally seen as the population it wants to work with.

The results did not show that the hypothesis was correct. The two sex roles focused on were in the middle of the completion spectrum. However, the research did show that sex roles had a significant relationship to completion rate. Of the variables measured it was the only one that had a relationship to completion rate.

The limitations on this research are that the number of participants was small and only one location was looked at. This information cannot be carried over to form a theory of addiction. It will take more research to see if the significance of sex role remains when the numbers are higher. Other researchers would also want to extend the research to other treatment programs.

The importance to social work practice and to the addiction treatment field is that we can improve our outcomes in addiction programs. As mentioned above it is known that many aspects of sex role are learned. Any learned behavior can be subjected to change through intervention. This is especially possible in the present time. There is an increasing amount of attention being paid to developing

new sex roles for both men and women. The impetus of the women's movement has created a situation where much of the population is open to looking at different behavior for both males and females.

While this research has focused on the narrow area of addiction treatment it can go far beyond that area and be included in all areas of social work practice. As discussed above the consensus of most researchers is that sex role is one of the foundations of mental health. The relationship between sex role and completion of treatment can be extended to many situations. If we develop interventions that help individuals change their adopted sex role we may be able to see change in all areas of their life. People usually see us when they are having problems in their lives and a change that will increase their esteem would assist improvement in all areas.

APPENDIX A
TABLE 1 FEMININITY & MASCULINITY RAW SCORES

Categorical Variable Codes

Sex: 1=Female 2=Male
Race: 1=White 2=Black 3=Hispanic 4=Puerto Rican 5=Asian
Sex Role: 1=Feminine 2=Masculine 3=Androgynous
4=Undifferentiated
Status: 1=Completed 2=Not Completed

BREAKDOWN FOR FEMININITY RAW SCORES

VARIABLE	LEVEL	N	SUM	MEAN	S.D.
SEX	1	20	105.85	5.2925	0.5946
SEX	2	42	199.93	4.7602	0.8808
OVERALL		62	305.78	4.9319	0.8334

CASES INCLUDED 62 MISSING CASES 0

BREAKDOWN FOR MASCULINITY RAW SCORES

VARIABLE	LEVEL	N	SUM	MEAN	S.D.
SEX	1	20	100.95	5.0475	0.5957
SEX	2	42	209.79	4.9950	0.8225
OVERALL		62	310.74	5.0119	0.7522

CASES INCLUDED 62 MISSING CASES 0

TABLE 2 CHI-SQUARE: RACE BY COMPLETION STATUS

CASE	WHITE	BLACK	HISPANIC
1	14.000	15.000	2.0000
2	11.000	13.000	5.0000

CHI-SQUARE TEST FOR HETEROGENEITY OR INDEPENDENCE

CASE		VARIABLE WHITE	BLACK	HISPANIC	
1	OBSERVED	14	15	2	31
	EXPECTED	12.92	14.47	3.62	
	CELL CHI-SQ	0.09	0.02	0.72	
2	OBSERVED	11	13	5	29
	EXPECTED	12.08	13.53	3.38	
	CELL CHI-SQ	0.10	0.02	0.77	
		25	28	7	60

OVERALL CHI-SQUARE	1.724
P-VALUE	0.4224
DEGREES OF FREEDOM	2

CASES INCLUDED 60 MISSING CASES 0

CHI-SQUARE TEST FOR HETEROGENEITY OR INDEPENDENCE

CASE		VARIABLE WHITE	BLACK	
1	OBSERVED	14	15	29
	EXPECTED	13.68	15.32	
	CELL CHI-SQ	0.01	0.01	
2	OBSERVED	11	13	24
	EXPECTED	11.32	12.68	
	CELL CHI-SQ	0.01	0.01	
		25	28	53

OVERALL CHI-SQUARE	3.144E-02
P-VALUE	0.8593
DEGREES OF FREEDOM	1

CASES INCLUDED 53 MISSING CASES 0

TABLE 3 CHI-SQUARE: SEX BY COMPLETION STATUS

CASE	MALE	FEMALE
1	21.000	10.000
2	21.000	10.000

CHI-SQUARE TEST FOR HETEROGENEITY OR INDEPENDENCE

CASE		VARIABLE MALE	FEMALE	
1	OBSERVED	21	10	31
	EXPECTED	21.00	10.00	
	CELL CHI-SQ	0.00	0.00	
2	OBSERVED	21	10	31
	EXPECTED	21.00	10.00	
	CELL CHI-SQ	0.00	0.00	
		42	20	62

OVERALL CHI-SQUARE	0.000
P-VALUE	1.0000
DEGREES OF FREEDOM	1

CASES INCLUDED 62 MISSING CASES 0

TABLE 4 CHI-SQUARE: AGE BY COMPLETION STATUS

CASE	A18_30	A31_43	A44_56
1	9.0000	15.000	7.0000
2	13.000	14.000	4.0000

CHI-SQUARE TEST FOR HETEROGENEITY OR INDEPENDENCE

CASE		VARIABLE A18_30	A31_43	A44_56	
1	OBSERVED	9	15	7	31
	EXPECTED	11.00	14.50	5.50	
	CELL CHI-SQ	0.36	0.02	0.41	
2	OBSERVED	13	14	4	31
	EXPECTED	11.00	14.50	5.50	
	CELL CHI-SQ	0.36	0.02	0.41	
		22	29	11	62

OVERALL CHI-SQUARE	1.58
P-VALUE	0.4539
DEGREES OF FREEDOM	2

CASES INCLUDED 62 MISSING CASES 0

TABLE 5 CHI-SQUARE: EDUCATION BY COMPLETION STATUS I

CASE	ED9_11	ED12	ED13_17
1	8.0000	9.0000	14.000
2	10.000	12.000	9.0000

CHI-SQUARE TEST FOR HETEROGENEITY OR INDEPENDENCE

CASE		VARIABLE ED9_11	ED12	ED13_17	
1	OBSERVED	8	9	14	31
	EXPECTED	9.00	10.50	11.50	
	CELL CHI-SQ	0.11	0.21	0.54	
2	OBSERVED	10	12	9	31
	EXPECTED	9.00	10.50	11.50	
	CELL CHI-SQ	0.11	0.21	0.54	
		18	21	23	62

OVERALL CHI-SQUARE 1.74
P-VALUE 0.4194
DEGREES OF FREEDOM 2
CASES INCLUDED 62 MISSING CASES 0

TABLE 6 CHI-SQUARE: EDUCATION BY COMPLETION STATUS II

CASE	HIGHSCHL	COLLEGE
1	17.000	14.000
2	22.000	9.0000

CHI-SQUARE TEST FOR HETEROGENEITY OR INDEPENDENCE

CASE		VARIABLE HIGHSCHL	COLLEGE	
1	OBSERVED	17	14	31
	EXPECTED	19.50	11.50	
	CELL CHI-SQ	0.32	0.54	
2	OBSERVED	22	9	31
	EXPECTED	19.50	11.50	
	CELL CHI-SQ	0.32	0.54	
		39	23	62

OVERALL CHI-SQUARE	1.73
P-VALUE	0.1887
DEGREES OF FREEDOM	1

CASES INCLUDED 62 MISSING CASES 0

TABLE 7 CHI-SQUARE: SEX-ROLE BY COMPLETION STATUS

CASE	MALE	FEMALE	ANDROG	UNDIFF
1	7.0000	5.0000	16.000	3.0000
2	9.0000	8.0000	4.0000	10.000

CHI-SQUARE TEST FOR HETEROGENEITY OR INDEPENDENCE

CASE	VARIABLE MALE	FEMALE	ANDROG	UNDIFF	
1 OBSERVED	7	5	16	3	31
EXPECTED	8.00	6.50	10.00	6.50	
CELL CHI-SQ	0.13	0.35	3.60	1.88	
2 OBSERVED	9	8	4	10	31
EXPECTED	8.00	6.50	10.00	6.50	
CELL CHI-SQ	0.13	0.35	3.60	1.88	
	16	13	20	13	62

OVERALL CHI-SQUARE 11.91
P-VALUE 0.0077
DEGREES OF FREEDOM 3
CASES INCLUDED 62 MISSING CASES 0

APPENDIX B
BEM INVENTORY

Developed by Sandra L. Bem, Ph.D.

_____Age_____ Sex_____

_____

Date_____ 19__ _____

_____ Yr. in School_____

DIRECTIONS

On the opposite side of this sheet, you will find listed a number of personality characteristics. We would like you to use those characteristics to describe yourself, that is, we would like you to indicate, on a scale from 1 to 7, how true of you each of these characteristics is. Please do not leave any characteristic unmarked.

Example: sly

Write a 1 if it is never or almost never true that you are sly.
Write a 2 if it is usually not true that you are sly.
Write a 3 if it is sometimes but infrequently true that you are sly.
Write a 4 if it is occasionally true that you are sly.
Write a 5 if it is often true that you are sly.
Write a 6 if it is usually true that you are sly.
Write a 7 if it is always or almost always true that you are sly.

Thus, if you feel it is **sometimes but infrequently true** that you are "sly," **never or almost never true** that you are "irresponsible," and **often true** that you are "carefree," then you would rate these characteristics as follows:

Sly	3
Malicious	1

Irresponsible	7
Carefree	5

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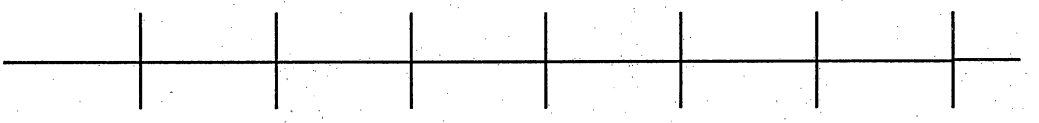

Never or almost never true	Usually not true	Sometimes but infrequently true	Occasionally true	Often True	Usually True	Always or almost always true

Defend my own beliefs		Adaptable		Flatterable	
Affectionate		Dominant		Theatrical	
Conscientious		Tender		Self-sufficient	
Independent		Conceited		Loyal	
Sympathetic		Willing to take a stand		Happy	
Moody		Love children		Individualistic	
Assertive		Tactful		Soft-spoken	
Sensitive		Aggressive		Unpredictable	
Reliable		Gentle		Masculine	
Strong personality		Conventional		Gullible	
Understanding		Self-reliant		Solemn	
Jealous		Yielding		Competitive	
Forceful		Helpful		Childlike	
Compassionate		Athletic		Likeable	
Truthful		Cheerful		Ambitious	
Have leadership abilities		Unsystematic		Do not use harsh language	
Eager to soothe hurt feelings		Analytical		Sincere	
Secretive		Shy		Act as a leader	
Willing to take risks		Inefficient		Feminine	
Warm		Make decisions easily		Friendly	

	a	b	Class	
R.S.				
S.S.				
			a-b	SS diff

APPENDIX C

BEHAVIORAL HEALTH SERVICES, INC.

AUTHORIZATION TO RELEASE PATIENT/CLIENT INFORMATION

I, _____ (Print Name of Patient, Client, Participant) hereby authorize Behavioral Health Services, Inc., it's employees, agents and consultants to disclose medical records and information obtained during the course of my diagnosis, treatment and/or contact for medical, mental health, and/or conditions related to alcohol and/or drug abuse to the following:

Social Work Dept. California State University - Paul Sharpe, student
Individual/Organization to Receive Information Relationship

5500 University Parkway
Street Address Telephone

San Bernardino, CA 92407
City State Zip

TYPE OF INFORMATION: Results of BEM Inventory, program completion status, demographic information, e.g. gender, age, ethnicity, etc.

PURPOSE: For a research project by above named graduate student.

DURATION: This consent is subject to revocation by me at any time except to the extent that action has been taken on this consent prior to revocation. If not earlier revoked, this consent will expire no later than sixty (60) days after the date of discharge, unless the following date, event or condition occurs sooner:

RESTRICTIONS: I understand that the requestor may not redisclose and use this information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

COPY: I further understand that I have right to receive a copy of this authorization upon my request.

Copy requested and received:____Yes____No____Initials

Date_____ Signature (Patient/Client/Participant)_____

Date of Birth_____S.S.#_____ Treatment Dates_____

Date_____Witness_____

Release of Information Name

General Release by BHS, Inc.

32-001 (R-12/91) I.D.#

APPENDIX D

This statement will be given to all participants.

Debriefing Statement

Thank you for taking the time to complete this survey. The Bem Inventory is designed to determine your sex-role as defined by this test only. This may or may not be your sex-role. The information will be used only to see if sex-role has any relationship to program completion. Depending upon the results of this research project, components of this program may be changed in the future to enhance the chance of patients completing the program. All the counseling staff are available to discuss your feelings concerning the test. Paul Sharpe, the student conducting this research is available to discuss any aspect of the project with you. You may also contact Dr. Hunt of the Social Work Department, California State University, San Bernardino with any questions. The number is 909-880-5501.

APPENDIX E

May 24, 1993

Social Work Department
California State University, San Bernardino
5500 University Parkway
San Bernardino, California 92407

Dear Faculty:

Mr. Paul Sharpe has requested permission to conduct a research project involving patients at American Hospital. After careful review permission is granted to conduct the research project. It will involve requesting patients in our six month residential program to take the Bem Sex Role Inventory. All projects of this nature are totally voluntary and any patient may decline to participate.

It is our policy, and the requirement of federal law, that we maintain our patients confidentiality and anonymity. Therefore, no names or other identifying marks will be allowed for this project. The study will be limited to the results of the Bem Inventory, completion status and demographic information such as age, ethnicity etc. All releases of information, original tests, etc., will be kept at the hospital in the patient's medical record.

Thank you for your time and consideration. If you have any further questions feel free to call me.

Respectfully,

J. K. Elliott,
Administrator

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