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Understanding the social and community support experiences of sexual and gender minority individuals in 12-Step programs

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Abstract

Sexual and gender minority individuals (*e.g.,* gay, bisexual, non-binary, transgender; SGMI) are 2-6 times as likely as cisgender heterosexual individuals to experience alcohol or other substance use disorders. SGMI participate in 12-Step groups, such as Alcoholics Anonymous (AA), at high rates. Though social support is an established mechanism through which 12-Step programs support reductions in substance use, little is known about SGMI's experiences of the social support in 12-Step programs. This qualitative study aims to understand the experiences of social and community support among SGMI involved in 12-Step programs. This study employed thematic analysis to interpret open-ended responses from 302 SGMI who had participated in 12-Step programs. Data was from The PRIDE Study, a large, national, online. longitudinal, cohort

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Disclosure statement

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study of SGMI. Two themes emerged about how SGMI experienced social and community support in 12-Step programs: beneficial connections and harmful environments. Beneficial connections included a sense of community, shared experiences, and skills provision. Harmful environments included marginalization, oppression, violence, and bullying. This study highlights the variability of experiences of SGMI participating in 12-Step programs. These findings suggest that many SGMI may benefit from 12-Step programs but may need support in coping with potential harms that can emerge through participation.

Keywords

Mutual help groups; substance use; social support; sexual and gender minority individuals; LGBTQ-affirming services

Sexual (*e.g.,* bisexual, gay, lesbian, pansexual) and gender (*e.g.,* transgender, genderqueer, non-binary) minority individuals (SGMI) are approximately 2-6 times as likely as heterosexual and cisgender individuals to experience alcohol or other substance dependence (Cochran et al., 2003; McCabe et al., 2009; Rowan & Faul, 2011). Among sexual minority individuals (SMI), approximately 13-20% meet criteria for past-year alcohol dependence and 3-6% meet criteria for past year other substance dependence; among gender minority individuals (GMI), 11.2% meet criteria for past-year alcohol dependence and 15.2% meet criteria for past year other substance dependence (Cochran et al., 2003; McCabe et al., 2009). Twelve-Step groups, such as Alcoholics Anonymous (AA), are the most common source of support for alcohol and other substance-related problems in the United States (Kelly et al., 2020). SMI utilize 12-Step programs at higher rates than their heterosexual counterparts, though no known research has compared rates of 12-Step involvement between GMI and cisgender individuals (Allen & Mowbray, 2016; McCabe et al., 2009; McGeough, Karriker-Jaffe, et al., 2021). SGMI also experience barriers to successful involvement in 12-Step groups, including experiences of homophobia and transphobia from group members and rejection from sponsors due to their sexual orientations and gender identities (Hall, 1996; Sanders, 2020). Social support is a key mechanism through which 12-Step programs facilitate recovery from alcohol and other substance-related problems (Donovan et al., 2013; Groh et al., 2008; Kelly et al., 2020), so the discriminatory social experiences described by SGMI in 12-Step programs (Hall, 1996; Sanders, 2020) may be particularly detrimental to their substance use outcomes.

Previous research suggests a complex picture wherein SGMI experience unique social barriers to engaging in 12-Step participation (Hall, 1996; Sanders, 2020) yet continue to participate in 12-Step programs in high rates (Allen & Mowbray, 2016; McCabe et al., 2009; McGeough, Karriker-Jaffe, et al., 2021). One possible explanation is that 12-Step programs address unique needs and offer unique benefits for SGMI. A limited body of research has explored the needs of SGMI, typically focusing on sexual minority individuals, in 12-Step programs. The need for self-acceptance, both of one's sexual orientation and gender identity but also as someone who struggles with addiction, emerged as relevant across multiple studies (Matthews et al., 2005; Sanders, 2020). In a study of gay men in AA (gender identity not reported), Kus and Latcovich (1995) identified a critical need for gay men to be working

through internalized homophobia and understanding how the AA program could support that process and other challenges associated with being a gay man. Matthews et al. (2005) identified how lesbian women (gender identity not reported) described needing to learn what resources (e.g., interpersonal, situations, and tools) were necessary for their recovery and connect with something bigger than themselves, which often required redefining spirituality to reconcile it with their sexual identities. Lastly, though anonymity is central to the premise of the 12-Step program, Kus and Latcovich (1995) found that gay men found assurances of the confidentiality about their sexual orientations to be critical for authentic participation in the program. An article focused on the AA experiences of GMI individuals found that by connecting with other GMI, some GMI participating in AA accessed information about and resources for social and medical gender transitions that supported their recovery by reducing gender dysphoria (Matsuzaka, 2018). Unfortunately, most past research focused on the needs and benefits of SGMI in 12-Step programs is typically dated and reliant on small samples of SMI (e.g., Hall, 1994; Kus & Latcovich, 1995), failing to capture a representative picture of the current needs and benefits of SGMI in 12-Step programs, with a particular paucity of research exploring the needs of GMI.

Research on the needs addressed by 12-Step programs among general populations identified a range of mechanisms through which the program contributes to reductions in substance use. Reviews by Donovan et al. (2013) and Kelly et al. (2020) found structure, exposure to behavioral norms and role models for working toward abstinence, engagement in rewarding non-substance-related activities, development of more effective coping skills, goal-directedness and recovery motivation, improved self-efficacy and psychological wellbeing, and reductions in impulsivity and craving contribute to the benefits of 12-Step participation. Social support is a particularly thoroughly explored need of 12-Step participants and mechanism of change in 12-Step programs (Donovan et al., 2013; Groh et al., 2008; Kelly et al., 2020). Though there is no agreed-upon definition of social support, Hogan et al. (2002) write that features of social support are “the structural aspects of social networks (*e.g.,* the size of a person’s social circle or the number of resources provided), functional aspects of social support (*e.g.,* emotional support or a sense of acceptance), enacted support (*e.g.,* provision of specific supportive behaviors in times of distress, such as reassurance or advice), and the subjective perception of support by the recipients” (p. 382). Many dimensions of social support have been identified in the extant literature and have been found to be differentially associated with physical and mental health outcomes (Chronister et al., 2006; Schaefer et al., 1981). Reviews of the research on 12-Step programs suggest that multiple facets of social support are modified through 12-Step participation. In terms of structural changes to social support that emerge from 12-Step participation, 12-Step participation contributes to a shift in one’s social network, involving an increase in the number of individuals who support abstinence (Donovan et al., 2013). A review focused specifically on the relationship between social support and 12-Step programs found that 12-Step involvement is related to positive functional types of support such as higher friendship quality (i.e., closeness, trust, respect, and supportiveness), particularly with friends involved in 12-Step programs and support for abstinence from substance use (Groh et al., 2008). Having a sponsor (i.e., an AA member who serves as a mentor) may be a particularly valuable source of enacted and general social support in 12-Step programs (Groh et al.,

2008). These aspects of social support may be important elements of 12-Step programs' effectiveness in reducing substance use. Furthermore, general friendship quality, friends' support for abstinence, and AA member-based support for reduced drinking mediate the relationship between AA involvement and abstinence over time (Groh et al., 2008).

Social support may be a particularly important need for SGMI. Within 12-Step programs, SGMI endorse a range of social support needs from the program. Additionally, SGMI have lower levels of social support than heterosexual individuals (Eisenberg & Resnick, 2006; Jorm et al., 2002), while also acknowledging needing and actively seeking social support (Degges-White, 2012). Past research has identified several elements of social support as necessary for SGMI involved with AA, some of which are unique to SGMI. Matthews et al. (2005) identified relationships with other people as a central need of lesbian women participating in AA. This included friendship network connections, creating recovery support networks, socializing with others who did not use substances, and finding alternatives to gay bars for forming connections. Similarly, the study by Kus and Latcovich (1995) identified building a new support system of gay people as an important need for gay men involved in AA and highlighted the importance of receiving recovery support from other gay and lesbian individuals in spaces designated for gay and lesbian individuals. They argued that such spaces make it easier to establish trust and discuss personal experiences without worrying about rejection based on sexual orientation. They also promote a sense of shared experiences without the burden of needing to teach heterosexual individuals about the experiences of gay men (*e.g.,* explaining the coming out process) and facilitate discussions about how to apply the AA program to challenges unique to gay men. An article focused on the AA experiences of GMI individuals found benefits of attending GMI-specific meetings and building a support network of GMI people in recovery, which allowed participants to access support for needs related to their recovery (Matsuzaka, 2018).

As with the general literature focused on the experiences of SGMI in 12-Step programs, relatively little is known about the experiences of social and community support among SGMI involved in 12-Step programs. Prior research in this area is dated, reliant on small, convenience samples, and not inclusive of all sexual and gender minority individuals. Many aspects of social and community support of 12-Step participation identified among general populations have not been examined among SGMI. To fill these gaps, this qualitative study aims to understand the experiences of social and community support among SGMI involved in 12-Step programs, including potential beneficial and detrimental aspects of 12-Step involvement. Better understanding both the potentially beneficial and detrimental roles of support in 12-Step programs for SGMI facilitates the identification of opportunities for intervention to improve individual experiences and promote well-being through program and system-level change.

Methods

This study employed The Population Research in Identity and Disparities for Equality (PRIDE) Study, a national, large-scale, longitudinal, cohort study to administer surveys that employed open-ended questions to ask participants about their substance use and experiences with substance use treatment and resources. Thematic analysis guided the

construction of the survey and subsequent analysis (Corbin & Strauss, 1990). This study was approved by the Institutional Review Board at Stanford University School of Medicine (#48707) and deemed exempt from review as secondary data analysis by the Institutional Review Board at the University of Kansas.

Sampling

This study utilized data collected through The PRIDE Study, a national, large-scale, longitudinal health cohort study of respondents who are at least 18 years old; identify as lesbian, gay, bisexual, transgender, queer, genderqueer (LGBTQ) or as another sexual and/or gender minority; can read and understand English, and reside in the United States or its territories (Lunn et al., 2019). Participants were recruited by The PRIDE Study through community partnerships (*e.g.,* centers and service providers oriented toward the LGBTQ community who distributed recruitment materials to their members/patients), events (*e.g.,* LGBTQ Pride events, conferences focused on LGBTQ issues), and online channels (*e.g.,* Facebook-sponsored content). All data were collected via a supplemental survey distributed to all participants of The PRIDE Study.

For this study, inclusion criteria were that participants must: (1) identify as a sexual and/or gender minority (*e.g.,* gay, lesbian, bisexual, transgender, queer); (2) endorse having ever experienced a problem with alcohol or another substance; (3) have attended at least one 12-Step meeting in their lifetime based on self-report through the survey.

Procedures

Participants in The PRIDE Study were sent email notifications about the opportunity to complete a survey about their alcohol or other substance use and experiences with substance use treatment and other resources. Interested participants were asked screening questions to determine if they experienced a problem with alcohol or another substance; participants who endorsed either were taken to the survey. This study employed a survey of validated measures about substance use (Alcohol Use Disorder Identification Test (AUDIT; Bohn et al., 1995; scale 0-40, and World Health Organization World Mental Health Composite International Diagnostic Interview- Substance Abuse Module (WHO WMH-CIDI-SAM; Cottler, Robins & Helzer, 1989; scale 0-16) and multiple choice questions about sexual orientation, gender identity, and race to provide descriptive statistics of the sample and experiences with substance use treatment and resources, including mutual help programs, and thirteen open-ended questions about experiences in mutual help programs (*e.g.,* “What have you liked about participating in a 12-Step program?”), with the open-ended items being analyzed for this study. Open-ended questions gave participants the opportunity to provide their own descriptions and framing of these experiences. See Table 1 for a complete list of open-ended questions included in the analysis. Only participants who endorsed having ever attended a 12-Step meeting were asked the open-ended questions about their experiences participating in 12-Step programs. Completion of the survey took approximately 30 minutes. Participants were compensated with an $8 Amazon gift card for completing the survey.

Participants

Of the 4,294 participants who completed the screening question, 1,637 participants were eligible to participate in the survey; 363 participants attended at least one 12-Step meeting and were asked about their experiences in 12-Step programs; and 302 participants completed the open-ended response items. Please see Table 2 for a full description of participant demographic characteristics.

Data Analysis

Open-ended statements were analyzed using thematic analysis (Braun & Clarke, 2012). Two analysts engaged in open coding of written answers to the questions on the survey related to their involvement in 12-Step programs. Each analyst read the segments of text to develop familiarity with the data and identified codes to describe participants' experiences with 12-Step programs. They met to discuss the open coding process and the initial list of codes, noting a prevalence of codes related to social and community support. They organized these codes into themes and subthemes related to social and community support, creating a codebook to guide further analysis. The codebook included preliminary themes of experiencing victimization/discrimination, lacking LGBTQ community, mutual support and skills, sense of community, and validating identity. These themes were ultimately revised and classified as sub-themes under the two overarching themes of beneficial connections and harmful environments. Data were then uploaded to Dedoose (Sociocultural Research Consultants, 2018) for analysis using the codebook. Throughout two subsequent rounds of coding, the themes were revised to most accurately represent the data. As a final stage of analysis, the themes were refined while writing the manuscript. All themes and sub-themes were discussed until consensus was reached.

Findings

Thematic analysis resulted in the development of two themes related to how SGMI in 12-Step substance use programs experienced social and community support: beneficial connections and harmful environments. These themes encompass a range of helpful and harmful aspects to community and social support. Additionally, while some sub-themes are specific to gender and sexuality, others are broader. We include all sub-themes to represent participants' experiences inclusive of and beyond their sexual and gender identities.

Beneficial Connections

Beneficial connections included the ways in which 12-Step programs helped participants develop a sense of community, identify with others who have a shared experience of substance use and/or SGMI identity, and provided an opportunity for skill provision and sharing. Importantly, some participants noted an absence of beneficial connections, which made their experience in the program challenging or non-beneficial but did not fall into the theme of "harmful environments" as in these cases the experiences and outcomes of 12-Step participation were not described as detrimental or harmful. Therefore, we include data related to a lack of beneficial connections in this section as well.

Sense of community

Many participants described the sense of community they gained from 12-Step involvement as beneficial. Sense of community included broad descriptions of support as well as support provided by the group community specifically for managing addictive behaviors and other mental health conditions. When asked what was helpful about the program, participants shared a sense of "community support" or said, "I attend the meetings for myself and feeling part of a community" (57, white, cisgender gay man). This sense of community was experienced in group-oriented ways, as indicated by participants sharing community benefits such as "the fellowship" and "the camaraderie," but also in more individual ways such as by building friendships, accessing support, and reducing isolation. One participant described a helpful component of the 12-Step program to be "the friends I have made in the program" (gay, cisgender man; race and age not reported) while another expanded on this by describing "I made new friends who continue to be supportive of my sobriety" (41, white, lesbian cisgender woman). Relatedly, close friendships often meant increased support for both substance use and other issues with which participants needed help. One participant shared how friends they made in the 12-Step group also provided support related to their mental health:

> I love having people who support me and that I know I can call at any time if I'm struggling. For me, with bipolar disorder, staying connected is especially important because I can easily bounce from one extreme to the other and not notice it, but my friends in the program look out for me now (22, white, queer, transgender and non-binary person).

One participant who faced some challenges in the 12-Step program shared a benefit to making friends in group meetings for program engagement:

> It was easier for me when I made 1:1 connections with other members and met them individually away from meetings to talk. Having a sponsor helped. Being able to call friends or talk to them via text or Facebook also made it easier for me to reach out for support (46, white, gay, cisgender man).

This support from friends in the 12-Step programs helped participants reduce isolation. Numerous participants shared how the meetings made them feel "less alone" and how they built "life-long friendships".

Shared Experience

Expanding on a general sense of community, participants described the importance of having people around them with whom they shared similar experiences or identities. This theme showed up in two ways: 1) shared experience of addiction and 2) shared sexual and/or gender minority identity. First, participants shared how they appreciated building community with others who understood and experienced addiction. One participant described: "Being with people whom you do share common traits in background and beginnings of addiction" (pansexual, non-binary person; race and age not specified) while another described "the fellowship of others who have and/or or experiencing addiction" (56, Latino and Asian, gay, cisgender man). Another shared how "having a group of people to be around who have had

similar experiences" (52, white, pansexual, non-binary person) was beneficial to them in their recovery.

Building on the need to be around other people working to maintain sobriety, participants shared that it was meaningful for them to be in community with other SGMI also in recovery. One participant said this was necessary to their recovery because in "straight groups… [I] can not be honest" (gay, cisgender man; age and race not reported). Another participant said they "didn't always feel comfortable with others who weren't lgbtq" (65, white, asexual and gay, cisgender man).

Several participants shared that they attended groups that were SGMI-specific. One participant said, "I loved that the group I went to was all queer people" (30, white, asexual and queer, non-binary person). Another participant shared how having an SGMI-focused group eased some anxiety for them, stating that they appreciated "Lgbtq or young people-friendly meetings" and "knowing that the group is going to accept you" (23, white, queer, cisgender woman). Participants shared the benefit to being around SGMI in recovery. For example, participants shared "having supportive people around that are also LGBT+" (29, white, sexual orientation and gender identity not specified). Another participant credited their longevity in the program to the other SGMI in recovery within their groups: "I know I stayed as long as I did because back then it was the only space to meeting other LGBTQ+ folks who were also clean and sober" (56, American Indian, queer, Two-Spirit and transgender man).

Alternatively, not all participants who wanted SGMI groups had access to them or found them helpful. Some participants discussed wanting SGMI-specific 12-Step groups but not having them in their community. One participant shared:

> Finding a queer group has been difficult (not a queer 'accepting' group, but a group of actual queer people I won't have to explain my identities to, as well as the fact that I feel like my other lived experiences as they relate to being an addict are so different than the majority of other attendees (24, white, queer and asexual, trans masculine).

Other participants shared how "there weren't any active LGBTQ groups in my area" (32, white, lesbian and queer, genderqueer woman) or there was a "lack of LGBT groups or awareness of LGBT needs in regular groups" (56, white, queer, transgender man). Importantly, a couple participants shared how SGMI-specific groups shifted in a way that was not helpful to them. One participant shared: "Also, some groups in the LGBT community where and when I was going to meetings were a bit "elite" in how they viewed themselves (56, Latino and Asian, gay, cisgender man). Another said "when it gets watered down… like when it becomes a LGBT support group for people w drinking/drugging problems vs a roadmap for sober living for everyone that may or may not be attended by LGBT folks as well" (52, Latino, gay, cisgender man).

Skill Provision and sharing

Finally, an important aspect of connection was the ability of participants to share their experiences and skills they learned, as well as to listen and learn from others in the meetings.

One participant shared that they liked “hearing other people’s stories and see them nod even when sharing my most embarrassing moments. Having a space to talk freely w/out judgment. Learning to do things that don’t include drinking” (50, white, gay, cisgender man). In this way, they described the mutual support that comes from sharing, listening, and learning in community. Mostly, participants shared how they learned skills from listening to others in groups. Sometimes skills were directly related to being sober but also pertained to other facets of life as one participant shared: “Being given tools to help first stop drinking, then deal with other issues (getting and keeping a job, taking care of my apartment, going to school at night, registering to vote)” (71, white, bisexual, cisgender woman). Another participant said:

> The most helpful aspect for me is that it taught me skills for dealing with life that don’t involve drinking. It taught me how to interact better with other people, which helped because I was so socially anxious I had to drink to go to parties or other events. (41, white, bisexual, transgender man).

Participants specifically shared how listening and learning from others helped them to stay sober: “The group support dynamics were also important especially during the first 90 days. It was really helpful to have other people telling their stories, and how they personally were keeping themselves clear and clean” (56, Latino and Asian, gay, cisgender man).

Harmful Environments

Not all participants had positive experiences with social networks and community within 12-Step meetings. Harmful environments included actions, behaviors, or sentiments within 12-Step programs and were discussed by participants in two ways: 1) marginalization and oppression and 2) violence and bullying.

Marginalization and oppression

Participants described varying ways that meetings or the 12-Step program more broadly contributed to oppression and marginalization based on gender and sexuality as well as intersections of identity (*e.g.,* religion). Participants generally shared broad observations that the program or meeting structure was oppressive, and this often showed up in individual actions or behaviors. For example, one participant said:

> I felt like the program itself was very oppressive. There was rampant homophobia in meetings that were not specifically designed to welcome folks who were LGBTQ+, and even within those groups, there were a number of incredibly toxic behaviors that were allowed to go unchecked (56, American Indian, queer, Two-Spirit and transgender man).

Another participant shared that “We get a few old timers (more than 25 years) that hog the meetings and who do have some problems with Trans people.” (pansexual and queer, genderqueer; age and race not reported). Sometimes, marginalization was discussed in terms of a gender binary with hetero- and cisnormativity. Participants described 12-Step programs as “very gendered… men are expected to sponsor men, and women are expected to sponsor women. This also ends up being heteronormative” and “the gender divide has made it

difficult. While I am male-identified, I am not always comfortable with such a strict split between men and women" (41, white, bisexual, transgender man).

Importantly, SGMI not only discussed oppression related to gender and sexuality. They often discussed how oppression related to sexual and gender minority identities, and particularly a binary understanding of gender, intersected with other forms of oppression. One participant described their intersecting identities and how they experienced oppression within 12-Step programs:

> I am multi racial (Indigenous, Black, White), Sexually Fluid, Transgender (FTM/NB), disabled and neuro divergent. 12 Step programs cause issues with my mental health and people in the program give me harmful advice, say hurtful things, treat me terribly and racism is extremely prevalent. There are absolutely no safe spaces for trans people locally in recovery programs at all (34, multi-racial, sexually fluid, transgender male and non-binary person).

Participants also shared the ways in which religion showed up in 12-Step programs and how that impacted them in harmful ways. We include this sub-theme under marginalization and oppression based on how participants described their experiences. For example, participants shared feeling "not welcome due to my non-Christian beliefs" (52, white, gay, cisgender man) Some participants also described the "religious trauma triggers" (33, Hellenic, same-gender loving, transgender man) related to their own experiences as SGMI and for other reasons. One participant shared:

> Religion was an issue for me growing up, and once I was in foster care, I thought I could put that BS behind me, but AA came in and triggered me every single time, and the people were dickheads about it (42, white, bisexual, cisgender woman).

Although participants recognized that the program itself does not prescribe a specific religion for participants, individual meetings or participants may encourage religious identification and practices.

Violence and bullying

Finally, some participants shared experiences with personal or secondary victimization, bullying, and fears of violence in the program. When asked what made the program challenging or unhelpful, one participant responded "All of the victimization in the program" (58, cisgender man; race and sexual orientation not reported). One participant shared that they left the program due to "being a young woman and being PREYED upon by older and younger men at meetings" (23, white, queer, cisgender woman). Another shared experiences of "the backstabbing, the sexual assaults on women, people taking advantage of others" (43, white, queer, non-binary and trans masculine person). Some participants talked about bullying, such as the participant who said people in meetings were "making fun of folks who were able to express emotions" (56, American Indian, queer, Two-Spirit and transgender man). A couple participants shared experiencing the intersections of sexual and gender minority identities and violence in the meetings. One said: "There was also a lot of predators and self-proclaimed 'tranny chasers'" (33, Hellenic, same-gender loving, transgender man). Another shared: "I am a trans man, and there wasn't an LGBT AA in my

small community. I didn't feel like I could be out about that I'm much more comfortable around women but they said the sponsors had to be same sex. The men there were very open about being violent and that scared me" (asexual, transgender man; age and race not reported). Thus, violence and bullying, often related to SGM identity, made involvement and accessing social support in 12-Step programs challenging.

Discussion

This qualitative study explored the social and community support experiences of SGMI involved in 12-Step programs. Findings contribute to our understanding of the role of support in 12-Step programs through both beneficial connections and harmful environments. Understanding the complexity of these experiences as potentially helpful and/or harmful increases understanding of SGMI experiences in 12-Step programs and suggests areas for intervention to improve individual experiences and promote well-being through program and system-level change.

Respondents in this study echoed a number of sentiments about social support found in previous studies about 12-Step programs that were not focused on sexual orientation and gender identity. Namely, past research has identified structural, functional, and enacted support as key elements of social support (Hogan et al., 2002) with 12-Step program offering all three (Donovan et al., 2013; Groh et al., 2008). The subthemes of beneficial connections identified in this study parallel these findings. Sense of community and shared experience constitute aspects of functional support, while skill provision and sharing constitute aspects of enacted support. Furthermore, participants described expanding their social network through 12-Step participation, an example of structural support.

SGMI discussed aspects of their experience of 12-Step programs that were not captured through these existing frameworks of social support (Groh et al., 2008; Hogan et al., 2002). A central finding in our analysis of the shared experience subtheme was that many respondents benefited from connecting with other SGMI. Past research focused on the aspects of social support afforded through 12-Step participation have not explicitly considered common identities and related experiences as facets of social support (Donovan et al., 2013; Groh et al., 2008). Related research demonstrates how SGMI generally receive greater support from other SGM people compared with non-SGM friends and family members (Doty et al., 2010; Paceley, Hwu, et al., 2017).

A notable finding from this study is the high variability of experiences of 12-Step programs among SGMI with participants endorsing beneficial connections as well as harmful environments. While some participants described exclusively beneficial or harmful experiences, many relayed varied experiences that were both positive and negative. This suggests the importance of further examining the impacts of beneficial connections and harmful environments in conjunction with each other. Past research has considered the influence of varied experiences of microaffirmations, microaggressions, violence, and adversity on mental health among SGMI, concluding that each permutation of these experiences has a distinct impact on mental health (Sterzing et al., 2019). However, no known research has examined the impact of these experiences in the context of mutual

help groups; it may be that the types of microaffirmations, microaggressions, violence, and adversity experienced in these spaces, the risk and protective factors of these experiences, and the effects of these experiences may be distinct from beneficial and harmful experiences in other contexts. Better understanding the experiences of both beneficial connections and harmful experiences, the effects of these experiences, who is most likely to experience them, and under what conditions is critical for helping individuals to select support resources that are most likely serve their needs and least likely to impart undue harm. In particular, it is critical that we examine how these experiences, and their impacts differ across sexual orientations, gender identities, and intersecting identities, such as race/ethnicity, age, and socioeconomic status. Though a small body of research has considered the experiences of some subpopulations of SGMI in 12-Step programs (e.g., Jerome & Halkitis (2014) examined the experiences of Black SGMI who use methamphetamine in 12-Step Programs), such research rarely examines variability in these subpopulations.

Limitations

Though this study makes an important contribution to the literature by exploring the experiences of social and community support of SGMI in the context of 12-Step groups, this study is not without limitations. This study is limited by the lack of depth in answers provided by respondents. Open-ended surveys allow for a large number of responses, but lack the depth to explore individual participant experiences. Also, because this sample included individuals who had attended 12-Step programs at any point in their lifetimes, participants may have limited or biased recall of their experiences or have been describing experiences from decades ago. Because of a range of sociopolitical changes that have influenced the experiences of SGMI in society, some responses may not generalize to the current zeitgeist (Hatzenbuehler, 2014). Furthermore, most of the experiences described refer to 12-Step involvement prior to the COVID-19 pandemic; the pandemic has led to a proliferation of online meetings and other changes (*e.g.,* working from home, changes in social networks) that likely influence facilitators and barriers to involvement and experiences of 12-Step programs, including both experiences of harassment and of affirming social connection (Bergman et al., 2021). At the present moment, it is impossible to determine the extent to which these changes will be long-lasting. There are sampling issues that limit generalizability, such as the self-selected nature of the sample and the lack of racial diversity compared with the general U.S. population. Whereas 84.1% of this sampled identified as non-Latino, non-multi-racial White, only 77% of the U.S. population identifies as non-Latino, non-multi-racial White (U.S. Census Bureau, 2017). Therefore, this sample may not generalize to the general population of SGMI involved in 12-Step programs. Despite these limitations, this study is strong in its large sample size, inclusion of SGMI across sexual orientations and gender identities and across the U.S., and utilizes one of the most robust samples of any study of SGMI experiences in 12-Step programs.

Implications for practice

This study identified benefits and challenges that SGMI experience in the context of 12-Step groups; these findings can assist service providers in working with clients to determine whether or how to become involved with 12-Step groups, supporting them through their

involvement, and addressing structural and organizational barriers to inclusive participation. Past research identified how service providers have a role in increasing the likelihood and duration of 12-Step participation for their clients (Kelly & Yeterian, 2008, 2011), yet this work must be done with the context of SGM experiences in mind. Consistent with other research, our findings suggest that service providers who aim to facilitate client involvement in 12-Step groups should highlight the benefits to involvement (Kelly & Yeterian, 2008, 2011). Sharing SGM-specific benefits, such as an increased sense of community with other SGMI, may be particularly important. Relatedly, service providers can introduce clients to current members of 12-Step groups, which may increase the likelihood of client participate (Kelly & Yeterian, 2008, 2011). Due to unique benefits and challenges of 12-Step participation experienced by SGMI, it may be particularly useful for service providers to introduce SGM clients to other SGMI involved in 12-Step groups.

The findings from our study revealed that some participants experienced harm or trauma as a result of their involvement in 12-Step groups. It is well established in the literature that traumas – such as victimization, bullying, and stigma – are detrimental to mental health and substance use outcomes (Fish et al., 2019; McGeough et al., 2021; Paceley, Goffnett, et al., 2017; Sterzing et al., 2019). Service providers should be transparent about the potential challenges and harmful dynamics that SGMI may experience in 12-Step groups. Service providers should share that other SGMI have experienced marginalization, bullying, and religious trauma in 12-Step groups. When clients have this information, they can make an informed decision about whether to be involved in a 12-Step group and/or how to identify and select a group that is affirming. Service providers can support SGMI in identifying a group that may best fit their needs (such as an SGMI-specific 12-Step group) or identify a different type of groups or programs. Indeed, 12-Step programs may not be the most appropriate resource for all clients. Particularly for clients who struggle with histories of religious trauma, secular alternatives, such as SMART Recovery, may provide many of the same benefits of 12-Step involvement without the risks of religious re-traumatization (Kelly & Dentato, 2016).

Service providers should stay in close contact with clients about their ongoing experiences in 12-Step groups to help them overcome barriers to effective involvement (Kelly & Yeterian, 2011), process challenges, or find alternatives if the 12-Step group is not working for them. Service providers should support SGM clients in addressing concerns about potential harms of participating in 12-Step programs, including developing a safety plan for how they can care for themselves and access support if harms occur. Service providers can help clients identify beneficial and challenging aspects of program participation to reinforce progress as well as support clients in addressing challenges. Depending on the challenge a client experiences, strategies could include utilizing a different 12-Step group (*e.g.,* a group that is more supportive of one's SGM identity and its intersection), a supplemental support resource (*e.g.,* a community group focused on SGM issues that is not specifically focused on addiction), or a different resource entirely, such as other mutual help groups, including SMART Recovery or LifeRing (Zemore et al., 2018). If a client chooses to remain in a 12-Step group with challenges, such as disagreements with program framing or experiences of discrimination, service providers can support them with developing coping skills and strategies. Past research has identified strategies for coping

with some of these problems in the context of 12-Step programs endorsed by SGMI who participate in 12-Step programs, including cultivating an SGM-subculture within 12-Step programs (such as forming groups specifically for SGMI), rephrasing 12-Step texts to be inclusive of gender minority individuals, and employing only the aspects of the program that appear to meet their needs (Hall, 1996; Matsuzaka, 2018). Additional research has identified cognitive-behavioral strategies for coping with marginalization, generally, such as cognitive restructuring and reducing avoidance patterns (Pachankis et al., 2020).

Importantly, the burden for coping with marginalization, oppression, violence, and bullying should not fall solely on the shoulders of SGMI; rather, practitioners must engage as change makers to reduce oppression and trauma within existing 12-Step groups. Structural strategies to reduce harm might include developing or promoting SGMI-specific 12-Step groups, including meetings specifically for sub-populations of SGMI, like SGMI of color, having inclusive marketing materials for 12-Step groups, and offering training or resources to 12-Step groups to promote inclusion and respect. Service providers can also support the development of secular programs, such as SMART Recovery. Related literature on shifting communities and organizations toward acceptance may provide some possible group-level interventions. For example, ensuring groups meet in spaces with gender neutral bathrooms, include visibility of other SGMI, make use of gender inclusive lists of sponsors (rather than exclusive male and female lists), and offer SGMI-specific resources can reduce stigma and promote acceptance within organizations and communities (Paceley et al., 2020).

Although some past research has considered the role of service providers in facilitating 12-Step involvement among general populations, no known research has empirically validated these approaches for SGMI specifically (Kelly & Yeterian, 2008, 2011). Future research must explore which of these strategies are most effective for supporting healthy and constructive 12-Step involvement among SGMI and under what circumstances these strategies should be applied (*i.e.,* when a service provider should help a client to become more involved in 12-Step programs *vs.* when a service provider should support a client in withdrawing from 12-Step programming and pursuing an alternative resource). Though 12-Step programs appear to be beneficial for many SGMI, the ultimate impacts of these programs on SGMI and the factors that influence the impacts of 12-Step programs on SGMI continue to be poorly understood. In the absence of well-established best practices, it becomes even more critical for service providers to be responsive to client preferences in guiding their decisions about how to support them.

Conclusion

This study explored the social and community support experiences of SGMI involved in 12-Step programs. Findings reveal a nuanced understanding of the role of support in 12-Step programs through both beneficial connections (sense of community, shared experiences, and skill provision and sharing) and harmful environments (marginalization and oppression and violence and bullying), both related and unrelated to their SGM identities. This highlights the wide variety of experiences of SGMI in 12-Step programs. These findings suggest that many SGMI may benefit from 12-Step programs, but many SGMI may need support in overcoming and coping with potential harms that can emerge through 12-Step programs.

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Table 1.

Open-ended questions.

What made you consider becoming involved in a 12-Step program?
How did you decide to become involved in a 12-Step program?
What made you decide to become involved in a 12-Step program?
What have you liked about participating in a 12-Step program?
What have you disliked about participating in a 12-Step program?
What has made it easier for you to participate in a 12-Step program?
What has made it more difficult for you to participate in a 12-Step program?
What has made your continue to attend 12-Step meetings? (if currently active) OR What has made you stop attending 12-Step meetings? (if not currently active)
What aspects of your 12-Step participation, if any, have been most helpful for addressing your drinking or drug use problem?
What aspects of your 12-Step participation, if any, have not been helpful, or have been harmful, for addressing your drinking or drug use problem?
How, if at all, has your life improved through participating in a 12-Step program?
How, if at all, has your life been negatively impacted through participating in a 12-Step program?

Table 2.

Descriptive statistics.

Sexual Orientation	**Frequency**	**Percent (%)**
Asexual	19	6.3
Bisexual	62	20.5
Gay	128	42.4
Lesbian	56	18.5
Pansexual	41	13.6
Queer	107	35.4
Questioning	2	0.7
Same-Gender Loving	15	5.0
Heterosexual	9	3.0
Another	2	0.7
Two-Spirit	9	3.0
Multiple	115	38.1
Total Respondents (N)	**302**	
Gender Identity*	**Frequency**	**Percent (%)**
Agender	13	4.3
Cisgender man	68	22.5
Cisgender woman	53	17.5
Genderqueer	39	12.9
Man	96	31.8
Non-binary	56	18.5
Questioning	8	2.6
Transgender man	40	13.2
Transgender woman	15	5.0
Two-Spirit	4	1.3
Woman	47	15.6
Another	18	6.0
Multiple	139	46.0
Total Respondents (N)	**302**	
Race/Ethnicity*	**Frequency**	**Percent (%)**
American Indian	13	4.3
Asian	8	2.6
Black	21	7.0
Hawaiian	0	0.0
Latino/a/x	17	5.6
Middle Eastern/North African	2	0.7
White	274	90.7
Another	13	4.3
Multiple	20	6.6

Sexual Orientation	Frequency	Percent (%)
Total Respondents (N)	**302**	

	Mean	Std. Dev.	Min.	Max.
Age	45.91	14.39	22	80
Past-Year Alcohol Use (AUDIT)	1.20	3.01	0	16
Lifetime Alcohol Use (AUDIT)	9.13	5.53	0	16
Past-Year Substance Use (CIDI)	1.57	3.71	0	16
Lifetime Substance Use (CIDI)	6.42	6.47	0	16
Total Respondents (N)	**302**			

Note:

* Respondents were allowed to provide multiple answers, so the total number of responses do not equal the N of the study