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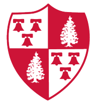

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Alcoholics Anonymous is a fellowship of people: A qualitative study.

Sara Matsuzaka
Montclair State University, matsuzakas@mail.montclair.edu

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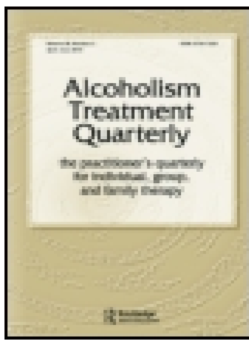

Alcoholism Treatment Quarterly

ISSN: 0734-7324 (Print) 1544-4538 (Online) Journal homepage: http://www.tandfonline.com/loi/watq20

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Sara Matsuzaka

To cite this article: Sara Matsuzaka (2018): Alcoholics anonymous is a fellowship of people: A qualitative study, Alcoholism Treatment Quarterly

To link to this article: https://doi.org/10.1080/07347324.2017.1420435

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Alcoholics anonymous is a fellowship of *people*: A qualitative study

Sara Matsuzaka

Fordham University Graduate School of Social Work, New York, NY

ABSTRACT

This New York City-based qualitative study rooted in minority stress and grounded theories explores the experiences of 11 transgender and gender nonconforming (TGNC) adults in Alcoholics Anonymous (AA). Three themes emerged in the study: (1) AA as a foundation for sobriety and gender transition; (2) experiences with gender minority-based stigma in AA; and (3) use of adaptive strategies to negotiate survival in AA. This paper concludes with recommendations for AA members, substance abuse treatment professionals, social workers, and other healthcare providers to enhance TGNC experiences within substance abuse treatment and recovery communities.

ARTICLE HISTORY
Received 8 October 2017
Revised 7 December 2017
Accepted 19 December 2017

KEYWORDS
Alcoholics anonymous; gender nonconforming; LGBTQ; substance use disorder; substance abuse treatment; transgender

Substance use disorder (SUD) is a condition in which the use of alcohol and/or drugs leads to clinically significant impairments that have both acute and enduring effects on individuals, families, groups, communities, organizations, and society at-large (American Psychiatric Association [APA], 2013). SUD is known to indiscriminately affect all people regardless of their characteristics. However, rates of substance use within the transgender population are estimated to be higher than those within the general population (Hotton, Garofalo, Kuhns, & Johnson, 2013; Operario & Nemoto, 2005; Ramirez-Valles, Garcia, Campbell, Diaz, & Heckathorn, 2008). Gender minorities are particularly vulnerable to developing SUD as a maladaptive means of coping with chronic minority-based stressors (Lenning & Buist, 2013; McCabe, Bostwick, Hughes, West, & Boyd, 2010; Meyer, 2015; Meyer & Frost, 2013, 2013). The estimated size of the transgender population has doubled since 2011, with approximately 0.6% of the adult population in the United States (US) identifying as transgender (Flores, Herman, Gates, & Brown, 2016). With its burgeoning size and visibility (Kanamori, Cornelius-White, Pegors, Daniel, & Hulgus, 2017) and an ongoing lack of protections against stigma and discrimination (Johnson, 2013), prevalence rates of SUD within the transgender population are expected to grow.

Alcoholics Anonymous (AA) remains a predominant figure in the formation of recovery communities worldwide. Founded in 1935 with the implicit intent

CONTACT Sara Matsuzaka smatsuzaka@fordham.edu
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of helping cisgender heterosexual men to recover from the disease of alcoholism, its admittance of the LGBTQ+ community has been gradual. However, AA is currently the proprietor to thousands of lesbian, gay, bisexual, transgender, queer (LGBTQ+) specific meetings worldwide. Despite the expanding presence of the AA LGBTQ+ population, the needs of transgender and gender nonconforming (TGNC) AA members have remained largely unaddressed. This is evidenced, in part, by the dearth of meeting options for gender minority AA members. For example, there are currently over 850 AA meetings per week in New York City, of which, approximately 80 meetings are LGBTQ+-specific, with only 1 meeting being TGNC-specific (Inter-Group Association of AA of NYC, n.d.). As a consequence, TGNC populations are at risk of being left on the fringes of the largest self-supporting recovery community in the world.

There is an absence of published literature around the experiences of TGNC individuals in any of the 12-Step programs. With the high prevalence of SUD within the transgender population (Hotton et al., 2013; Operario & Nemoto, 2005), there is a need for data that clarify the benefits of and barriers to the involvement of gender minorities in the most widespread global mutual aid organization of alcoholics. This study attempts to address this gap in the literature. This article reports on a New York City-based qualitative exploration ($N = 11$) on the experiences of TGNC adults within AA. The study was conducted with approval by the Fordham University Institutional Review Board. The findings of the study suggest that: (1) AA has utility in providing a foundation for both sobriety and gender transition; (2) TGNC adults experience gender minority-based stigma, microaggressions, and discrimination in AA; and (3) TGNC adults use adaptive strategies to negotiate survival within AA's hetero- and cis-normative framework. This paper provides recommendations for AA members and healthcare providers to enhance TGNC experiences within substance abuse treatment and recovery communities.

Literature review

A literature review was conducted to understand the characteristics and experiences of the transgender population with alcoholism, recovery, and AA involvement. Table 2 provides detailed information about terminology used in this article and related to the transgender population. Various databases were utilized for the literature review, including Gender Studies Database, Medline, PSYCInfo, LGBT Life with search terms including AA, gender nonconforming, LGBTQ, SUD, substance abuse treatment, transgender, and 12-Step.

Transphobic stigma and discrimination

TGNC individuals are vulnerable to intersecting axes of oppression, stigma, and discrimination based on race, ethnicity, gender, class, citizenship, sexual

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orientation, among other identifying factors (Lenning & Buist, 2013). According to Goffman (1963), a stigmatized individual is perceived by those within dominant social groups as having "an undesirable difference." Stigma can be understood as a social process, within a socio-cultural, economic, and political context, of "othering" and labeling a group with the intent of subordination (Deacon, 2006; Link & Phelan, 2001; Poteat, German, & Kerrigan, 2013). Hatzenbuehler, McLaughlin, Keyes, and Hasin (2010) defined structural stigma as "the societal norms, environmental conditions, and institutional laws and practices that limit the resources, opportunities, and well-being of stigmatized people."

Transgender individuals face psychological challenges related to the identification, understanding, and acceptance of their gender identity, as well as the internal struggle before, during, and after gender affirmation surgery (Lenning & Buist, 2013). These challenges are linked to external stressors related to interpersonal and structural forms of stigma and discrimination (Gordon & Meyer, 2007; Greene, 2004; Johnson, 2013; Lenning & Buist, 2013; Lombardi, 2009). TGNC individuals are reported to experience high rates of interpersonal stigma based on their gender identity status (Bockting, Miner, Romine, Hamilton, & Coleman, 2013; Bradford, Reisner, Honnold, & Xavier, 2013; Grant et al., 2011). Furthermore, research indicates an association between living in high structural stigma states (e.g., states with high rates of heteronormative social policies, attitudes, and behaviors) with disproportionate rates of mental and physical health issues among LGBTQ+ populations (Hatzenbuehler et al., 2014, 2010).

Dearth of culturally-competent treatment options

The expectation of provider-based stigma and discrimination with substance abuse treatment facilities may dissuade TGNC individuals from seeking help for their substance use issues (Eliason & Hughes, 2004; Lyons et al., 2015; Senreich, 2011; Sperber, Landers, & Lawrence, 2005). Such expectations are supported by evidence suggesting that transgender individuals experience various forms of stigma and discrimination within substance abuse treatment facilities, including being misgendered, refused the right to continue hormone replacement therapy, and exposed to culturally incompetent clinical staff (Eliason & Hughes, 2004; Sperber et al., 2005).

There is also evidence that transgender individuals experience stigma within social service agencies (Bockting et al., 2013; Grant et al., 2011), reflecting a lack of cultural competency among service providers (Dispenza & O'Hara, 2016). This finding is supported by studies highlighting the inadequate preparation of social work students for work with transgender populations (Dillon et al., 2004; Logie, Bridge, & Bridge, 2007; Martin et al., 2009; Morrow & Messinger, 2006). In one study, Logie et al. (2007) found

that nearly half of graduate students in the sample perceived themselves as having inadequate training and levels of competence for adequate work with the LGBTQ population.

With a dearth of transgender-affirming substance abuse treatment options, TGNC populations rely largely on free community-based mutual support programs such as AA to build a foundation for recovery. Many substance-abusing LGBTQ+ individuals encounter health care providers who provide 12-Step facilitation, an evidence-based practice for the treatment of SUD involving referrals to 12-Step mutual support programs (Kelly & Hoeppner, 2012; Kelly & White, 2012; Project MATCH Research Group, 1997). However, without empirical support of the effectiveness of 12-Step programs specifically with the TGNC population or qualitative data on the actual experiences of TGNC populations with 12-Step programs, the use of 12-Step referrals for TGNC individuals can be considered impetuous.

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Brief history of AA

In 1935, Bill Wilson, a Caucasian heterosexual cisgender alcoholic male, and Dr. Bob, a Caucasian heterosexual cisgender male physician, formed AA, a mutual support program for alcoholics (AA, 2001.). Currently, there are an estimated 2 million AA members worldwide and its seminal literature, *Alcoholics Anonymous*, informally referred to as "The Big Book," has sold more than 30 million copies (Inter-Group Association of AA of NYC, n.d.). The purpose of AA, as articulated in the "Preamble," is to help alcoholics "stay sober and help other alcoholics to achieve sobriety" (Inter-Group Association of AA of NYC, n.d.).

AA originated from The Oxford Group, a Christianity-based organization that sought to help people solve their problems by building a connection to a Christian God. While the "Preamble" of AA explicitly states that it "is not allied with any sect, demonization, politics, organization or institution...... " (Inter-Group Association of AA of NYC, n.d.), the "Second Tradition" of AA reads, "For our group purpose, there is but one ultimate authority – a loving God as he may express Himself in our group conscience...... " (AA, 1952). In addition, four of the 12-Steps upon which the program is based incorporate the word "God" (AA, 1952).

AA operates as a self-supporting organization whereby funds for meetings, events, and literature are garnered entirely through voluntary member contributions. As an entity without any formal hierarchical structure and disavowing leadership, AA meetings offer some autonomy to each of its meetings with regards to selecting the meeting name, focus area, format, rules, and location. For example, a meeting may be formed to cater to the specific needs of lesbian alcoholics, but members may choose to include a rule that explicitly permits the involvement of TGNC individuals.

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Conversely, a meeting for "men-only" may choose to disavow the involvement of transmen based on what sex they were assigned at birth.

LGBTQ+ AA involvement

For the first three decades of AA, sexual minorities maintained a status of double anonymity with regards to their alcoholic identity (in congruence with AA's policy around anonymity) and their sexual identity (based on fear of stigma and discrimination). In 1967, the first gay AA meeting was held in San Francisco (AA, 1989). In 1974, the General Service Conference of AA voted for the formal inclusion of gay AA meetings in AA directories (Borden, 2007). Today, there are thousands of LGBTQ AA meetings occurring worldwide. In 1989, AA published its first piece of literature focused on its sexual minority members, "AA and the Gay/Lesbian Alcoholic" (AA, 1989). To-date, there has been no literature published by AA that alludes to the experiences of queer and/or TGNC individuals.

State of evidence: LGBTQ+ experiences in AA

There is a gap in the literature related to the experiences of TGNC populations in AA, despite comparable literature on the experience of gay and lesbian AA members (Bliss, 2011; Hall, 1990, 1994; Kus, 1989, 1992; Suprina, 2006). These largely qualitative-driven studies have focused on the concepts of spirituality (Bliss, 2011; Kus, 1989, 1992), belonging (Suprina, 2006), and tensions within AA participation (Hall, 1990, 1994) for sexual minority (i.e., gay and lesbian) participants. In a qualitative study involving 35 lesbian AA members in San Francisco, Hall (1990, 1994) found that AA involvement for the study participants involved tensions related to assimilating versus differentiating in AA. There is an unmet need for studies examining the experiences of TGNC adults in AA.

Theoretical framework

Minority stress theory (Meyer, 2003) is a useful framework for understanding how persistent exposure to gender minority-based stressors partially explain the disproportionately high rates of health and mental health issues among transgender populations compared to the general population. While originally developed for application with sexual minority (lesbian, gay, bisexual) populations (Meyer, 2003), recent evidence indicates an applicability of minority stress theory toward the TGNC populations (Hendricks & Testa, 2012). Minority stress theory posits that persistent exposure to stigma and discrimination among minority populations can lead to adverse health and mental health outcomes due to the effects of: (1) distal stressors, involving external sources of stigma and discrimination; and (2) proximal stressors,

involving internalized transphobia (Meyer, 2015; Meyer & Frost, 2013). Furthermore, minority stress theory discusses social support as a protective factor in the face of distal and proximal stressors (Meyer, 2003)

Within the minority stress framework (Meyer, 2003, 2015), the use of drugs and alcohol could be viewed as a maladaptive behavioral response for coping with stressors related to real or anticipated gender minority-based manifestations of stigma, discrimination, and violence (Hendricks & Testa, 2012). Thus, for TGNC individuals in recovery, AA becomes a location presenting with the potential to either buffer the negative cumulative effects of societal stigma and discrimination or to exacerbate them through further exposure to interpersonal and institutional stigma and discrimination. The consequence of reinforced exposure to gender minority-based stigma and discrimination within AA may include the potential exacerbation of symptoms related to their substance use issues (Meyer, 2015).

Additionally, application of a minority stress framework to exploring the experiences of gender minorities in recovery could place consideration to a self-identification as an "alcoholic in recovery" as an added minority identity, particularly within the LGBTQ+ culture where alcohol use remains normative. LGBTQ+ social environments, situated within bars and nightclubs, have long served as locations for sexual and gender minorities to congregate, explore, develop, and express their identities, protected from societal scrutiny (Cartier, 2013). Upon getting sober, sexual and gender minorities in recovery may face a need to remove themselves (for a time being) from LGBTQ+ socialization environments in order to sustain abstinence from alcohol and drug use. However, such separation from mainstream LGBTQ+ socialization environments presents with risks of isolation from a minority social culture which provides acceptance and social connection.

Furthermore, stigma and biases around SUD are further complicated by the intersecting influences of minority identity statuses related to race, ethnicity, gender, sexual orientation, age, citizenship, class, ability, among other identifiers. With consideration to qualifying an "alcoholic" identity as a minority status, the interlocking influences of other minority statuses can be found to compound exposures to stigma, microaggressions, and discrimination. In other words, any inquiry around the experiences of gender minorities in recovery is inseparable from discussions around race/ethnicity, sexual orientation, class, among other affiliated factors.

Methods

This study used qualitative methods to explore the experiences of TGNC adults within AA and was rooted in grounded theory, a methodology for generating theory from systematic processes of data collection and analysis (Charmaz, 2000; Glaser, 1978, 1992; Glaser & Strauss, 1967; Strauss, 1987;

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Strauss & Corbin, 1990, 1998). The use of qualitative interviews for data collection was selected based on the exploratory nature of this research to gather the subjective experiences of members from a marginalized group. Data analysis consisted of coding methods consistent with the procedures of grounded theory (Strauss & Corbin, 2008).

This study took into consideration the potential effects of the researcher's status as a Japanese-American, lesbian, first-generation immigrant with clinical experience in the substance abuse treatment field of social work. Various techniques were incorporated into the methodology to enhance rigor and protect against biases based on the positionality of the researcher, including member-checking, an audit trail, peer debriefing, and reflexivity (Lincoln & Guba, 1985). Specifically, the interview transcripts and field notes were provided to all participants to be member-checked for accuracy; a reflexive audit trail was maintained to include a transparent description of the steps taken throughout the course of the research; and peer debriefing was used to illuminate any of the researcher's implicit biases and assumptions.

Sampling plan

A non-probability purposive snowball sampling method was employed to identify study participants ($N = 11$) from AA recovery communities within New York City. This sampling method was selected based on the difficulty of accessing a marginalized and anonymous population in recovery within AA. The criteria for selection of participants for the study included adults (age 18 and older) who identified as transgender or gender non-confirming, reported a history of substance use issues, were either currently or formerly active members within AA, and had a minimum of 90 days of sobriety (i.e., abstinence from all chemical use). All interview participants were compensated with a $20 Amazon gift card.

The initial recruitment of study participants was aided through the cooperation of key informants within the Ackerman Institute's Gender and Family Project, Callen-Lorde, The Center, and a closed group within Facebook for transgender and gender nonconforming persons in New York City. Additional participants were subsequently recruited by the primary data sources that referred additional qualifying individuals for inclusion in the study. As a central component of grounded theory, theoretical sampling was used as a concept-driven method of sampling whereby participants were recruited through chain sampling until no new conceptual categories of data emerged (Charmaz, 2006; Strauss & Corbin, 1998).

Using exponential non-discriminative snowball sampling, 11 research participants were recruited, including three transfemale, three transmale, and five gender nonconforming persons ranging in ages from 28 to 66 years of age. Of the 11 participants, eight identified their race as Caucasian with two identifying

their ancestry as multiracial (i.e., Caucaisan, Hispanic, African). Of the six participants who identified their sexual orientation as queer, five identified as gender nonconforming. Of the five participants who identified as transmale or transfemale, four identified as having a heterosexual sexual orientation. One participant identified as having a bisexual sexual orientation. Table 1 details the participant information in greater detail.

Data collection

Data were collected in July-August 2017 and primarily involved conducting 60-min semi-structured qualitative interviews. Seven interviews were conducted in-person at an agreed upon location and four interviews were conducted using a video telephony application upon participant request. All interviews were audio-recorded with participant consent. The interview was guided by an interview schedule which was pilot-tested with a TGNC adult in recovery. Sample questions in the interview schedule included: "What were the circumstances that led to you entering into recovery?" "What role does AA involvement play in your life?" "How have your experiences been with regards to feeling welcomed, or not welcomed, in AA based on your gender identity?" Informed consent was obtained for all interviews.

Data analysis

Data analysis involved using coding methods to identify common themes from the semi-structured interviews (Strauss & Corbin,2008). Specifically, open coding, axial, and selective coding (Strauss & Corbin, 2008) were used to analyze data from the interviews for the identification and categorization of conceptually similar themes (Charmaz, 2006). Through constant

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Table 1. Participant code and demographics.

Participant Code	Age	Sex Assigned at Birth	Gender Identity	Sexual Orientation	Race/Ethnicity
P1	48	Male	Transfemale	Heterosexual	Caucasian
P2	29	Female	Genderqueer	Queer	Caucasian
P3	29	Female	Transmasculine	Queer	Mixed – Caucasian/ Hispanic
P4	60	Male	Transfemale	Heterosexual	Caucasian
P5	36	Female	Transmale	Heterosexual	Caucasian
P6	58	Female	Transmale	Heterosexual	Caucasian
P7	28	Female	Transmasculine	Queer	Caucasian
P8	42	Female	Gender nonconforming	Queer	Caucasian
P9	35	Female	Transmasculine	Queer	Caucasian
P10	29	Female	Transmale	Queer	Mixed – Caucasian/ Hispanic/African
P11	66	Male	Transfemale	Bisexual	Caucasian

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Table 2. Transgender terminology.

Transgender	There are many categories within the umbrella term "transgender," including: transsexual, transvestite, transmale, transfemale, transmasculine, transfeminine, genderqueer, gender nonconforming, nonbinary, drag king, and drag queen. Transgender individuals identify their gender in ways that are not congruent with conventional societal expectations around gender (Valentine, 2007).
Cisgender	Cisgender individuals have gender identities that are congruent with the sex they were assigned at birth (Mayer et al., 2008).
Gender Identity	Gender identity is an individual's sense of their gender (APA, 2008).
Gender Conformity/Gender Nonconformity	Gender conformity can be defined as the degree to which an individual's gender identity and gender expression conforms to social expectations of gender. Gender non-conformity involves possessing a gender identity and expression that is not congruent with social constructions of gender (Nuttbrock, 2012).
Gender Binary System	The gender binary system or gender binarism is the classification of gender based on birth sex and assumes an alignment between sex, gender, and sexuality (Nuttbrock, 2012) to the exclusion of sexual and gender minorities.
Gender Dysphoria	Gender dysphoria reflects persistent, clinically significant distress experienced by an individual regarding the sex they were assigned at birth (APA, 2013).
Gender Transition	Gender transition involves the process of actualizing one's gender identity, but is not a requirement for identifying as transgender. Transition may involve social transition (i.e., name change, use of different pronouns, changes in gender expression) and medical transition (i.e. gender affirmation surgery) to align their gender identity and sexual characteristics (Coleman et al., 2012; Deutsch, 2014).
Heteronormativity, Transphobia, Cisgenderism	Heteronormativity is an ideology that promotes gender binarism, heterosexuality, and gender normativity. Transphobia involves the "irrational fear, discrimination against, social rejection, hatred, or persecution" toward transgender individuals. Cisgenderism involves an ideology that promotes gender binarism and cisgenderism as normative (Scott-Dixon, 2006).
Passing, Visible, Stealth	Passing refers to an individual's capacity to be perceived by others as cisgender, regardless of their gender identity. Being visible refers to a transgender individual being open about their transgender status. Conversely, being/going stealth refers to not being openly transgender in most or all situations.

comparative analysis, data were first compared with one another then coded into descriptive and analytic categories that were subsequently compared, categorized, and refined during the course of the data collection and analysis process (Strauss & Corbin, 1998). Memoing was used to detail the investigator's thoughts related to conceptual analysis (Glaser, 1998). The result included the identification of 35 codes which generated 12 categories which were then organized into a theoretical framework (Strauss & Corbin, 1998).

Results

Three major themes were identified as part of this study. These included: (1) AA as a foundation for sobriety and gender transition; (2) experiences with

gender-based stigma and microaggressions in AA; and (3) use of adaptive strategies to negotiate survival in AA.

AA as a foundation for sobriety and gender transition

All the study participants noted that AA involvement has played a fundamental role in building a foundation for sobriety, with most identifying AA as supportive of their gender affirmation process. The use of AA to build a foundation for recovery was indicated by many as a necessary preliminary step as part of the gender transition process.

Gender dysphoria as a cause for progressive alcohol use

Many experienced gender dysphoria as a cause of their progressive alcohol use with the use of alcohol as a means to suppress awareness, cognitions, and feelings related to their gender identity. Participant 1 (transfemale, age 48) observed the role of gender dysphoria as a risk factor for her developing alcohol use issues by saying, "I definitely had the gene and I think I would have been an alcoholic anyways, but, um, it was kind of fueled to the fire that I was also experiencing gender dysphoria." Participant 3 (transmasculine, age 29) elaborated on the associations between alcohol use and gender dysphoria by noting, "Not being comfortable in your own skin is crazy-making. I have no doubt that I drank just to get away from that discomfort for a long time."

Transitioning in sobriety

For most participants, building sobriety within AA was a necessary first step to addressing their issues with gender dysphoria. Participant 11 (transfemale, age 66) described the associations between her getting sober, her subsequent gender transition, and messaging she encountered in AA as follows:

> Early sobriety and facing gender identity at the same time was profound. I am not the only person who transitioned in early sobriety. I think the drugs and alcohol is the wall that holds it back and without it… And the language of AA is 'today is the first day of the rest of your life, 'today is a new beginning,' 'you're only as sick as your secrets.' I tried being sober as a guy and it was like, 'I don't want to do this. I don't care.'

In particular, AA was highlighted as helping many participants to first address their issues with alcoholism and build clarity through sobriety, which then served as a basis for gender exploration and affirmation. Participant 9 (transmasculine, age 35) observed the following about sobriety providing the mental clarity he needed to begin the gender transition process: "I'd been using drugs and alcohol for many years so when I decided to stop doing those it was at a junction where I wanted to have a clarity of mind to be in a position to start hormones."

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The sequential nature of the process of transitioning after getting sober was repeatedly highlighted by participants with Participant 11 (transfemale, age 66) noting "I couldn't have transitioned without sobriety. I couldn't have stayed sober." Similarly, Participant 5 (transmale, 36) expressed gratitude for sobriety as aiding him in the process of gender affirmation by sharing, "Getting sober helped me to find my identity."

Still others described their challenges dealing with gender dysphoria in sobriety, and transitioning later after several years of sobriety. Participant 4 (transfemale, age 60) described her process of maintaining sobriety for over a decade before transitioning in recovery, and the associated challenges with suppressing her gender identity:

> When I first got sober, those issues, that was the first thing to come up and I couldn't deal with it then. I squished it down for another 17 years – a long time. As I got older and in recovery, it just kept creeping up and got stronger – stronger than ever before when I was a child or in my adulthood. So, all of that stuff, I could not deny anymore.

She later alluded to the impact sobriety had on her decision to transition and the corresponding role her gender transition has had on her ability to stay sober by noting, "The fact that it happened to me in sobriety and because of sobriety is a big deal. It was a huge part of me staying sober."

In addition to AA's utility in helping individuals build sobriety which participants highlighted as being critical to the gender transition process, AA also provides a sober support system for gender transition-related issues. This is particularly evident with TGNC individuals who use AA to gain support for their overlapping recovery- and gender transition-related needs. Participant 10 (transmale, age 29) described the benefits of his TGNC sober community as he engaged in the transition process:

> It also helped me in my transition because I didn't know anyone in the community at all before I started going there. It was like, they kind of take you under their wing, as in any other meeting, I got connected and really. . .they kind of held my hand through the whole transition process. . .still transitioning.

These descriptions from the participants indicate challenges with gender dysphoria as being associated with their alcohol use histories as well as emotional distress before and during sobriety. Participants chronicled their need to get sober in order to build mental clarity about whether or not and how they wanted to proceed with gender transition. Furthermore, gender transition was repeatedly noted as a critical component to address the gender dysphoria that was perpetuating addictive behaviors. In other words, participants highlighted that gender transition was not possible without sobriety, and sobriety was not possible without gender transition.

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Experiences with gender minority-based stigma and microaggressions in AA

Most study participants reported experiencing stigma and microaggressions within their AA involvement. Participants discussed experiencing both interpersonal and structural forms of stigma and microaggressions which they identified as mirroring that which they regularly experience within society.

Interpersonal stigma and microaggressions in AA

Most participants described experiencing microaggressions by non-TGNC AA members within AA meetings or in AA socialization settings. Participant 3 (transmasculine, age 29) discussed feeling "othered" within AA meetings:

> I don't think everybody necessarily thinks much about how uncomfortable it can be to be trans in the rooms. It's a pretty hetero space in general. People say alcoholism is a disease of separation. There are so many ways we can feel separate but being trans can put you out on a limb.

Participant 11 (transfemale, age 66) recalled experiencing gender identity-based microaggressions within an AA-sponsored social dance:

> As I was moving in transition, I started going to straight social events. I was at a dance once, and a guy asked me to dance, and we were dancing. After, I think one of his friends must have told him that I was trans, and he reacted badly. He was aggressively rude, and I was shocked.

In addition, she expressed feeling alienated at an AA conference based on her gender identity and gender expression:

> I can remember another time I went to a conference and I showed up as mostly male and the Saturday night banquet I dressed as female and I sat at a table and no one sat with me. I sat by myself.

Participant 11 (transfemale, age 66) discusses "coming out" as transfemale at an AA-sponsored event and the subsequent negative reactions she received from her AA peers. The process of "coming out" about one's gender identity was discussed as rendering individuals vulnerable toward stigma, microaggressions, and discrimination. Similarly, Participant 10 (transmale, age 29) described experiencing microaggressions after he came out as a transman within his AA homegroup, where he was originally known based on the sex he was assigned at birth. He shared his feelings as follows: "The fellowship I relied upon so deeply for so long was just torn from under me. I was pretty much left…kind of felt alone…" Other experiences with harmful encounters upon "coming out" are described by Participant 2 (genderqueer, age 29) who recalled, "The meeting was about to start and I was about to say something. This guy came up to me and basically said, 'You're always going to a woman to me.'"

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Participant 1 (transfemale, age 48) described feeling alienated in LGBTQ+ and gay male AA communities following her gender transition.

> I have found myself more discriminated against in LGBT meetings than in straight meetings. When I started to transition, I just became invisible. I felt very frozen out and a lot of transwomen that I know who want to get out in the gay community have had this same experience.

This communication exemplifies how experiences with microaggressions are not exclusive to being perpetrated by non-LGBTQ+ identified AA members.

Structural stigma in AA

Structural forms of stigma in AA, as detailed by participants, are based largely around the programmatic components related to AA literature, rules, and meeting structures. The primary text of AA, *Alcoholics Anonymous*, has remained largely in its original form which was written and published in 1939, and updated in 1955 and 2001. This text features the dominant perspectives of Caucasian, heterosexual, cisgender men (AA, 2001) and, as such, is criticized by participants as marginalizing the experiences of alcoholic minorities. Participant 5 (transmale, age 36) spoke to the omitted perspectives of minority populations by noting, "…most of us aren't in it. I'm sure people of color have issues with it. Women have issues with it."

The cis- and hetero-normative components of AA are present in its literature as well as the implicit rules of the organization. For example, the Preamble of *Alcoholics Anonymous* reads, "Alcoholics Anonymous is a fellowship of men and women…" to the exclusion of those who do not identity within the gender binary (Inter-Group Association of AA of NYC, n.d.). AA also features implicit rules that restrict sponsorship, sober support, and fraternization to same-sex relationships out of a perceived need to prevent potential tension due to romantic and/or sexual entanglements. Correspondingly, AA meetings are largely structured on gender binary conceptions of gender with men's-only, women's only meetings, and mixed gender meetings. Participant 2 (genderqueer, age 29) expressed their frustration around the cis- and hetero-normative components of AA:

> A program where they say 'men with the men, and women with the women,' and 'Alcoholics Anonymous is a program of men and women.' I heard that line, right away I was turned off and felt, 'You don't belong here.'

Intersectionality of minority experience

The experience of intersecting forms of stigma and microaggressions in AA based on other minority identities such as gender, race, and religiosity were discussed by the participants. Misogyny was often cited as being present in the interpersonal, group, and structural characteristics of AA. As a mixed-race individual of Caucasian and Puerto Rican descent, Participant 3

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(transmasculine, age 29) described the manifestations of racism and misogyny in AA:

> As our society is in general, the patriarchy… I think men end up being the bottom line in AA and they are the keeper of the traditions and how the program is in the future. …there's an old guard that's very white and very masculine.

In addition, despite AA asserting that the organization does not have any religious affiliations, participants noted feeling uncomfortable with the religious undertones present within the institution's literature due to supposed associations between religiosity and biases toward sexual and gender minority lifestyles. Participant 2 (genderqueer, age 29) explained their initial thought process upon entering AA and encountering semantics in the literature related to religiosity. They stated, "I think that as queers, we're taught that God hates us…so why would we go to a program that's so focused on God?" In this experience, the participant expressed feeling "othered" and how this threatened to be a deterrent to AA involvement.

Most of the participants alluded to some form of experience with stigma or microaggressions within AA based on their gender minority and intersecting dimensions such as race, gender, and religiosity. These experiences were discussed as manifesting in interpersonal and structural forms within AA meetings and in AA fellowship. All participants demonstrated a willingness and capacity to persevere in AA despite such alienating and degrading exposures.

Use of adaptive strategies to negotiate survival in AA

All participants described use of adaptive strategies to negotiate survival within AA, including assimilation into or disidentification with the dominant AA culture. These adaptive strategies were executed uniquely or within subculture formations (i.e., individual or collective levels). The use of these adaptive strategies varied based on age, feminine or masculine identification, and transgender or gender nonconforming identity status (i.e., binary versus nonbinary identification). The result of these adaptive strategies and the increasing visibility of TGNC populations in AA is the integration of the TGNC and dominant AA cultures.

Assimilation into the dominant AA culture

Several participants described processes of assimilating into the dominant AA culture with respects to meeting involvement, fellowship/socialization, adopting dominant AA cultural norms, and not challenging hetero-normative and cis-normative frameworks. Assimilation is a style of acculturation where an individual becomes immersed into a new culture (Sam & Berry, 2010), which, in this case, involves TGNC individuals adopting much of the

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socio-cultural norms of the dominant AA culture. Four of the 11 total participants, all of whom identified as transfemale or transmale and with a mean age of 48 years of age, described using assimilation strategies as part of their AA involvement included. Strategies used to assimilate into the dominant AA culture were identified as: passing/being stealth, emphasizing an "alcoholic" versus "transgender" identity, and accepting any manifestations of gender-based stigma as reflective of the larger society.

Passing/being stealth. Participants who employed assimilation strategies described the role of passing or being stealth in order to immerse into the dominant AA culture. Participant 10 (transmale, age 10) discussed his experiences with choosing to be stealth in meetings to avoid tense interpersonal encounters:

> When the few times I've gone to new meetings and people don't know me, I've stayed stealth just cause if I was just passing through in a way where I'm not going to see these people again and I'm just going once cause I'm in the area, I just leave it as is. Most of the time though, well…I get misgendered – I would just like not come out.

Participant 3 (transmasculine, 29) also described their experience with passing in the rooms and selectively choosing to be stealth about their gender identity:

> I pass. I can be stealth in meetings and I don't necessary have to be known as a trans person. So, I can make the choice whether to out myself if I'm speaking. I have done that before and I've gotten some weird reactions, so now I don't except for when I'm in LGBT meetings. That makes me feel othered in a space where we're supposed to have the common peril and the common solution. Gender in the rooms is so oppressive.

Participant 5 (transmale, age 36) recounted his experiences with passing (i.e., as a cisgender male) in AA meetings and how that has protected him from experiences with stigma and discrimination.

> I've not had that problem, but largely because I pass. I'm fully aware that that's a privilege I have, that's not had by everyone. But, I'm still always like, my antennas are always up. I don't think, if you're a trans person, you ever stop wondering if people can clock you. Even if they don't, as a general rule, I don't think you ever stop thinking, 'Am I safe here?' There's always a little bit of that hyper awareness and concern for safety.

Despite his not having experienced direct forms of stigma, microaggressions, or discrimination, he expresses persistent anxieties about being recognized as transgender.

Primacy on alcoholic identity. AA espouses adopting an identity as "an alcoholic," as emphasized by the cultural norm of AA members having

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to preface any of their shares in meetings by disclosing their name and status of their alcoholic identity (e.g., "Hi, my name is Bill and I'm an alcoholic"). This is further promoted in the Preamble of *Alcoholics Anonymous* which states that "the only requirement for membership is a desire to stop drinking" (AA, 2001). Participants who described assimilation strategies as part of their AA involvement tended to place primary emphasis on their alcoholic identity over all other personal identifications. Participant 3 (transmasculine, age 29) summarized this by stating, "When I go to the rooms, my identity as an alcoholic supersedes everything."

Participant 1 (transfemale, age 48) explained her preference for general AA meetings versus transgender-specific meetings by stating, "When I go to an AA meeting, I'm looking to talk about my alcoholism and not specifically about my transition. I'm much more comfortable in non-special interest meetings as an AA meeting."

Accepting AA as microcosm of larger society. Assimilation into the dominant AA culture does not signify an absence of experiences with stigma, microaggressions or discrimination, but rather, a willingness to cope without trying to challenge the dominant norms.

Participant 5 (transmale, age 36) expressed a willingness to accept forms of gender minority-based microaggressions within his AA homegroup in order to be included within the culture. He stated, "Some of them are a little uncomfortable about it, but they care about me, and they don't want me to drink. They still want me to be alive and healthy and happy, but some of them aren't as friendly towards me."

Similarly, Participant 6 (transmale, age 58) discussed accepting and enduring the misogynistic components of AA because of the benefits of AA involvement. He notes, "There's a lot of sexist shit in the 'Big Book.' I mean, I would really be happy if they got some people together to revise some of that… Other than that, it's a good tool to grow by… They say, 'Take what you need, and leave the rest.'"

Participant 6 (transmale, age 58) describes complying with AA rules around gender-specific meetings based on the sex an individual was assigned at birth by noting, "The thing is, I'm a man. I don't belong in women's meetings. Part of being a man is you accept the shit that goes along with it and part of that means you don't go to women's meetings anymore."

This communication emphasizes how one's levels of acceptance of AA's cis- and hetero-normative, and gender binary components is influenced by one's own beliefs about gender binarism and other variables such as age, race/ethnicity, and degree of desire to "pass."

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Disidentification strategies within dominant AA culture

The process of "disidentification" (Esteban Munoz, 1999) is useful in animating how gender minority adults in recovery work with and against dominant ideologies in AA communities to meet their socio-cultural and sobriety needs. Applied to this study, the concept of disidentification (Esteban Munoz, 1999) refers to a process through which participants strive to meet their unique sobriety and identity needs by neither extricating from nor positioning themselves in opposition to AA, but rather by attempting to change it from within. Seven of the 11 total participants (1 genderqueer, 1 gendernonconforming, 3 transmasculine, 1 transmale, 1 transfemale) with a mean age of 36 years of age alluded to using disidentification strategies as part of their AA involvement. These strategies included: applying an interpretive approach to AA literature, challenging AA's gender binary components, and cultivating a TGNC sub-culture of supports.

An interpretive approach to AA literature. Some participants discussed modifying semantics of the AA literature to apply to their non-binary views. Participant 3 (transmasculine, age 29) described coping with the cis- and hetero-normative content of AA literature by stating, "I rewrote the whole Big Book in gender neutral language for myself. I typed it all out. It's 168 pages. I'm not the only one who has done that." Similarly, Participant 8 (gender nonconforming, age 42) referenced a particular chapter within *Alcoholics Anonymous* that they identify as having misogynistic undertones:

> Oh God. 'To Wives?' There's this one women's meeting that I go to occasionally and every time I go there, I feel like they're reading 'To Wives.' The thing about the literature is…I've always had sponsors who, we would re-do the literature together and kind of sift through the 1930's patriarchal language to try and get at what's actually useful and what I identify with.

Here, they discuss using their sponsor to interpret AA literature in a manner with which they can identify with and find non-offensive.

Challenging AA's gender binary components. Several participants expressed frustration with the exclusionary undertones of the Preamble for non-binary AA members. Participant 8 (gender nonconforming, age 42) described their TGNC meeting as the only meeting they have encountered which uses a modified version of the Preamble which traditionally states that "Alcoholics Anonymous is a fellowship of men and women who share their experience, strength, and hope…" (AA, 2001). Participant 8 (gender nonconforming, age 42) states, "…the trans group is the only group I've been to where it's reworded: 'Alcoholics Anonymous is a fellowship of humans who share their experience strength and hope…'" Similarly, Participant 9 (transmasculine, age 35) describes personally modifying the Preamble to be gender non-

specific by noting, "Most of the openings, the Preamble says 'men and women' and I hate that. The readings are really gendered – I'll always change it to 'they.'"

TGNC-specific AA subculture. Many TGNC participants indicated the benefits of attending TGNC-specific meetings and building a support network of TGNC people in recovery. Participant 3 (transmasculine, age 29) described their TGNC meeting as a safe space to gather support for their sobriety and gender transition-related needs:

> I guess what I'm saying is that people coming in they just need a place to talk about their transition. There are spaces to talk about being trans but there aren't even that many specific places around. So many people their addictions are intertwined with their gender identity. Their transition.

Similarly, Participant 8 (gender nonconforming, age 42) discussed their TGNC meeting as a safe space to discuss intersecting alcoholic and transgender identity issues:

> I mean the trans meeting is a space where people share not only about their recovery from alcoholism, but also their process of being trans or figuring out their trans identity. In a way, it's more than an AA meeting cause it's not just about alcoholism.

These communications capture the efforts of several participants to disidentify from the majority AA culture, while embracing some of the core components of AA, including the 12-Steps, sponsorship, fellowship, and the use of the "Big Book." Their willingness to challenge some of the dominant norms of AA not only results in beneficial changes at individual and collective levels, but also has ramifications for the larger AA community.

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Integration of TGNC and dominant AA communities

Integration is defined as a process of acculturation that occurs when a new group of individuals come into contact with a host/dominant culture (Sam & Berry, 2010) inciting changes in both groups through cross-cultural adaptations (Ward, Bochner, & Furnham, 2001). Participants noted experiencing positive changes related to sobriety, sober connectivity, and gender affirmation as a result of their AA involvement. Correspondingly, the presence of TGNC people in recovery within AA, regardless of their adaptive strategies, promotes change within the dominant AA culture.

Participant 5 (transmale, age 36) described experiencing changes within his home group members with regards to their understanding and acceptance of his gender identity:

> I went into that room female and now I'm male. They spent a lot of time trying to figure out what to call me. They were all trying to be supportive. It was a home

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> group so we all really care about each other. As I go through the transition process, they're like, 'What's going on here? You're looking a little different.' They're like 'He?' 'She?' They've had to reprogram themselves and that's been a process.

Participant 8 (gender nonconforming, age 42) describes the capacity for experiencing increased understanding and acceptance as a gender nonconforming person within dominant AA spaces, by noting that "…the more straight cisgender meetings I go to, I feel like I bring in a certain amount of anxiety to those meetings when I first go in, but the longer I stay anywhere and share and listen to other people and identify, the more I feel like they see me as me."

Participant 11 (transfemale, age 66) discussed the interplay of AA as a microcosm where shifting societal views on transgenderism are enacted:

> Eventually, you're going to have addicts and alcoholics in their 20's and 30's and they're going to see trans people and not freak out. I can remember the first meeting I went to, we had a meeting on Saturday night in the basement and I walked in presenting as female for the first time, in four-inch heels and a leather skirt and all that, and they were like, 'Seriously?' I was like, 'Yeah, gotta start somewhere.'

Discussion

The responses of the participants in this study provide evidence that: (1) AA is a beneficial tool for building a foundation for sobriety which aids in the gender affirmation process for TGNC adults with SUDs; (2) TGNC adults experience gender identity-based stigma and microaggressions in AA; and (3) TGNC adults in recovery employ adaptive strategies to navigate survival within AA. These findings are supported by a minority stress theory (Meyer, 2003) framework which posits that stigmatic exposures can lead to adverse health and mental health outcomes among TGNC adults (Meyer, 2015; Meyer & Frost, 2013).

In accordance with literature discussing the benefits of AA involvement (Kelly & Hoeppner, 2012; Kelly & White, 2012; Project MATCH Research Group, 1997), participants of this study indicated AA as a useful tool for building a lifestyle of recovery. Furthermore, many of the participants revealed the use of AA as providing them with connectivity to a gender transition-related support system, which is in alignment with assumptions within minority stress theory related to the protective factors of support systems in coping with minority stress (Meyer, 2003). Most of the participants of this study referenced their inability to get sober had they not transitioned, and their corresponding inability to transition had they not become sober through AA involvement. They offered varied reasons for the need for building sobriety prior to transition, including the need for physiological and emotional health and mental clarity to proceed with the transition

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process. In addition, many participants discussed their need to transition as part of their gender identity affirmation process in order to stay sober, noting gender dysphoria as a primary cause of their substance use histories. Furthermore, Participant 1 (transfemale, age 48), Participant 4 (transfemale, age 60), and Participant 11 (transfemale, age 66) reported engaging in gender transition after having over a decade in sobriety and formerly identifying as gay men in AA. While their experiences in AA varied, each echoed the interdependent nature of gender affirmation and sobriety.

Most of the participants experienced stigma and microaggressions within AA, mirroring their regular exposures to gender identity-based minority stressors in society. The participants of this study varied in their extent and duration of gender transition and in their motivations to "pass" or to be visibly transgender or gender nonconforming. The extent to which participants could "pass" or chose to "pass" appeared to correspond with the extent of and distress over experiences with stigma and microaggressions in AA. For example, participants who expressed the least distress over experiences with stigmatic experiences with AA identified as transmale (Participant 5, age 36; Participant 6, age 58). Along with gender identity, age may also be an associating factor, with participants who expressed the most distress over experiences with stigma in AA skewing younger in age (Participant 2, genderqueer, age 29; Participant 3, transmasculine, age 29; Participant 7, transmasculine, age 28; Participant 10, transmale, age 29). Furthermore, alignment with a gender nonconforming identity (i.e., genderqueer, transmasculine) compared with a transgender identity (i.e., transmale, transfemale) appeared to be associated with greater levels of distress over the gender binary components of AA. These findings suggest possible associations between levels of distress with stigma and microaggressions in AA with gender identity, age, and levels of agreement with the gender binary system.

The participants from this study revealed several strategies of coping with stigma and microaggressions experienced in the interpersonal and structural components of AA. These strategies included participants' assimilation into or disidentification from the dominant AA culture. Both strategies entailed continued use of AA but differed in the extent to which participants chose to adopt and integrate into the AA culture, including its cis- and heteronormative components. The core differences between the strategies involved participants who chose to assimilate into the dominant AA culture by adopting its rules and norms without challenge, compared to participants who chose to disidentify from the dominant AA culture and explicitly challenge AA's gender binary components as well as to engage in a separate TGNC AA sub-culture.

Four out of the 11 participants (Participant 1, transfemale, age 48; Participant 4, transfemale, age 60; Participant 5, transmale, age 36; Participant 6, transmale, age 58) described an assimilatory approach to AA

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involvement. Seven of the 11 participants (Participant 2, genderqueer, age 29; Participant 3, transmasculine, age 29; Participant 7, transmasculine, age 28; Participant 8, gender nonconforming, age 42; Participant 9, transmasculine, age 35; Participant 10, transmale, age 29; Participant 11, transfemale, age 66) described a disidentification approach to AA involvement. The use of the two strategies appeared to be associated with gender identity and age, with those assimilating into AA culture being older and with a transgender identity and those disidentifying from AA culture being younger and with a predominantly gender nonconforming identity. It should be noted that the motivations for and actual experience of using adaptive strategies to maintain AA affiliation were unique for each participant. Ultimately, the use of adaptive strategies to negotiate survival in AA enabled the participants to maintain involvement in AA by balancing their unique needs based on their interlocking gender minority and alcoholic identifications, among other factors.

Many of the participants described the process of integration at individual, group, and institutional levels that results from their involvement as TGNC adults in AA. Some of the participants experienced positive interactions with individual cisgender AA members who gained understanding of TGNC issues and supported them through their gender transition process in recovery. Still others expressed feeling marginalized through their transition experiences in AA. Some participants alluded to feeling unwelcome within particular AA groups following their gender transition (e.g., women's meetings for a transmale; gay meetings for a transfemale). Conversely, others indicated examples of group-level changes within specific AA meetings to be more inclusive of its TGNC members (e.g., use of a non-binary alternative to the Preamble; explicit statements specifying that TGNC AA members are welcome).

As an emerging population, the increased visibility of TGNC adults in AA inevitably places pressure on the establishment to change. However, all participants noted AA as being an institution that is slow to change with respects to its programmatic components, literature, policies, and social norms. One participant explicitly highlighted AA as a microcosm of the larger society and indicated that AA will be forced to change when society changes its attitudes, beliefs, and behaviors about TGNC populations. Until then, grassroots efforts to promote greater inclusivity of TGNC individuals within AA, which, itself, is a bottom-up institution, are needed by its members to promote more systemic change.

Recommendations for healthcare providers

A significant concern emerging from these findings relates to evidence that TGNC adults in recovery are experiencing similar forms of gender minority-based stigma in AA that they face in society. Several recommendations are

proposed for substance abuse treatment professionals, social workers, and healthcare providers to provide for greater inclusivity of TGNC adults with SUDs at individual, group, and organizational levels of implementation.

First, substance abuse treatment professionals, social workers, and other healthcare providers should seek or advocate for their agencies to provide them with cultural competency trainings to enhance their preparedness for work with TGNC populations. Second, students within fields of social work, nursing, psychology, and medicine can advocate for cultural competency trainings within their academic institutions in accordance with mandates by organizations within their respective fields that specify that they be adequately prepared for work with TGNC clients (American Counseling Association, 2010; American Nurses Association (ANA), 2015; American Psychological Association, 2015; CSWE, 2015; Institute of Medicine, 2011; NASW, 2012).

Third, service providers are encouraged to regularly reflect upon their own potentially stigmatizing beliefs and attitudes about TGNC individuals, seeking supervision, as necessary, so they may not do unintentional harm on TGNC clients. Fourth, all healthcare providers and AA members can seek to gain awareness, understanding, and acceptance of TGNC populations by involvement with TGNC-affiliated community organizations.

Fifth, AA members may advocate via bottom-up procedures for changes to literature and rules that alienate its TGNC members. Additionally, all providers may use preliminary data from this study to inform the use of 12-Step facilitation with TGNC adults in recovery.

Finally, agencies serving TGNC adults with SUDs can promote greater TGNC inclusivity by eradicating policies and procedures that marginalize TGNC individuals; updating screening and assessment forms and procedures to be trans-affirmative; providing protections for TGNC clients against stigma, microaggressions, and discrimination; and providing staff with sufficient training and supervision for effective work with this high-risk population (Burdge, 2008; Eliason & Hughes, 2004; Lurie, 2005).

Limitations

There were several methodological limitations to this study. The major limitations of the study related to its use of non-probability sampling methods and a small sample that was overrepresented by Caucasian participants which yields an inability to make generalizable statistical inferences from the sample to the population. There were several challenges to recruiting transfemale/transfeminine participants, particularly those from racial/ethnic minorities, potentially due to the heightened anonymity of this population due to multiple intersecting marginalizing identities and their related resistance to AA involvement. Due to the nature of recruitment of participants

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utilizing existing participants, there were limitations with regards to the representativeness of the participants and the potential of oversampling within a particular network of peers. The use of qualitative interviews includes some limitations specific to a reliance on self-report and vulnerability toward social desirability bias. Finally, due to the geographic limitations that prevent generalizability of findings, there will be a need for additional inquiry into how TGNC adults experience AA in less metropolitan locations.

Future directions

TGNC populations are diverse with respects to sexual orientation, race/ethnicity, class, and other factors. The results of the proposed study inform future empirical studies related to how the use of and efficacy of AA involvement is associated with TGNC member's intersecting identifications based on age, class, gender, race/ethnicity, religiosity, sexual orientation, and transition status. Replications of the study are needed in additional geographies to understand the experiences of TGNC adults in AA in other urban, suburban, or rural locations where there may or may not be developed LGBTQ+ and TGNC communities. Furthermore, additional qualitative inquiries should explore the phenomenon of TGNC subculture formations in AA.

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