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Art Therapists' Familiarity with and Beliefs about  
Twelve-Step Addiction Recovery Groups

by David H. Brickhouse, Bachelor of Arts

A Research Project Submitted in Partial  
Fulfillment of the Requirements  
for the Degree of  
Master of Arts  
in the field of Art Therapy Counseling

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May 2, 2024

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## ABSTRACT

### ART THERAPISTS' FAMILIARITY WITH AND BELIEFS ABOUT TWELVE-STEP ADDICTION RECOVERY GROUPS

by

DAVID BRICKHOUSE

Chairperson: Dr. Jayashree George DA, ATR-BC, LMFT

This research proposed to study what art therapists know and believe about twelve-step addiction recovery groups such as Alcoholics Anonymous (AA), Narcotics Anonymous (NA), and Cocaine Anonymous (CA). The aim was to better understand the field's familiarity with 12-step recovery, identify misconceptions about 12-step groups, and assess the comfortability of incorporating 12-step philosophy into clinical practice. Findings include that art therapists integrate 12-step into art making, are likely to refer clients to 12-step groups, and that higher familiarity with 12-step was associated with more positive perceptions and greater integration with clinical practice. The study participants also agreed that accessibility was one of the primary strengths of 12-step recovery and that clinicians' personal involvement in 12-step strongly influences their clinical approaches. Increasing art therapists' familiarity with the benefits, dangers, and nuances of 12-step groups will help them better guide clients through addiction recovery.

*Keywords: Art therapy, 12-step recovery, addiction, clinical practice, attitudes, beliefs, associations*

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## CHAPTER I

### INTRODUCTION

“You’re an atheist, right? I don’t think that’s for you.” This was the extent of my college counselor’s response when I asked if Alcoholics Anonymous (AA) might be helpful for me. I had quit drinking for the first time a couple of weeks previously and was half-heartedly attending counseling sessions in an attempt to stay “sober”. In a couple of months, I would relapse after passing my finals, which was the only real reason I had briefly quit drinking. There would be almost two more years of active addiction and an outpatient rehab program before I would attend my first AA meeting.

I was fortunate enough to attend an outpatient, cognitive behavioral therapy (CBT) treatment program led primarily by counselors, who were also in recovery. They were extremely knowledgeable about peer support groups for addiction recovery, including Refuge Recovery, SMART Recovery, AA, and Narcotics Anonymous (NA). I attended Refuge Recovery (a peer-support group based on Buddhist principles), but there were only a couple of meetings held each week and I felt like I needed more support. AA and NA meetings were more accessible and numerous.

Most of my counselors were active members of either AA or NA, which are both based on a 12-step model. In this research proposal, “12-step groups” are defined as peer-support groups whose primary purpose is to help others recover from substance use disorders by following an adapted version of the twelve steps as they first appeared in the Big Book of Alcoholics Anonymous. They supported me through the process of finding a recovery community and dispelled many of the beliefs I held about 12-step recovery groups. I believed that they were Christian organizations comprised of older people with “real” rock-bottom stories. How could a young atheist with a relatively short addiction career fit into AA or NA?

My counselors became role models for me, and by following their advice, I found AA groups specifically for agnostics/atheists, young people, and LGBTQ+ people. I found my people, worked the twelve steps, and became confident enough to find wisdom and community in “traditional” AA meetings as well. Without the support of counselors familiar with 12-step recovery, it would have taken me much longer to find my place in AA, which is the keystone of my long-term sobriety.

There has been a significant amount of research on the topic of clinician attitudes, beliefs, and knowledge regarding 12-step recovery (Chappel & DuPont, 1999; Dennis et al., 2013; Fenster, 2006; Glassman et al., 2022; Humphreys, 1997; Laudet & White, 2005). Generally, clinicians have positive attitudes towards 12-step programs (Fenster, 2006; Humphreys, 1997; Laudet & White, 2005); however, researchers have identified common misconceptions about 12-step recovery as well as demand for greater clinician familiarity with 12-step groups (Chappel & DuPont, 1999; Laudet & White, 2005). These attitudes, beliefs, and knowledge inform referral practices as well, with specific populations being less likely to be referred to 12-step groups (Humphreys, 1997; Laudet & White, 2005).

Research has also been conducted on Twelve-Step Facilitation (TSF) treatment protocols. In TSF treatment programs, counselors encourage 12-step meeting participation, provide education about 12-step programs, and/or incorporate 12-step philosophy into clinical practice (Dennis et al., 2013; Donovan et al., 2013; Kaskutas et al., 2009; Timko & Debenedetti, 2007; Wells et al., 2014). While there are some variations in treatment outcomes, TSF treatment programs are effective at increasing 12-step group participation and promoting abstinence (Dennis et al., 2013; Donovan et al., 2013; Kaskutas et al., 2009; Timko & Debenedetti, 2007; Wells et al., 2014). These studies have demonstrated that

clinical outcomes improve when clinicians are familiar with 12-step recovery and facilitate involvement with it.

Qualitative studies of former 12-step members have helped to identify the strengths, weaknesses, and nuances of 12-step recovery (Glassman et al., 2022). This type of research is critical for providing clinicians with a picture of 12-step recovery that is not based on cultural stereotypes and assumptions. It also demonstrates how experience within groups can diverge from 12-step philosophy and that there is a great deal of cultural and philosophical diversity within the 12-step community (Glassman et al., 2022).

### **Research Significance**

While the question of clinician familiarity and beliefs about 12-step recovery has been explored within the broader mental health sphere, I have not found any research documenting what art therapists know and believe about 12-step recovery. Some art therapists, like Holt and Kaiser (2009), have developed art therapy protocols intended to facilitate 12-step recovery. While developing these protocols helps expand the art therapy toolbox, it would be important to understand if art therapists would be willing to utilize these types of tools in the first place. Additionally, greater art therapist familiarity with 12-step recovery is likely to yield art therapy protocols that more effectively integrate its philosophy and strengths.

By focusing this type of study on the art therapy profession, it will also be possible to assess whether art therapy pedagogy is sufficiently preparing art therapists to understand and incorporate 12-step recovery into clinical practice. This study could lead to further research exploring how cultural misconceptions of 12-step recovery are linked to imagery (particularly in movies and television) that can be explored with art therapy. Art therapy may

also be particularly useful for concretizing and processing the more abstract concepts of 12-step philosophy such as higher power, acceptance, powerlessness, and spiritual awakening.

My personal experience reflects the research findings that clinician familiarity with 12-step recovery can make a significant difference in the life of a client. In a time of increasing healthcare costs, 12-step groups fill a critical need by providing free addiction treatment throughout a lifetime. They are a powerful yet imperfect resource that art therapists can help clients navigate through. Understanding their nuances and limitations can help a client avoid roadblocks and pitfalls while also finding what is most useful for them.

### **Research Question**

This thesis proposed to answer the following question: How do art therapists' perceptions of 12-step addiction recovery influence treatment practices? This question explored beliefs, values, attitudes, and associations.

### **Definition of Terms**

For this thesis, 12-step groups were defined by their focus on the twelve steps, a suggested series of stages that were formulated by the founders of Alcoholics Anonymous (AA). Members work the steps with a sponsor, another non-professional group member who has already completed the steps at least once, and whose function is to help guide others through the twelve steps. The twelve steps are:

1. We admitted we were powerless over [addictive substance] – that our lives had become unmanageable.
2. Came to believe that a Power greater than ourselves could restore us to sanity.
3. Made a decision to turn our will and our lives over to the care of God as we understood Him.
4. Made a searching and fearless moral inventory of ourselves.

5. Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.
6. Were entirely ready to have God remove all these defects of character.
7. Humbly asked Him to remove our shortcomings.
8. Made a list of all persons we had harmed, and became willing to make amends to them all.
9. Made direct amends to such people wherever possible, except when to do so would injure them or others.
10. Continued to take personal inventory and when were wrong promptly admitted it.
11. Sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of his will for us and the power to carry that out.
12. Having had a spiritual awakening as the result of these Steps, we tried to carry this message to [addicts], and to practice these principles in all our affairs.

*(The Twelve Steps | Alcoholics Anonymous, n.d.)*

It should be noted that there are peer support groups that follow the 12 steps but focus primarily on process addictions (such as binge eating and gambling) or supporting loved ones of addicts. These include Overeaters Anonymous (OA), Gamblers Anonymous (GA), Adult Children of Alcoholics (ACA), Al-Anon, and Codependents Anonymous (CODA). For this thesis, “12-step recovery” will refer specifically to substance addiction recovery and include groups such as AA, NA, Cocaine Anonymous (CA), and Heroin Anonymous (HA).

Professional treatment agencies or clinicians that use the 12 steps listed above will be referred to as “twelve-step facilitation (TSF),” a term that I created. This is an important

distinction because 12-step recovery groups are intentionally non-professional. “Art therapist” will be defined as a person actively working towards or having already obtained a master’s degree in art therapy who regularly uses art therapy in clinical practice. “Clinician” refers to a professional administering counseling or psychotherapy to a client.

Existing literature regarding this and adjacent topics was reviewed before the research methodology was created. The literature review indicated that this research question had been addressed in the broader mental health field, but that it had not yet been focused on the art therapy profession.

## CHAPTER II

### REVIEW OF LITERATURE

To investigate the bilateral relationship between 12-step recovery and clinician characteristics/practices and how this relationship affects treatment outcomes, I searched for relevant literature within three main categories: “12-step recovery,” “Clinical Practice,” and “Treatment Effectiveness.” (see Figure 1). I used the following databases: Academic Search Complete, ERIC, Health Source – Consumer Edition, Health Source: Nursing/Academic Edition, Humanities International Complete, APA PsychArticles, APA Psychinfo, Art Full Text (H.W. Wilson), MEDLINE Complete, CINAHL Plus with Full Text, Cochrane Central Register of Controlled Trials, Cochrane Clinical Answers, Cochrane Database of Systemic Reviews, Cochrane Methodology Register, Social Work Abstracts, and SocINDEX with Full Text. Searches were facilitated by EBSCO, Google Scholar, RefSeek, and the Southern Illinois University Edwardsville Library. Alternate search terms within the aforementioned categories are presented in Table 1.

#### **Figure 1**

*Intersection of Search Terms*



**Table 1***Alternate Search Terms*

| 12-Step Recovery          | Clinical Practice | Treatment Effectiveness |
|---------------------------|-------------------|-------------------------|
| Self Help Groups          | Familiarity       | Outcomes                |
| Alcoholics Anonymous (AA) | Attitudes         | Relapse                 |
| Narcotics Anonymous (NA)  | Beliefs           | Abstinence              |
|                           | Fidelity          |                         |
|                           | Competency        |                         |
|                           | Congruence        |                         |

**Treatment Effectiveness Common Factors**

Clinicians perceived as credible are more likely to influence client change and have favorable treatment outcomes (Dennis et al., 2013). According to Interpersonal Influence Theory, credibility is a product of expertness, trustworthiness, and attractiveness (Dennis et al., 2013). Expertness is influenced by the clinician's knowledge, training, and reputation; trustworthiness is a product of openness, authenticity, and honesty; and attractiveness is created through likability and shared background (Dennis et al., 2013).

***Therapeutic Alliance***

Establishing a strong therapeutic alliance by fostering collaboration early in treatment results in better treatment retention and substance abuse outcomes (Campbell et al., 2015). The converse is also true, early client dissatisfaction is a strong indicator of early dropout (Wells et al., 2014).

It has also been found that measuring and integrating the perceived therapeutic alliance of the client as well as the clinician was a stronger predictor of clinical outcomes in youth addiction treatment than a single perspective was (Van Benthem et al., 2020). The



study found that youth who had high therapeutic alliance ratings from both the client and clinician perspectives “had an eightfold odds of favorable treatment outcome compared with youth with a weak alliance according to both perspectives” (Van Benthem et al., 2020, p. 1593). This study showed that taking both perspectives of alliance into account increased the already strong correlation between therapeutic alliance and treatment outcomes. Like Cambell et al. (2015), this study confirmed that early alliance was a strong predictor of outcomes.

After an extensive literature review, Meier et al. (2005) concluded that establishing an early therapeutic alliance consistently predicted successful outcomes for substance use disorder treatments (p. 313). Successful outcomes included increased retention and engagement in treatment as well as improved drug use (Meier et al., 2005). The literature review also found that more study is needed concerning the factors that form therapeutic relationships (Meier et al., 2005). However, they did preliminarily conclude that “clients’ demographic or diagnostic pre-treatment characteristics, as well as therapist age and gender, do not appear to play an important role in the prediction of the quality of the therapeutic alliance” (Meier et al., 2005, p. 314). Clinician familiarity and membership within 12-step recovery groups may contribute to forming an early therapeutic alliance.

### ***Fidelity***

Campbell et al. found that some dimensions of fidelity were strong indicators of treatment retention and successful outcomes, while others were not. Competency and global empathy (two dimensions of fidelity) are strongly associated with increased treatment retention and decreased drug use (Campbell et al., 2015; Guydish et al., 2014). Interestingly, adherence, another fidelity dimension, has a much weaker association with beneficial outcomes (Campbell et al., 2015; Guydish et al., 2014). This suggests that flexibility when

applying manualized treatment protocols allows clinicians to better attune to the unique needs of clients, improving the alliance and more directly addressing clients' specific needs (Campbell et al., 2015).

### **12-Step Recovery and Treatment Effectiveness**

Belonging to a 12-step addiction recovery group such as Alcoholics Anonymous (AA), Narcotics Anonymous (NA), and Cocaine Anonymous (CA) is a cost-effective way to promote abstinence and reduce relapse in people with substance use disorders (Humphreys & Moos, 2001; Kelly et al., 2020; Laudet & White, 2005; O'Brien & McLellan, 1996; Project MATCH Research Group, 1998; Timko & DeBenedetti, 2007).

Research has also found that 12-step involvement, (i.e. participating in more 12-step activities such as having a sponsor, providing service, and reading 12-step literature) is more strongly correlated with long-term recovery success than meeting attendance (Timko & DeBenedetti, 2007). This suggested that encouragement to actively participate in the specific elements of a 12-step program is likely to produce better clinical outcomes than simply requiring meeting attendance. Kaskutas et al. (2009) echoed the observation, saying "we believe that there are many individuals who attend AA but tend to sit around the edges, arriving late and leaving early and never connecting much with the people in the program" (p. 236).

### ***Beneficial Characteristics of 12-Step Groups***

Outcome studies and qualitative studies of 12-step group members and ex-members have both identified belongingness as a key beneficial element of 12-step groups (Glassman et al., 2022; Timko & DeBenedetti, 2007). Reading 12-step literature and providing service were also found to be strongly associated with improved substance use outcomes (Timko & DeBenedetti, 2007).

Identified through a systematic review of qualitative research, other common change mechanisms are “rock bottom” moments and accepting powerlessness over substances (Glassman et al., 2020). Interviews with ex-members of AA have also identified attractive qualities of AA: a fellowship providing comfort, motivation, acceptance, support, and love; an open-ended, personalized definition of “higher power”; problem drinking conceptualized as a symptom of deeper problems; and a disease model of addiction that reduces shame about past behavior (Glassman et al., 2022).

### ***Detrimental Characteristics of 12-step Groups***

While 12-step recovery has empirical evidence to support its efficacy, it also has limitations and potentially damaging characteristics. In a qualitative interview study of ex-members of AA, the following detrimental experiences were reported: cult-like indoctrination; internalizing fear-based messages; loss of personal identity and autonomy; various degrees of social control; damaging relationships with domineering sponsors; notion of powerlessness damaging self-esteem and sense of agency; religiosity in meetings; victim-blaming during personal inventories; restricted life outside of AA; dangerous, authoritative medical instructions; and inadequate protection of vulnerable members against predators (Glassman et al., 2022).

The Alcoholics Anonymous General Service Office has published a “Safety Card,” which is read at meetings and openly addresses the personal safety concerns raised by the ex-members in the Glassman et al. (2022) study. Amongst other points, it says:

- Anonymity in A.A. is not a cloak for unsafe and illegal behavior. Addressing such behavior and/or contacting the proper authorities when appropriate, does not go against any A.A. traditions and is meant to ensure the safety of all in attendance.

- Predatory behaviors and unwanted sexual advances are in conflict with carrying the A.A. message of recovery and with A.A. principles.
- A.A. does not provide medical advice or detox services; it has no opinion on outside issues, including medication. Medical advice should come from a qualified physician.

*(Safety Card for A.A. Groups, 2022)*

Glassman et al. (2022) found “a disparity between the idealistic principles of AA and the actual experiences of the participants” (p. 411). For example, according to AA literature, atheists and agnostics are welcome and encouraged to find a non-theistic higher power that works for them (“We Agnostics,” 2002). Despite this, many meetings are overtly religious and atheists may be uncomfortable with the spiritual emphasis of the 12-steps (Humphreys, 1997).

While agnostics, atheists, and non-Christians may struggle to find acceptance in more overtly Christian meetings, there are alternative resources available. There are intentionally secular AA meetings, such as my home group, “We Agnostics,” which encourages atheists, agnostics, and religious people to “express any doubts or disbeliefs they may have, and to share their own personal form of spiritual experience, their search for it, or their rejection of it” (*Agnostic AA Preamble*, n.d.). Alcoholics Anonymous has also published a pamphlet containing ten stories by atheist/agnostic AA members to reemphasize that AA is a non-religious organization and to demonstrate how 12-step recovery is useful to non-believers (*The “God” Word: Agnostic and Atheist Members in A.A.*, 2018).

There are also unofficial (as in non-approved by the Alcoholics Anonymous general conference) secular 12-step resources that specific members, meetings, or sponsors may choose to use. Because of its decentralized structure, AA meetings are free to use unofficial

12-step literature. AA Agnostica is an organization created by atheist/agnostic AA members that has published stories of atheists/agnostics in AA as well as seventeen alternative versions of the 12 steps (*AA Agnostica*, n.d.).

### **12-Step Recovery and Clinical Practice**

Twelve-step facilitation (TSF) treatment is an evidence-based therapy practice in which qualified clinicians incorporate 12-step principles into treatment and/or facilitate involvement in 12-step groups (Dennis et al., 2013; Kaskutas et al., 2009). A variety of TSF interventions have been developed.

Timko & Debenneti (2007) developed an Intensive Referral Program (IRP) intervention in which counselors would provide an introduction to 12-step principles and information, connect clients with 12-step members who would accompany them to meetings, review client concerns, and encourage involvement. They found that this intervention increased 12-step involvement, a predictor of treatment success (Timko & Debenedetti, 2007). A similar intervention was developed from the Intensive Referral Program and applied to stimulant users, resulting in the manualized Stimulant Abuser Groups to Engage in 12-Step (STAGE-12) intervention (Donovan et al., 2013). It was found that STAGE-12 increased 12-step involvement and that the “dose” of STAGE-12 was positively correlated with 12-step participation (Donovan et al., 2013; Wells et al., 2014).

Making Alcoholics Anonymous Easier (MAAEZ) is a TSF intended to “kick-start” recovery by helping clients interact with members of AA and NA (Kaskutas et al., 2009). Like STAGE-12 and IRP, it encourages interaction with active members but is also facilitated by a counselor who is an active member of AA, NA, or CA and addresses the topics of spirituality, myths about AA, types of meetings, sponsorship, and practical living advice (Kaskutas et al., 2009).

### ***Twelve-Step Facilitation (TSF) Treatment Effectiveness***

A variety of TSF interventions, including Intensive Referral Program (IRP), Stimulant Abuser Groups to Engage in 12-Step (STAGE-12), and Making Alcoholics Anonymous Easier (MAAEZ), have empirical evidence supporting their effectiveness in addiction treatment (Donovan et al., 2013; Kaskutas et al., 2009; Timko & DeBenedetti, 2007; Wells et al., 2014). The IRP and STAGE-12 interventions were associated with higher rates of abstinence and 12-step meeting attendance and involvement (Timko & DeBenedetti, 2007; Wells et al., 2014).

MAAEZ participation increased overall abstinence rates and the participants who attended all six sessions achieved an exceptional abstinence rate of 92% (Kaskutas et al., 2009). Additionally, MAAEZ is effective at increasing abstinence rates in subgroups that have historically been less responsive to TSF interventions: single people, people with severe psychiatric diagnoses, atheists, agnostics, people with more treatment history, and people with more AA exposure (Kaskutas et al., 2009).

### **12-Step Recovery and Art Therapy**

Holt & Kaiser (2009) developed a series of art therapy interventions designed to help clients work through the first of the 12 steps. They provided artwork examples from clients for each prompt as well as general statements about their experiences. Their approach utilizes techniques and theory from Motivational Interviewing and the Stages of Change model (Holt & Kaiser, 2009). They diverged from Horay (2006), an art therapist who believed that Motivational Interviewing was not compatible with a 12-step approach (Holt & Kaiser, 2009). Holt & Kaiser (2009) concluded that “the very action of creating artwork catalyzes internal and external processes linked to interpersonal connection that can enhance motivation, a key factor in generating lasting change” (p. 250).

Krebs (2008) studied how art therapy interventions could be used to enhance steps one, two, and three of the 12 steps. This study occurred within group settings ranging between four and twenty participants for twelve sessions. Participants created a collage, drawing, clay sculpture, and painting about each of the first three steps. While only 40% of the participants reported that the art-making increased their understanding of the first three steps, many reported that it assisted them with locating their personal progress within each step (Krebs, 2008). Art-making also aided discussions about appropriate expressions of emotions and the shame associated with addiction.

Similarly, Julliard (1995) concluded that a combination of art therapy collage-making and role play helped increase client belief in the first three steps. While the mean belief-in-step-one scores were not statistically significant between the pre and post-tests, Julliard (1995) found that there was an overall increase among the six group members in the study and particularly high increases with some of them.

Twelve-step-based art therapy interventions have also been applied at the public health level. Lorenz et al. (2022) found that briefly training a variety of healthcare professionals in “Literacy-Free 12 Step Expressive Art Therapy” impacted change variables amongst Zambian people with substance use disorders. While the art therapy interventions were not administered by trained art therapists, clients reported increased motivation to change, increased openness to participation, and decreased rates of using alcohol, cannabis, inhalants, and cigarettes (Lorenz et al., 2022). Additionally, the two-day training increased the healthcare professionals’ belief in the importance of addiction treatment; however, it did not decrease the stigma they felt toward substance users (Lorenz et al., 2022).

### **Clinician Familiarity with 12-Step Groups**

Familiarity with 12-step recovery has been shown to influence perceived clinician credibility and is influenced by factors such as clinician recovery status and agency treatment orientation (Dennis et al., 2013; Fenster, 2006). Clinicians in recovery are expected to have greater familiarity with 12-step groups and are perceived as being more credible than clinicians not in recovery (Dennis et al., 2013). Treatment agencies that are 12-step oriented are more likely to employ clinicians in recovery and are also more likely to refer clients to 12-step groups at the expense of alternative addiction self-help groups (Fenster, 2006; Glassman et al., 2022; Humphreys, 1997).

There are mixed opinions regarding familiarity, and therefore fidelity, in practice. Fenster (2006) identified an overfamiliarity with 12-step recovery, such that alternative aftercare treatment options are ignored at the client's expense. On the other hand, Laudet & White (2005) believed that there is a critical lack of clinician 12-step knowledge and that there is a demand to fill this gap. They also identified a phenomenon in which clinicians believe they are more familiar with 12-step recovery than they actually are (Laudet & White, 2005). Clinicians may be surrounded by 12-step "lore" but unfamiliar with its interpretation within 12-step practice, leading to widespread misunderstandings (Chappel & DuPont, 1999; Laudet & White, 2005).

### ***Clinician Attitudes and Beliefs About 12-Step Groups***

Overall, clinicians generally have positive perceptions of 12-step recovery and its effectiveness, resulting in high referral rates (Fenster, 2006; Humphreys, 1997; Laudet & White, 2005). However, negative attitudes and beliefs about 12-step groups are widespread among clinicians. Some of the most widely-held negative beliefs about 12-step groups are that: they are too intense for some people; people can become dependent upon them; they



lack professionalism and empirical evidence of effectiveness; members spread bad advice; they are only useful in early recovery; they are limited to only one substance; and they are religious (Chappel & DuPont, 1999; Laudet & White, 2005).

These negative perceptions are similar to those expressed by ex-AA members in the interviews conducted by Glassman et al (2022). Clinician concern about dependency on 12-step groups mirrors the ex-AA members' statements about cult-like indoctrination and reductions in life outside of AA (Glassman et al., 2022). Ex-members also noted concerns about a lack of professionalism and bad advice-giving, particularly concerning instructions about taking doctor-prescribed medications (Glassman et al., 2022). Religiosity in meetings also appears to be a common concern among professionals and ex-members (Chappel & DuPont, 1999; Glassman et al., 2022; Laudet & White, 2005).

Clinicians also hold beliefs about how client characteristics are likely to affect their success with 12-step groups. Clinicians are more likely to refer clients to 12-step groups if they are “unemployed, older than 65, homeless, and newly diagnosed, and having attended NA or AA in the past” (Humphreys, 1997, p. 1447). If a client is an atheist, less religious, has milder substance abuse problems, or has comorbid psychiatric conditions, then they are less likely to be referred to 12-step groups (Humphreys, 1997; Laudet & White, 2005).

Finally, clinicians believe that 12-step meetings are widely available (Fenster, 2006), so even if they hold negative attitudes towards 12-step groups, they may still refer clients to “the only game in town” (Humphreys, 1997, p. 1448).

### **12-Step and Trauma**

In her book, *Trauma and the 12 Steps*, Jamie Marich (2020), discussed how 12-step practices can be more trauma-informed by encouraging flexibility, emotional safety, and respect for past experiences. She also outlined how some steps, particularly four and five, can

be very useful for people to process and make sense of their trauma, but only if it occurs within the context of safety (Marich, 2020). She examined how 12-step recovery has pioneered practices that are now considered mainstream in psychotherapy, including narrative-style practices and radical acceptance (Marich, 2020).

Marich is an active 12-step member as well as a therapist and has observed how many therapists criticize or completely write off 12-step as a meaningful treatment approach. She called on the psychotherapy profession to become more informed about the nuances and flexibility of 12-step practice to understand how it can be integrated into trauma therapy (Marich, 2020). She believed that therapists can play a vital role in the “proper guidance” (Marich, 2020, p. 85) that is required to work the 12 steps in a way that is meaningful and avoids harm.

In his groundbreaking book on the traumatic roots of addiction, *In the Realm of Hungry Ghosts*, Dr. Gabor Maté (2010) reflected on his personal experience of attending AA meetings to address his compulsive shopping addiction. Maté expressed warm feelings towards the meetings he attended and found that its members were welcoming, insightful, and admirable (Maté & Levine, 2010).

## **Conclusion**

There is literature to demonstrate that treatment outcomes improve when clinicians include 12-step information in sessions, demonstrate familiarity with 12-step principles, take active steps to ease the referral process (like contacting active members), avoid assuming who can/cannot benefit from 12-step groups based on criteria like religiosity, and favor building therapeutic alliance and 12-step competency over strict adherence to treatment manuals (Campbell et al., 2015; Dennis et al., 2013; Laudet & White, 2005). Existing literature has also documented common misconceptions and negative perceptions of 12-step

recovery that are present among mental health clinicians despite generally favorable attitudes (Chappel & DuPont, 1999; Fenster, 2006; Humphreys, 1997; Laudet & White, 2005).

Finally, trauma-focused clinicians have written about the intersections and compatibility of 12-step recovery and trauma-based treatment (Marich, 2020; Maté & Levine, 2010).

### CHAPTER III

#### METHODOLOGY

This research proposed to answer the following question: How do art therapists' perceptions of 12-step addiction recovery influence treatment practices? I explored this question using a qualitative research design that gathered data through in-depth, semi-structured interviews and that followed a constructivist paradigm (Leavy, 2017). Qualitative research uses inductive designs to explore and/or describe a topic by producing rich, subjective data to generate meaning (Leavy, 2017). This type of study was well suited to study the research question because of its focus on the subjective perceptions of 12-step recovery. Most research on this subject has been quantitative, survey-based, and focused on the broader population of mental health professionals. This method provided a deeper well of information on how the art therapy field interacts with the 12-step world.

I used the in-depth interview methodology because I believed it was the best way to explore the research question at a deep level with art therapists. In-depth interviews relied on conversation as the primary exploration tool and occurred one-on-one between the researcher and a single participant (Leavy, 2017). Rapport building, active listening, and open-ended questions/probes elicited information from the participants while also giving them the freedom to provide detailed responses and guide the conversation (Leavy, 2017).

I used a semi-structured format that followed general lines of inquiry without being completely open-ended or limited to a script of predetermined questions (Leavy, 2017). Because this was my first time interviewing in this way, I created an interview guide to help me stay on track and keep the conversation flowing when I become stuck (Leavy, 2017). My questions were open-ended, and non-directive, and became more specific as the interview progressed (Flick, 1998; Roberts, 2020). I followed Robert's (2020) guide on constructing

interviews, which included an orienting question, main questions, follow-up questions, and probes.

Not all follow-up questions were asked to each participant and some questions were improvised in the moment. This was done to deepen and follow the lines of inquiry in accordance with semi-structured interviewing. Additionally, not all participants directly answered or correctly interpreted each question. Participants also provided answers at different points in the interview, so I grouped similar answers even if they were not responding to the same question.

I followed a constructivist paradigm because it values multiple meanings and subjective experiences (Leavy, 2017). Art therapists' daily interactions with their clients, other clinicians, 12-step recovery groups, the broader culture, and media constructed and reconstructed their perceptions of 12-step addiction recovery (Leavy, 2017). The constructivist paradigm allowed me to explore and interpret how meaning was generated and how it may influence clinical practice.

## **Population**

### ***Selection***

I defined an art therapist as a person who has obtained a master's degree in art therapy and who regularly uses art therapy in clinical practice. The selection criteria were:

1. The participant has worked as an art therapist in a clinical setting for at least one year.
2. Participant currently works or has previously worked with adult (18 years or older) and/or adolescent clients.

3. Participant has included substance use disorder treatment in at least one client's treatment plan and/or has referred at least one client to addiction treatment services while continuing to work with them.
4. Participant has encountered 12-step recovery in their personal and/or professional lives and is generally familiar with its structure and tenets.

### ***Sampling***

I used purposeful sampling to find research participants because I wanted to include art therapists who worked in the addiction treatment field, as well as a few who worked in related fields (such as psychiatric, trauma, dual-diagnosis, and eating disorder) that may have had some familiarity with 12-step recovery. This common familiarity among the subjects qualified this as homogenous sampling (Leavy, 2017). The benefit of purposeful sampling was that it allowed me to choose information-rich subjects from my population of interest, art therapists (Leavy, 2017).

### ***Attribute Coding***

Attribute coding captured the basic demographic information of interest for each of the five research participants. The participants in this study are all female identifying and use the pronouns she/her. None of them are currently affiliated with an organized religion, however, all of them (except for Patty) identify as spiritual. The sample is also predominantly white, with Patty being the only person of color. Additionally, all of them are middle-aged or older with a mean of 53.6 years. While there is low diversity in terms of age, gender, and race, this does accurately reflect the overall demographics of art therapists in the United States (Elkins & Deaver, 2015). Table 3 shows the results of attribute coding.

**Table 2***Attribute Coding- Participant Demographics*

| Name                     | Judy      | Darla     | Susie     | Megan     | Patty     |
|--------------------------|-----------|-----------|-----------|-----------|-----------|
| Years in Field           | 11        | 35        | 28        | 2         | 17        |
| Age                      | 36        | 70        | 53        | 68        | 41        |
| Gender                   | Female    | Female    | Female    | Female    | Female    |
| Race                     | White     | White     | White     | White     | Hispanic  |
| Religious<br>Affiliation | None      | None      | None      | None      | None      |
| Geographic<br>Region     | Northeast | Southeast | Southeast | Southwest | Northeast |
| Population<br>Density    | Urban     | Urban     | Suburban  | Rural     | Rural     |

This group consists of mostly experienced practitioners. Four of them range in experience between 11 and 35 years and one with 2 years of experience. They primarily live in the Eastern United States, with only Megan currently residing in the Southwest. However, some have moved to different regions throughout their careers. Susie recently moved to the Southeast, but she has a significant amount of experience practicing in the Midwest. Patty currently lives in the Northeast but most of her clinical experience occurred in the Southeast. They are also evenly distributed across urban, suburban, and rural areas.

There was additional demographic information that was volunteered. Judy, Darla, and Patty are all currently teaching art therapy courses at different, graduate-level art therapy training programs. This is significant because it means that their beliefs and attitudes have

influenced and are continuing to influence emerging art therapists. This adds weight to the results of this research.

Finally, none of the participants identified as addicts, alcoholics, or people in recovery from substance use disorders. However, one participant, Susie, volunteered that she is an active member of a 12-step group, Codependents Anonymous (CODA). While this study focuses on substance addiction groups, Susie's experience in CODA has been extremely influential in her clinical approach to substance addiction.

### ***Recruitment***

Recruitment occurred by posting a recruitment poster to the MyAATA Community forum, an online forum for members of the American Art Therapy Association (AATA). Participants were offered a \$100.00 incentive to participate in the study. Recruitment continued until five art therapists who met the selection criteria agreed to participate in the study. Because there was a high degree of interest in participating in the study, the first five participants were selected within a few days and a secondary "waitlist" was created for additional, potential candidates. One of the first five participants dropped out of the study before the interview, so one participant was pulled from the waitlist to take part in the study.

### **Researcher Stance**

Because I was operating under a constructivist paradigm, the knowledge that answered the research questions was co-constructed through my interaction with the interviewees (Roberts, 2020). Therefore, it was important to consider my attitudes and biases regarding 12-step recovery (Roberts, 2020). Since I am an active member of a 12-step group, I attempted to bracket my own experiences to obtain authentic stories about how the interviewees felt about 12-step recovery, their experiences with it, and how it informed their clinical practice. I did this by constructing neutral interview questions, noticing, and



documenting my responses within the transcripts as a way of accounting for them as they occurred, and discussing bias concerns with my research chairperson, Dr. Jayashree George. I used analytic memo writing and to process and interpret recurring themes in my countertransference (Saldaña, 2013).

### **Procedure and Tools**

I created an interview guide that consisted of an orienting question followed by main questions and optional follow-up questions. The orienting question laid out the expectations for the interview while also conveying respect for the interviewee's experience and knowledge (Roberts, 2020). The orienting question was "How did you learn about 12-step addiction recovery? I want to explore what you believe and feel about 12-step, substance addiction recovery groups like Alcoholics Anonymous (AA), Narcotics Anonymous (NA), and Heroin Anonymous (HA). This could include what you know about these groups, how you know it, and what you associate with them. I would also like to learn about your clinical experience and what role 12-step recovery may or may not play in your approach with clients. Will you help me better understand this subject by sharing your expertise?"

The main (or open) questions reflected the primary components of my research question while also being broad enough for the participants to express what they believed to be important (Flick, 1998; Roberts, 2020). Follow-up questions helped me and the interviewee more deeply explore the specific dimensions of the answers elicited by the main questions (Roberts, 2020). Unlike the main questions, the follow-up questions were optional and dependent upon the direction in which the interview proceeded. I used Flick's (1998) description of semi-standardized interviewing to incorporate a theory-driven structure into my follow-up questions. My initial interview guide appears in Table 2.

**Table 3***Interview guide*

| Main (open) Questions   | Follow-up Questions  |
|---|--|
| <p>Could you describe what you know about 12-step addiction recovery groups?</p>                        | <p>How did you learn about 12-step recovery groups?</p> <p>Where there any particularly useful or trustworthy sources of information?</p> <p>Did you encounter any false or unreliable information?</p>                                    |
| <p>When you think and talk about 12-step addiction recovery, what feelings emerge?</p>                  | <p>What emotions/sensations do you experience while regarding this subject?</p> <p>How intense are these emotions/sensations?</p> <p>Where are these emotions/sensations occurring in your body?</p>                                       |
| <p>As you are talking about 12-step groups, what images and/or words come to mind?</p>                  | <p>Where do you think these images or words come from?</p> <p>How might these images/words influence your opinions about 12-step recovery?</p>   |
| <p>In what ways do 12-step ideas or philosophy influence (or not influence) your work with clients?</p> | <p>Can you tell me about clients that have been involved in 12-step groups?</p> <p>What have your clients experienced in 12-step recovery?</p> <p>Can you tell me about therapeutic interventions that incorporate 12-step principles?</p> |
| <p>What do you believe about the effectiveness of 12-step addiction recovery?</p>                       | <p>What are the pros and cons of utilizing 12-step recovery?</p>   |

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Do you refer your clients to 12-step recovery groups?

What characteristics about a client might you consider before referring them to a 12-step group?

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I conducted all of my interviews over Zoom because I recruited participants nationwide. Each interview was approximately 60 minutes in length. I recorded the Zoom interviews and used the closed captioning tool to generate rough transcripts. The transcripts were corrected and formatted by hand and my responses to interview moments were captured in margin comments.

### **Analysis**

I began correcting and formatting interview transcripts as they were generated and then proceeded to coding analysis. According to Saldaña (2013), a code is “most often a word or short phrase that symbolically assigns a summative, salient, essence-capturing, and/or evocative attribute for a portion of language-based or visual data” (p. 3). The process of coding allowed me to distill the data captured through the interviews into categories and subcategories (Saldaña, 2013) and keep track of how the codes are emerging. I stayed open to emerging themes and how the research question was being answered. The major codes were then compared and integrated to create themes, which will then be used to create the assertions or theories that answer my research question (Saldaña, 2013).

To prepare the transcripts for coding, I made manual corrections to the rough transcripts and divided them into stanzas according to natural shifts in topic (Saldaña, 2013). I also “pre-coded” (Saldaña, 2013, p. 19) by highlighting significant moments from the interviews and making margin notes of my initial impressions.

During the coding process, I wrote analytic memos to capture my interactions with the participants and the data. This practice helped me think more deeply about the research content and generate ideas that became useful to the meaning-making process (Saldaña, 2013). It also helped me capture my personal experiences, biases, and countertransference.

In my first cycle of coding, I used attribute coding to capture the basic demographic information of the participants, as well as the setting, time, and format of each interview (Saldaña, 2013). This information was valuable for capturing the context for each participant and understanding how this potentially affected the data they provided. For example, therapists living in more rural areas, where there was lower diversity in types of 12-step meetings, were likely to have different perceptions of 12-step recovery in comparison to therapists living in suburban and urban areas, which had greater diversity.

Next, I performed structural coding to summarize and organize the answers to the main interview questions. Structural coding assigned a phrase to the data that directly answered the interview questions and was useful for creating a list of the major themes or topics (Saldaña, 2013). This broad coding technique helped me compare how the different participants answered the same interview questions and determine if there were common or divergent responses.

The last procedure I utilized in the first coding cycle was values coding. This technique applied codes that identify the values, attitudes, beliefs, and associations expressed by the interviewees (Saldaña, 2013). Values, attitudes, beliefs, and associations were components of a person's perceptions, which was what I aimed to study. Values coding helped me unpack what art therapists value about 12-step recovery, their attitudes towards it, and what they believe about it.

Values coding was the most in-depth process and was used to extract emergent themes. 995 unique codes were applied 1926 times to the five transcripts. The codes were designated as attitudes, beliefs, values, and associations. Attitude codes captured how the participants felt about something, namely their personal and professional feelings. Value codes captured the importance that the participants assigned to things and included personal values as well as professional practices and theories. Belief codes contained elements of values and attitudes with the addition of knowledge, experiences, and assessments of effectiveness. Saldana (2013) conceptualized beliefs as rules or working assumptions for engaging with the world. Association codes captured specific images and words that came to mind for participants during the interview. See Appendix A for an example of value coding within a transcript page.

During the second coding cycle, I used pattern coding to identify emergent themes from the interviews. Saldaña (2013) described pattern coding as “explanatory or inferential codes ... a sort of meta-code ... a way of grouping those summaries into a smaller number of sets, themes, or constructs” (p. 210). I looked for themes that connected art therapists’ perceptions of 12-step recovery to their clinical practices. This helped me discover how clinicians’ values, attitudes, and beliefs influence their treatment decisions. I asked my thesis chairperson, Dr. Jayashree George to review two transcripts and offer side comments to increase the level of accountability and objectivity in this qualitative study.

Codes were compiled and quantified to determine which were most frequently assigned to each transcript. Other codes that appeared less frequently but that appeared during significant moments in the interview were underlined. The codes were then compiled into the emergent themes of this study. Table 5 outlined the emergent themes and the main codes from which they were generated. This table only captures a small portion of the codes

used to create each theme and omits association codes because they were not as numerous or relevant for generating the themes. See Appendix B for an example of a spreadsheet used to compile value codes into a theme.

## CHAPTER IV

### RESULTS

In this section, I will present the results of this study. I will begin with the results of structural coding, which captured the explicit ways in which the research participants answered the interview questions. Then I will present the emergent themes that were discovered through values coding, which captured the explicit and implicit attitudes, beliefs, values, and associations of the participants.

#### **Structural Coding**

The results of structural coding were compiled and grouped into five main themes: familiarity with 12-step, feelings about 12-step, associations with 12-step, 12-step and in clinical practice, and 12-step effectiveness. The codes for each of these main themes appear on the next page in Table 4.

#### ***Familiarity with 12-Step***

Participants provided disparate answers that usually focused on their personal/professional experiences with 12-step. This section is divided into proficient, moderate, and minimal familiarity.

**Proficient Familiarity.** The subjects most familiar with 12-step, Judy and Susie, demonstrated their broad knowledge and deep understanding of this theme. Judy identified a range of 12-step fellowships, including Alcoholics Anonymous (AA), Narcotics Anonymous (NA), Heroin Anonymous (HA), Gamblers Anonymous (GA), Cocaine Anonymous (CA), Marijuana Anonymous (MA), and Overeaters Anonymous (OA), and understood their common origin in the 12 steps. She was also familiar with a variety of meeting formats, including online meetings, Big Book study meetings, speaker meetings, candlelight meetings, women's meetings, and newcomer meetings.

**Table 4***Structural Themes and Codes*

| Themes                       | Codes  |
|------------------------------|--|
| Familiarity with 12-step     | General beliefs/knowledge<br>Sources of knowledge<br>Reliable/useful sources<br>False information              |
| Feelings about 12-step       | Emotions<br>Emotional intensity<br>Somatic experience  |
| Associations with 12-step    | Images and words<br>Association origins<br>Association impacts   |
| 12-step in Clinical Practice | Impact on clinical practice<br>Sharing experiences<br>Case examples<br>Art interventions<br>Referral practices |
| 12-step Effectiveness        | Assessment of effectiveness<br>Pros<br>Cons  |

Judy also demonstrated familiarity with local meetings and an understanding of how meeting culture varies within her community. Some AA meetings in her area require



identification “as an alcoholic,” even for narcotic users. She also acknowledged that acceptance of medication-assisted treatment (MAT), such as suboxone, sublocade, and vivitrol, varies with her local meetings.

Judy felt like she has “always known [12-step was] around,” (p. 2, line 30) and that it was openly talked about while growing up. She became more knowledgeable about it through her undergraduate and graduate training as she decided to pursue a career in addiction counseling. She has also visited AA and NA meetings, which has shaped her knowledge regarding the atmosphere of 12-step meetings.

Susie stated that her familiarity with 12-step recovery started as personal and became more professional in her forties and fifties. She has attended CODA and Al-Anon as an active member and is close friends with a colleague who has been in addiction recovery for 40 years. She has also visited AA, NA, and GA. Her familiarity was not as broad as Judy’s, but it was deeper. She credited Dr. Alan Berger for her “nutshell of all nutshells” belief that 12-step recovery works because it “helps people recover their authentic voice.” (p. 4, lines 22-28) She was the only participant to credit and quote the Big Book of Alcoholics Anonymous, namely p. 417 on acceptance. She also cited women’s 12-step literature and understood the significance of working the steps in order, stating “some of my young folks in early recovery say ‘well, I’m just gonna start on step four’...but then I say, ‘have you heard that the steps were designed in a certain fashion, to work them in succession, has anyone mentioned that?’” (p. 13, lines 10-15).

Her familiarity was also evidenced throughout the interview by her use of 12-step words and phrases such as “a blueprint for living” (p. 22, line 36). Also, many of her beliefs regarding willingness, acceptance, and spirituality are directly aligned with 12-step philosophy. Her knowledge of 12-step and multicultural spirituality seems the strongest of all

the participants because she has facilitated spirituality groups in recovery settings. Susie also understood common myths about 12-step, including that it is overtly religious, that it is the “one way,” (p. 7, line 29), and that “[it] didn’t work for them. It’s not gonna work for me.” (p. 8, lines 23-24)

**Moderate Familiarity.** Megan and Patty were both moderately familiar with 12-step addiction recovery. Megan has the least amount of experience in the art therapy field and was still actively learning about 12-step recovery because she recently joined a treatment center that offers 12-step facilitation. She correctly identified that 12-step recovery has an open definition of higher power and that it is rooted in a spiritual foundation. She was primarily familiar with NA and online meetings and had not heard of Heroin Anonymous (HA) before. Megan has not visited a 12-step meeting before, although her colleagues have encouraged her to do so. She also identified a large range of information sources, including colleagues, clients, video documentaries, books, meditations, online American Art Therapy Association (AATA) continuing education units, and recovery personalities like Russell Brand.

Patty was primarily familiar with 12-step in the context of facilitating groups that combined DBT and 12-step at a state hospital. These groups included check-ins, psychoeducation, and open discussion and were facilitated by two therapists. Patty also attempted to replicate the non-hierarchical power structure and accessibility of 12-step in the hospital groups. She has visited 12-step meetings in the community as a graduate school requirement. This taught her how to find meetings and understand if they are open (visitors can attend) or closed (only identifying alcoholics/addicts can attend). Patty also understood the accessibility of 12-step meetings, that they are ongoing, low-to-no cost, open to people in pre-contemplation, and a way to join a community.

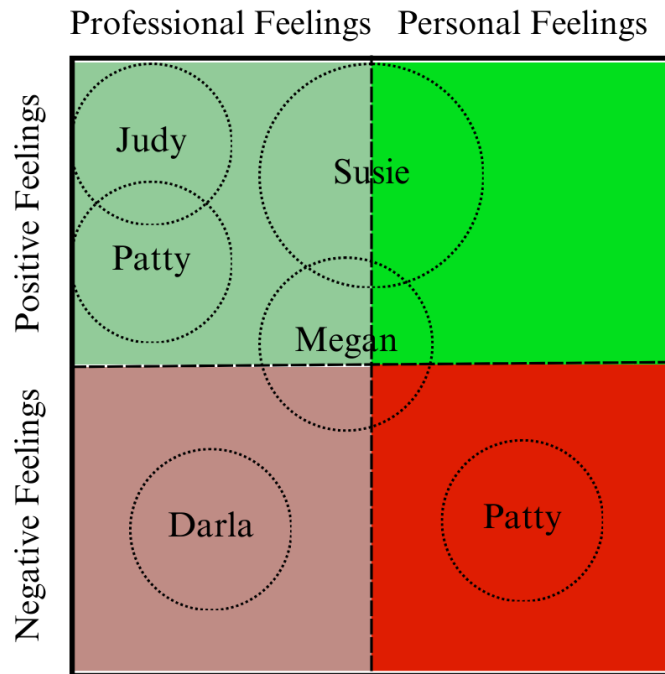
**Minimal Familiarity.** Darla was the least familiar with 12-step. Her experience with it was primarily in the 1980-90s at a 12-step treatment center and then for about a year in 2015. She expressed confidence in being familiar with the 12-step model and believed that her familiarity came from being around it (ie. in the milieu) in the treatment center, although she did not directly utilize it in her practice. Darla stated that she has visited 12-step meetings but did not elaborate on what she learned from them. She brought a print-out of the 12 steps to the interview and would occasionally stop to review it because it had been a while since she had engaged with it. She also could not recall specific sources of 12-step information and offered her assessment of its effectiveness instead. As the interview proceeded, she was able to recall more of her thoughts and feelings.

### *Feelings About 12-Step*

Most of the participants did not disclose feeling strong emotions while talking about 12-step recovery, however, Susie was the outlier in her responses. She immediately identified strong feeling words about 12-step recovery and did not make a distinction between personal and professional feelings. This is represented by her position in Figure 2, which depicts how the participants' positive and negative feelings towards 12-step show up within their personal and professional lives. She identified intense feelings of encouragement, enthusiasm, and hope. As she talked, her voice broke and she became teary-eyed while remaining focused and energetic. She quoted Anne Lamott's work regarding hope beginning in the dark and expressed feeling privileged to walk alongside others toward a better life. She also identified somatic sensations, saying that she felt warmth grow in her upper belly and throat. Susie stated that the interview process heightened her emotions because it felt affirming to articulate the things that move her and because she felt like I was emotionally receptive and attuned.

**Figure 2**

*Matrix of Participants' Feelings Toward 12-step within Personal and Professional Roles*



Judy reported that her personal feelings reflected how well 12-step worked for her clients and could not initially identify them. After further discussion, she identified feelings of openness and gratitude for 12-step which were “7 out of 10” (p. 6, line 17) in intensity. She felt “really great about it,” (p. 6, line 18) but also acknowledged that her feelings would be more intense if more of her clients engaged with 12-step.

In a similar vein, Darla stated that she did not have strong, personal emotions about 12-step recovery. She also separated her personal and professional feelings about the subject by saying that she felt that 12-steps “[is] not enough.” (p. 7, line 32) She did state that she felt passionate about working with the recovery population, but again, did not feel a strong connection to 12-step recovery.

Megan also seemed to have a more professional, removed response to these questions by saying that she felt curious about 12-step. She later stated that her curiosity had grown as the interview progressed. Megan was contemplating applying the 12 steps to her personal life and felt positively about the concepts of surrender, connection to inner-self, and an empowering, interchangeable higher power. Again, her responses reflected her active learning on the subject.

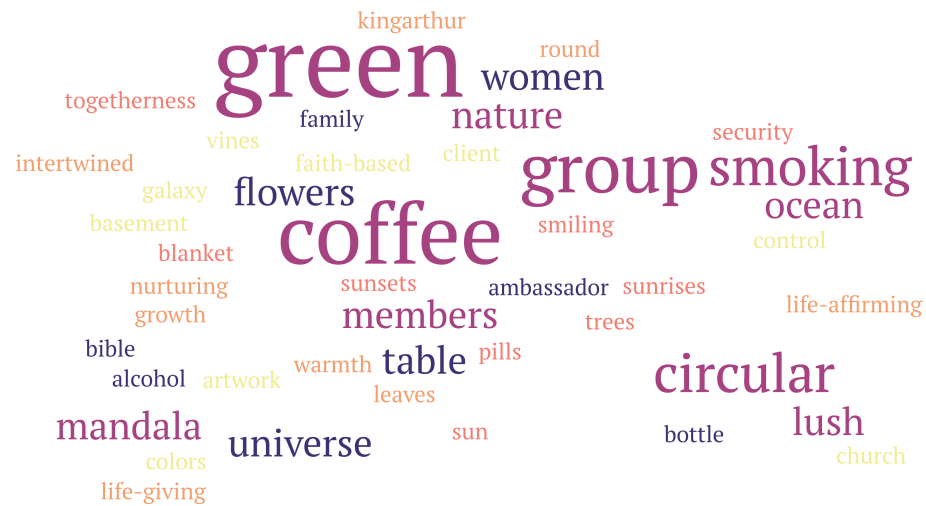
Patty also separated personal and professional feelings but expressed negative, personal feelings about 12-step recovery. She identified a feeling of disgust, “ew,” (p. 11, line 30) especially when thinking about giving things up to a higher power. She felt like this idea removed personal responsibility and accountability for actions. This discomfort expanded to situations in which clients would ask her to disclose her higher power. Because of the acute nature of the population, she avoided direct answers to these questions because an honest reply to the question could be physically, emotionally, and/or relationally dangerous. But she also clarified that she appreciated what 12-step did for her clients, particularly by providing structure, continuity, purpose, and something to look forward to.

### ***Associations with 12-step***

Judy and Megan both associated smoking and coffee with 12-step recovery. These are practically stereotypes of 12-step, but they are also very accurate. Megan acknowledged that these are not the healthiest behaviors, but that they are certainly better than using meth and fentanyl. While connecting these images to her opinions of 12-step, Megan stated that she thinks “it’s a good thing, but I wouldn’t want to go myself.” (p. 9, lines 38-39) She continued by saying that she would feel uncomfortable being a non-addict in a meeting space, even if one of her colleagues (who is in recovery) acted as an ambassador.

**Figure 3**

*Word Cloud of Images and Words Associated with 12-Step*



Megan also stated aversions to working in a 12-step-only, or faith-based treatment center. Earlier in the interview, Megan had also expressed concerns about becoming “addicted” to 12-step such that it dominated one’s social life and restricted members from re-engaging with daily life. Megan said that she felt like her answers painted a more negative view of 12-step recovery than she actually has.

Judy also associated 12-step with church basements, smiles, people being happy to see each other, and being welcomed and made to feel a part of. This warm atmosphere reflected her “generally...pretty good opinion” (p. 8, line 14) of 12-step and appeared to influence her referral practices. If she had not felt welcomed while visiting meetings, she said she would not be as likely to recommend it.

Darla did not associate 12-step with any images. She did associate it with the words “faith-based,” “control,” and “security blanket.” Darla viewed the 12-step meeting as a substitute parent fulfilling the attachment needs of the child (12-step member) that were

never met in childhood. It was like a security blanket that made members feel like they were being cared for. In later questions, Darla acknowledged that she is not a “bandwagon fan” (p. 5, line 32) of 12-step recovery. She used forceful verbs to describe how 12-step, “beats,” “drills,” and “feeds” its philosophy to members throughout the interview. After some exploration, Darla recalled that what bugs her most about 12-step is the idea of character defects, which she believed to be the basis of the model. She thought that the idea of character defects was “totally wrong” and that 12-step “tear[s] you down to build you back up.” (p. 13, line 27)

Susie, again, stood out, and associated 12-step recovery with “images of warmth,” including the sun, ocean, the color green, leaves, trees, vines, and a lush, nurturing environment. These images were connected with ideas of growth, hope, and empowerment. They reminded her that growth is available to anyone who seeks it and that people have more control than they realize. For her, growth was a call to action, which reflects a foundational principle of 12-step, that it is a “program of action.” Green vines moving in multiple directions connected with her belief that there are a variety of pathways to growth, and that 12-step is just one of them.

Patty associated 12-step with the names and faces of the group members who had been part of the DBT/12-step group in the state hospital. She also recalled the image of the room, notably how all the participants faced each other around a circular table. She connected this to King Arthur’s round table. Patty felt like they were doing the work together, and she would carry this value of egalitarian structure to her future groups.

### ***12-step in Clinical Practice***

All the participants agreed that their clients have shared their experiences in 12-step recovery with them. Patty added that in her groups, older members would bring in their

previous 12-step experiences to mentor younger members. This led to a dynamic of unofficial sponsorship in the hospital.

**Referral.** All the participants also agreed that they would refer their clients to 12-step groups, although there were some differences in referral considerations. Judy and Megan both said that they would refer any recovering client to a 12-step meeting. Judy also stated that she may refer clients to specific “specialty meetings” (ie. women’s meetings, LGBTQIA meetings, MAT meetings, etc.) based on client identity and cultural considerations. Darla did not want to venture a guess on referral practices based on client characteristics and assumed that there is guidance on referral practices that are based on DSM diagnoses.

Susie and Patty stated more specific client considerations that affect their referral practices. Susie believed that openness is a prerequisite for 12-step recovery. If someone was opposed to the concept of higher power, she would refer them to an alternative, like SMART recover, over 12-step. Similarly, if a client had a previous, negative experience in 12-step, she would refer them elsewhere first. Patty stated a client would need to take recovery seriously, be ready for change, and not be actively using before referring them to 12-step. This was primarily informed by her experience with resistant clients who would destabilize groups, trigger other members, and endanger others by bringing drugs into the hospital.

**Influence.** Judy and Susie both agreed that 12-step recovery had heavily influenced their clinical practices. Judy said she generally follows the first four steps with most of her clients, although she does not always use 12-step language. For clients with more long-term sobriety, Judy focused on the principles of the last three steps. She also explored 12-step concepts with her clients, including acceptance, willingness, purpose, meaning, community, and higher power.



Susie said that she felt like an ambassador for the 12 steps and used her personal connection with it to build authentic connections with her clients. She also stated that she worked 12-step principles into groups even when she was not functioning as a primary addiction counselor. She observed that some clients were hungry for these ideas and that previous clinicians had not “given quite the kudos that they could have to 12-step programs.” (p. 15, lines 8-9)

**Art Therapy Integration.** Judy often did “step work” through artmaking by having clients draw each step and take “it out of the language a little bit and playing with it.” (p. 12, line 26) She found that this can help get clients to engage with stuck points in their step work. She gave an example of a client who had been engaged with NA but was still struggling with her conception of a higher power. The client was pressuring herself to define what it meant, which was creating a stuck point in her step work with her sponsor.

Judy invited the client to intuitively paint her higher power using only lines, shapes, and colors. The process helped the client recognize the internal feelings she associated with her higher power, which led to an acceptance that she did not need to logically understand or label it. She could hold on to the feeling inside of herself and not feel pressured to conform to others’ higher power definitions. This provided the client with a new understanding, language, and imagery with which to return to her sponsor.

Susie integrated 12-step into artmaking as well. To introduce the idea of higher power, she had clients create bleeding tissue paper collages with no planning and no pre-conceived forms. She prompted them to explore with color to discover what a higher power, “meaning a source of energy outside yourself,” (p. 6, line 32) might look like. She also talked about exploring control through artmaking by having clients trace their hands and then writing things inside their control within their hands and writing things outside of their

control outside their hands. She found that this intervention was empowering because clients learned that they had more control than they realized.

Susie gave a clinical example of a client who was initially less engaged with the groups. The client had a severe, life-threatening addiction and his desperation was highly motivating: “he was hungry for it, he was ready, he wanted change.” (p. 19, line 14) The client approached Susie individually and asked for help with re-learning social skills as he could no longer talk to people without being intoxicated.

He quickly progressed in his recovery, became re-inspired by his creativity, and attended every art therapy group available. He was also inspired by the stories told in 12-step groups and would bring them into his sessions with Susie. Soon, he was coming to Susie with deeper questions about spirituality. She explored these ideas with him and offered him additional resources to encourage his spiritual exploration. Susie reported that the client graduated from the treatment center, remained sober, and recently graduated from college. She attended his college graduation ceremony.

Darla and Megan both talked about using 12-step in their practices indirectly. Darla expressed that she would probably recommend 12-step to clients, but only in addition to trauma work in therapy. For her, 12-step as a single treatment was not the answer. Similarly, to Judy, Darla talked about having clients draw the step that they are working on. She focused more on the emotional content because she believed this was not dealt with in 12-step and that 12-step members usually had a high degree of alexithymia.

Darla gave an example of working with an adolescent boy who created a clay sculpture depicting pills, an alcohol bottle, and other paraphernalia. He then wrote “mom, I’m an addict,” and gave the sculpture to his mom. Darla talked about how artwork can facilitate the difficult conversations that families have about addiction. With other clients, she

has observed how layers of resistance show up as mandalas; “ring inside a ring, inside a ring...layer, layer, layer of defenses...layers of protection to survive on a daily basis.” (p.15, lines 19-20) Darla also suggested that altered books and sand tray work could be useful art therapy interventions but was not familiar with any that directly incorporated 12-step practices. In general, she believed in focusing on simple interventions that deal with self-esteem, validation, empowerment, and love.

Because Megan’s colleagues at the treatment center are more 12-step-oriented, she did not view 12-step as her main approach. Like Darla, she was more interested in exploring clients’ emotional experiences in 12-step. In earlier questions, she talked about using art interventions to depict feelings of unmanageability, and, similarly to Judy and Susie, to explore a client’s higher power. Megan did not give a specific clinical example but did speak about observing how peers in 12-step were a positive influence and that clients became more open to engaging with 12-step the longer they stayed in treatment.

Patty discussed some of the art interventions used in the DBT/12-step group at the hospital. Clients at the state hospital were heavily restricted in their access to art materials outside of art therapy. Patty provided clients with high-quality art materials and tools because they were usually restricted to using crayons. Collages were a common intervention that focused on weekly themes. Using scissors in collage-making also facilitated important conversations about expressing feelings of safety and trust. Clients expressed whether they felt safe with sharp objects that day and could be provided with alternative options and/or support.

Patty also talked about using images for clients to reflect and meditate on their conceptions of higher power. She was intentional about bringing in images that were secular (sunrises, sunsets, nature, galaxies) rather than overtly religious. Patty did not share a

detailed case example but did recall challenges with a particularly resistant client who would frequently disrupt the group.

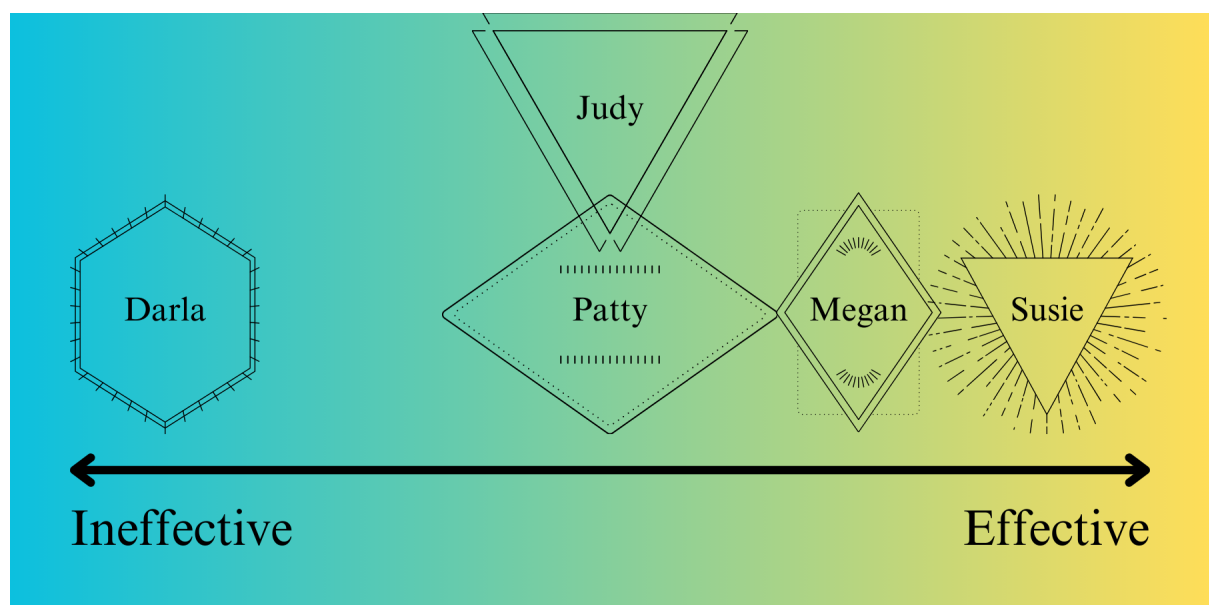
Patty reflected on how her experience facilitating DBT/12-step groups has influenced her approach to other groups. She has focused more on cultivating a non-hierarchical power structure and believes that this has created a more personable and authentic therapeutic presence. Her art interventions also shifted to be more community-focused. After she left the 12-step group, she created more community art, like murals, at the hospital.

### *12-Step Effectiveness*

Susie and Megan agreed that 12-step was effective if a person was engaged with it. Susie stated definitively that “If someone is willing and open, it can be 1000% effective...12-step programs work. Period.” (p. 22, lines 23-26) Susie also saw its effectiveness in the life of her friend/colleague with over 40 years of sobriety, who spoke with congruency about how she has benefited from the 12 steps.

### **Figure 4**

*Range of Beliefs in 12-Step Effectiveness*



One of the cons that Susie saw in 12-step is that not all meetings were equally accepting or welcoming. It was sometimes more challenging for clients in rural areas to find comfortable meetings because rural areas did not have the diversity of meetings that were present in suburban and urban areas. Susie always encouraged her clients to try out different meetings if they had negative experiences or felt like they did not fit the vibe of a particular meeting. She also noted that there were sometimes poor boundaries in sponsoring relationships.

Megan stated the 12-step was effective for those who stay focused on it. She believed 12-step was effective because of its attention to spirituality. Fostering a spiritual focus provided comfort and strength because it connected the person to something larger than themselves, which reduced the feelings of isolation. Megan also valued the personal spiritual journey and felt like people value spirituality less if it was prescribed to them. For her, the danger in spirituality arose when it became dogmatic and decreed.

Megan added that she believed the 12 steps were “solid principles to live by.” Personal inventory, fellowship, sponsorship, and the steps themselves were all valuable components. Megan worried that some people can go through the motions of 12-step without internalizing them and was also concerned about shaming narratives (ie. addicts do this...) that clients may have heard in 12-step meetings.

Judy and Patty questioned how effectiveness was defined and measured within the context of addiction recovery. Judy expressed that success was hard to measure because there was not a universal opinion on its definition. She has witnessed 12-step being part of people’s long-term recovery, but, for her, success was less about day counts (ie. length of continuous sobriety), and more about achieving a willingness to engage with recovery activities, principles, and life in general. She believed 12-step achieved these goals because it

was the most accessible recovery program, it was dependable, it was unconditionally accepting, and it was a life-long support system. For Judy, the downside of 12-step recovery was that some people were mandated to participate. She did not see it as a counselor's responsibility to force someone into it, although she acknowledged that court-mandated attendance may be valuable for some.

Patty questioned the idea that 12-step had to be studied in academia for it to be a legitimate, effective approach. She implied that academia was not the only source of knowledge, saying "I'm gonna assume [12-step] doesn't have a lot of like official, you know, researchy research...but so what?" (p. 23, lines 18-19). For Patty, there was wisdom outside of official research studies when she asked, "is it not reaching people and making them pause, and think, and slow down, and start to look inwards?" (p. 23, lines 19-20).

In her experience at the state hospital, Patty observed that the 12-step group was unique, laid-back, and very popular among clients. She summed up the practice of holding space and cultivating a 12-step atmosphere in an unintended poem:

But it was set aside.

It was calm.

It was quiet.

We had coffee.

(p. 18, line 5)

The group was an oasis from the noise of the hospital and the expectations of other therapy groups. The members built camaraderie and community that extended outside of the room. They mentored each other, invited others to join, and kept showing up. The group was so successful that additional 12-step groups formed and eventually became a dedicated department inside the hospital.

For Patty, the main downside of 12-step was that some groups were too dogmatic about a singular definition of higher power. She believed that the settings of community 12-step meetings may bias how the group utilized spirituality and religiosity. For example, a meeting based in a community center was more likely to be accepting of a broad definition of higher power than a meeting based in a church. In earlier questions, she also expressed concerns about the non-professional nature of community-based 12-step, that there were no therapists present to regulate someone who becomes triggered, which could lead to dangerous situations. Patty also acknowledged that this concern may be due to her experience with acute clients and that it may not be as significant a problem as she imagined.

Patty discussed her beliefs about 12-step effectiveness repeatedly throughout the interview. In summary, she believed that it worked well for a minority of people, but not for most. She believed 12-step, like cognitive behavioral therapy (CBT) and dialectical behavioral therapy (DBT), only addressed surface-level behavior, and that deeper work needed to be done for “real change” to occur. Patty also acknowledged that treatment centers have changed since her first experience with them in the early 90s. She has seen how they are more trauma-informed and have offered a wider range of treatment options and modalities.

### **Values Coding**

Values coding captured the explicit and implicit attitudes, beliefs, values, and associations of the participants. The most numerous and significant codes were then compiled into emergent themes, which reflect the most common and/or significant concepts that were explored in the interviews. Table 5 contains the emergent themes and the most prominent attitude, belief, and value codes that were used to construct them.

**Table 5***Emergent Themes from Values Coding*

| Themes   | Attitudes                         | Beliefs                          | Values                       |
|--|-----------------------------------|----------------------------------|------------------------------|
| 12-step is a large, accessible community.          | 12-step is accessible             | Variety of fellowships           | Asking for support           |
|  | 12-step is well-known             | Geography matters                | Open mind                    |
|  | Meetings are welcoming            | Meeting acceptance varies        | Psychoeducation              |
|  | Fellowship is dependable          | Gateway to support               | Outside support              |
| Interpreting 12-step in practice                   | Don't like higher power language  | 12-step recovers authentic voice | Translating 12-step language |
|  | Higher power language is thorough | Higher power is a barrier        | 12-step art making           |
|  | 12-step is a familiar language    | Population can't make amends     | Re-formatting amends         |
|  | "Character defects" bugs me       | Art as new 12-step language      | Extracting essence of steps  |
| Honoring agency and meeting clients where they are | Resistant clients are disruptive  | Engagement in 12-step varies     | Following client's lead      |
|  | 12-step is forceful               | Willingness required for 12-step | Client agency                |
|  | Clients are hungry for 12-step    | 12-step alternatives             | Multiple pathways            |
|  | 12-step is empowering             | Personal history is a barrier    | Person-centered              |



|                                      |                                    |  |                            |
|--------------------------------------|------------------------------------|--|----------------------------|
| Personal vs. professional identities | I stay in my lane                  | 12-step influences my practice         | Gauging self-disclosure    |
|                                      | I was a misfit                     | Self-disclosure leads to connection    | Authenticity               |
|                                      | I don't want 12-step for me        | Addiction is opposite of connection    | Redirecting questions      |
|                                      | Self-disclosure is uncomfortable   | Non-addicts can work with addicts      | Embodying principles       |
| Trauma and 12-step                   | 12-step only addresses the surface | 12-step works for a minority of people | Meditation and mindfulness |
|                                      | 12-step disempowers                | 12-step needs trauma accompaniment     | Trauma-informed approach   |
|                                      | 12-step slows down                 | Addictions are trauma-based            | 12-step as resourcing      |
|                                      | Clinicians are needed for safety   | Trauma pops back up                    | Gabor Mate's work          |

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### ***12-Step is a Large, Accessible Community***

This theme of accessibility appeared throughout all the interviews to differing degrees. Virtually everyone agreed that 12-step meetings were the most accessible resources for people in recovery. This was largely due to the multiple fellowships, the number and variety of meetings, and the welcoming community. It was accessible in terms of location, time, and cost, especially in comparison to professional treatment centers and 12-step alternatives such as Refuge and SMART Recovery, which were significantly smaller. 12-step was a dependable, low-to-no-cost support that was available for a lifetime. Patty

encapsulated this theme by saying 12-step “is the one that's most accessible, it's been around forever, everybody knows their name...because the latest and greatest is only offered in this state, in this town, at this time.” (p. 19, lines 36-38)

It was also culturally accessible. 12-step has become a part of the American (and now international) landscape. People have become familiar with it through their families, communities, schools, congregations, and popular culture. The associations in this theme (coffee, smoking, circular arrangement) reflected the larger cultural images of 12-step, and, in many cases, the reality of meetings. For better or worse, virtually everyone has heard of it – it was one of the first things to come to mind when someone decided to seek help. For many, it acted as a gateway to other supports, even if it turned out that 12-step was not a good fit for them.

The participants also acknowledged that geography mattered, especially when it came to meeting variety and acceptance. Clients in rural areas did not have the same in-person access to a variety of meetings that clients in urban or suburban areas do. This could be particularly challenging if a client possessed one or more target identities and was not able to access meetings that were accepting and safe. However, the participants also pointed out that the growth of online meetings (fueled by the pandemic) has made a variety of meetings more accessible regardless of geographic location. Participants stated that they talked with their clients about meetings they have attended and encouraged them to shop around other meetings if they had a negative experience. Judy said, “we do have such a thriving community in this area, that like if one meeting or one pocket of geography doesn't seem to work for somebody, they can try something else and...can always find something that works for them.” (p. 5, lines 15-17)

### *Interpreting 12-step in Practice*

Most participants shared how they translated 12-step concepts for themselves and their clients. In this way, interpretation relied on both clinical judgment and personal values. For Darla and Patty, who appeared to have more negative personal feelings about 12-step the higher power language and term “character defects” were some of the most off-putting. They wrestled with whether they would use these ideas with clients, and how they could be re-interpreted to “get the essence out of it, even if we're not doing it to the letter.” (Patty, p. 7, lines 8-9)

All the participants agreed that 12-step language was not always helpful for some clients, particularly if they were opposed to the idea of higher power or had previous, negative experiences in 12-step. However, the language of 12-step could be translated in a way that resonated with 12-step-resistant clients. Patty emphasized the open definition of higher power by having clients explore it with secular images like the universe and nature. She said this also allowed clients with varying belief systems to equitably participate in group therapy interventions.

Artmaking to explore higher power was also commonly discussed. Interpreting challenging spiritual ideas through materials, emotions, and imagery seemed to free up clients from the rigidity that comes with logic and written/spoken language. Art became a “new language to go back to the sponsor to really talk through it in a different way.” (Judy, p. 10, lines 22-23) Clients went back to their sponsors, showed them their art, and re-engaged in step work with new understanding and perspective.

Reinterpretation also occurred to meet the needs of specific client populations. In the hospital where Patty worked, most clients were cut off from their communities and severely limited in whom they were allowed contact. This presented a logistical problem to steps 8

and 9, the process of making amends. Many hospital clients were also unable to write an amends list or a personal inventory without becoming triggered. Patty challenged herself to rework these steps to meet these needs, namely by using the concept of self-forgiveness and focusing on what could be done within their control.

### ***Honoring Agency and Meeting Clients Where They Are***

This came up again and again as a strong set of values for all the participants. Even the participants who were most enthusiastic about 12-step recovery talked at length about honoring client agency and not pushing 12-step if it was unwanted. They acknowledged that 12-step engagement varied and if a client did not feel like 12-step was a good fit or if they had a negative history with 12-step, they would refer them to alternative support groups instead. Susie repeatedly emphasized that willingness was a requirement to begin 12-step and Judy voiced strong opinions about therapists not mandating 12-step attendance.

All the participants believe that there are multiple paths to recovery and value providing clients with choices. Susie said, “a little bit of misinformation is that there is only one way to get clean and sober” (p. 6, line 26). They also endorsed many concepts found in person-centered therapy, including following the client’s lead and unconditional positive regard. The participants less likely to use 12-step in practice (Darla and Megan) discussed how they were open to exploring 12-step in sessions if a client brought it up first, or if they knew that the client was strongly engaged in 12-step.

Darla felt like 12-step, and particularly treatment centers that were 12-step focused, did not honor these person-centered values and could be forceful in pushing their ideology. On the other hand, Susie felt like 12-step was empowering for clients and that it was often under-valued in therapy settings. Susie encountered many clients who were “hungry” for 12-step because previous clinicians had not sufficiently met their desire to explore it.

Darla, Megan, and Patty also acknowledged the challenges of working with resistant clients. They could be hard to work with and disruptive in group contexts. They talked about strategies for accepting and going slowly through resistance, as well as finding alternative forms of support for them.

### ***Personal vs. Professional Identities***

There were clear differences in how the participants thought about 12-step in their personal vs professional lives. Most of the participants drew clear distinctions between their personal and professional feelings. Their feelings primarily related to their professional opinions, ie. how it was or wasn't helpful to their clients. Patty expressed how she had negative personal feelings, but positive professional opinions regarding 12-step, saying "ew...but that's for me...again, I appreciate what it did for our clients." (p. 10, lines 3-6) Many of the clinicians struggled to identify how they felt about 12-step because most did not feel a significant, personal connection to it.

Susie, the only active 12-step member, was the exception to this trend. She quickly identified intense feelings and sensations that integrated professional and personal experience. She also talked about how her approach has been influenced by both personal and professional experiences. Her integrated identity was also evident in her comfort with self-disclosure, which she believed was a necessary part of cultivating authentic connection. Authenticity was her bedrock value as it underpinned her philosophy that 12-step worked because it recovered authenticity. Susie also stressed that she carefully gauged the appropriateness of self-disclosure and has done a lot of her work in CODA to create healthy boundaries with clients.

Susie also made a point to embody the recovery principles that she taught. Susie believed in practicing the principles she taught, namely that "the opposite of addiction is

connection.” (p. 21, line 3) For her, cutting ties with clients after they leave treatment would be hypocritical. She believed that maintaining authentic relationships was a key principle in successful addiction recovery. She has stayed in touch with some clients since they left treatment, despite her previous agency’s policies regarding multiple roles.

Other participants also experienced feeling like misfits within their agencies. Darla and Megan discussed friction between their approach and the culture of the agency and other clinicians. Darla felt pressured by clients to disclose her recovery status in part because her 12-step-focused colleagues were comfortable in doing so. She also believed that 12-step promoted the idea that only addicts could help other addicts, which created an additional barrier to building rapport. Megan expressed some concerns about a colleague in active 12-step recovery, who she felt, may have been allowing 12-step to dominate her life. Darla and Megan both talked about “staying in their lane,” because other clinicians focused so heavily on 12-steps.

Patty also expressed discomfort with self-disclosure, especially regarding higher power. She would usually redirect these inquiries from clients because she understood that an honest answer could be dangerous. Darla also redirected personal questions from clients to maintain her boundaries with self-disclosure.

### ***Trauma and 12-Step***

This theme was not as broadly distributed across the transcripts as the other themes, but it was extremely significant in the interview with Darla, and to a lesser extent with Megan and Patty. Most of Darla’s attitudes and beliefs were centered on the basis that 12-step did not work for most people because it did not address the trauma underlying addiction. She believed it did not work as a single treatment because, for real change to occur, 12-step needed to be accompanied by trauma-focused therapy.

Darla admired Gabor Mate's work, who was one of the first clinicians to thoroughly address the connections between trauma and addiction. She believed that 12-step only addressed the behaviors of addiction, and that "if the underlying trauma is not dealt with, then it's gonna pop back up somewhere" (p. 6, lines 17-18). This sometimes took the form of violence and criminal behavior in the adolescent population that she worked with. In her experience, childhood neglect and lack of safety/acceptance were present for most of her clients who struggled with addiction. She also acknowledged the 12-step could function as resourcing, a component of phase one treatment, by preparing clients for deeper trauma processing.

Megan conceptualized addiction as a "bio-psycho-social-spiritual problem" (p. 12, lines 38-39) that was rooted in trauma. Trauma caused social deficits, isolation, and a lack of belonging, which led to reliance on substances. Trauma caused discomfort and isolation, which was then soothed with drugs and alcohol. These maladaptive coping skills then metastasized into addiction. However, Megan did not conclude that 12-step was ineffective because it was not trauma-focused.

Patty did not discuss trauma explicitly, but many of her concerns regarding 12-step were rooted in how it handles safety and dysregulation. In her experience, it was easy for clients to be triggered in the hospital DBT/12-step groups, especially by the other members. Her role in the group often involved separating and re-regulating members who had become dysregulated. Patty expressed concerns that the non-professional nature of community 12-step groups could create dangerous situations when people become triggered and cannot regulate themselves.

## CHAPTER V

### DISCUSSION

This research found that attitudes, beliefs, values, and associations regarding 12-step recovery had a significant impact on art therapists' clinical practices. Art therapists with high levels of familiarity and positive feelings about 12-step more deeply integrated 12-step philosophy and practices into their clinical approaches. Conversely, low familiarity and negative perceptions led to more indirect use of 12-step recovery in therapy. This study also found that there was not a consensus among art therapy participants regarding how 12-step was viewed and used.

#### **Art Therapists' Perceptions of 12-step Recovery**

This research was significant because it focused specifically on how art therapists' perceptions of 12-step recovery influenced clinical practice. In this section, I will talk about all 12-step findings and how they relate to the existing literature. This has been studied in the broader mental health field but not in art therapy. The experience of the participants, their positions as educators, and a thorough analysis of transcripts add weight to the conclusions of this research.

#### ***12-Step Accessibility***

Results found that art therapists widely viewed accessibility and ubiquity as a major strength of 12-step recovery. This finding that art therapists believed that 12-step is accessible, has also been replicated in studies of the larger mental health field (Fenster, 2006)

The participants also noted how online meetings have reshaped the meeting landscape. Zoom meetings sprang out of necessity in the early days of the COVID-19 pandemic. This sentiment of online meetings being less intimidating, especially for people prone to social anxiety, was reported by a couple of the research participants, including Judy



when she said “it used to be anybody who has like, pretty severe social anxiety, I might pause a little bit before I would recommend it. But now that there's so many like virtual options...12 steps is a great answer for somebody, virtually.” (p. 12, lines 35-39). Online 12-step meetings have made 12-step more accessible than ever because many have persisted in hybrid or fully online formats even as the pandemic has abated. This has resulted in geography becoming less of a barrier to accessing a variety of meetings, especially those that hold space for participants with target identities. This implies that if art therapists become more familiar with a variety of online meetings, they can better serve their clients through accessible referrals. Darla and Patty, who held more negative views of 12-step, would still refer clients to 12-step in part because of this accessibility because in many cases, it is the only support option available (Humphreys, 1997).

This finding that virtual meeting options created in the wake of the COVID-19 pandemic have expanded accessibility for new and current 12-step members has been replicated in recent studies (Di Carlo et al., 2022; Galanter et al., 2022; Senreich et al., 2022). However, it has also been found that virtual meetings may introduce new challenges such as issues with time zones, lack of human touch, lacking technology at home, technological incompetency, lack of awareness of online options, and IT difficulties (Barrett & Murphy, 2020). Researchers are also still working to discover if online meetings are as effective as in-person meetings (Di Carlo et al., 2022).

### ***12-Step Interpretation***

I also found that it was common practice for art therapists to interpret or translate 12-step concepts for their clients. This was primarily done with the “stickier” ideas like higher power and control. Previous studies have also found that potential religiosity in 12-step is a common barrier for both clinicians and 12-step members (Chappel & DuPont, 1999;

Glassman et al., 2022; Laudet & White, 2005). AA Agnostica is a website created by AA members that has seventeen alternative versions of the 12 steps that may be more palatable to atheists, agnostics, and non-religious people (*AA Agnostica*, n.d.)

However, it also appeared that art therapists were uniquely qualified to deal with these challenging concepts. Most of the participants discussed art interventions that opened up the definition of higher power and encouraged clients to move out of language and logic into imagery and emotion. Art can move clients through areas of stuckness and deepen the felt sense of connection to larger forces.

There was also an indication that art therapists generally valued multiple paths to recovery, honored client agency, and tried to meet their clients where they were. The findings reflect the wide impact that person-centered theory has had on art therapy, and these same ideas dovetail with the traditions of 12-step. AA literature stressed that the steps (and all 12-step practices) are only suggestions, people are free to take or leave whatever they wish. Additionally, the “only requirement for membership is a desire to stop drinking” (*The Twelve Traditions of Alcoholics Anonymous (Short Form) | Alcoholics Anonymous*, n.d.). This membership requirement opened the room to anyone, at any stage of recovery. It is not uncommon for people to be intoxicated in 12-step meetings, although groups generally advise that intoxicated people talk to an individual member afterward and not share with the meeting.

But it is also important to recognize that these person-centered ideals of 12-step recovery are not always practiced. Dogmatic sponsors, groups, and treatment centers can present these ideas as mandates rather than suggestions. They also may have strict definitions of “sobriety” that do not include the drugs prescribed in medication-assisted treatment (MAT) even though the AA conference has clearly stated that it has no official opinions on

prescribed medications. Court-mandated attendance and engagement also challenge these ideals.

I have not found specific studies that address the practice of mental health professionals re-interpreting or “translating” 12-step language and ideas for clients and themselves. However, there are many resources created by 12-step members (although not conference-approved) that may aid art therapists in re-interpreting 12-step concepts.

There is also the *EZ Big Book of Alcoholics Anonymous*, which updated the 1930s language of the original Big Book to be more comprehensible by contemporary readers. It is intended to be accessible to a wide variety of reading levels, uses gender-neutral language, does not assume heteronormativity in alcoholic relationships, and uses all-encompassing terms to talk about spirituality (A Member of A.A., 2015). In my capacity as a sponsor, I have used this book with sponsees who struggle with reading comprehension. It is an excellent tool for removing barriers and making the ideas of 12-step more accessible.

### ***12-Step Effectiveness***

For the most part, the participants in this study were not significantly concerned with assessing the effectiveness of community 12-step and Twelve Step Facilitation (TSF) programs. Judy expressed doubts about how addiction recovery effectiveness was measured and Patty felt like “researchy research” may not fully capture the benefits that 12-step recovery can provide.

There were also mixed opinions regarding the existence of effectiveness studies, some felt like there was research that analyzed 12-step effectiveness, and some believed there probably was not much. The participants supported their conclusions with anecdotal evidence, and none directly cited the studies showing that belonging to 12-step recovery groups was a cost-effective way to promote abstinence and reduce relapse: (Humphreys &

Moos, 2001; Kelly et al., 2020; Laudet & White, 2005; O'Brien & McLellan, 1996; Project MATCH Research Group, 1998; Timko & DeBenedetti, 2007). Susie and Megan's belief that engagement in 12-step was key to its effectiveness was supported by Timko and DeBenedetti's (2007) findings. They found that engagement was more strongly correlated with long-term recovery success than meeting attendance (Timko & DeBenedetti, 2007).

### ***Pros and Cons of 12-Step***

Belongingness, which was discussed in different ways by Judy, Susie, and Patty has also been identified as a primary change agent in 12-step's effectiveness by existing literature (Glassman et al., 2020; Timko & DeBenedetti, 2007). Other beneficial elements of 12-step identified by Glassman et al. (2022), including comfort, acceptance, support, and a broad definition of higher power appeared throughout the interviews.

Some of the detrimental characteristics of 12-step discovered by Glassman et al. (2022), including powerlessness damaging sense of agency, religiosity in meetings, restricted life outside of 12-step, authoritative medical instructions, and occurrences of sexual assault, were also mentioned. There is still room for improvement when it comes to safety in 12-step meetings. Oftentimes, the best current solution lies in the variety of AA groups. Groups specifically for men, women, LGBTQ+ people, atheists/agnostics, and indigenous people provide safer meeting environments for people with target identities. Concern with religiosity was the most common among participants, and the other detrimental characteristics were mentioned infrequently. The participant's concerns with religiosity driving away atheists and agnostics were also echoed in the findings of Humphreys (1997).

Interestingly some of the other detrimental characteristics identified by Glassman et al. (2022) were not brought up by the participants, namely cult-like indoctrination, victim-blaming during personal inventories, and loss of personal identity and autonomy. This may

be due to the differences in the study populations. In the Glassman et al. (2022) study, the participants were ex-members of AA and not art therapists.

### ***Clinical Practice and 12-Step Facilitation Programs***

Some of the study participants' clinical practices also parallel those developed in evidence-based Twelve Step Facilitation (TSF) programs. Art therapists in this study talked about introducing 12-step principles and information, reviewing client concerns, and encouraging involvement, which were all key elements in the Intensive Referral Program (IRP) and the Stimulant Abuser Groups to Engage in 12 steps (STAGE-12) facilitation programs (Donovan et al., 2013; Timko & Debenedetti, 2007). However, the participants did not discuss connecting clients with active 12-step members who would accompany them to meetings, which was a key element of the IRP and STAGE-12 (Donovan et al., 2013; Timko & Debenedetti, 2007).

Judy and Susie, the participants with the highest 12-step familiarity talked more about the treatment interventions that paralleled the practices of Making Alcoholics Anonymous Easier (MAAEZ). These included addressing topics of spirituality, myths about AA, sponsorship, and types of meetings (Kaskutas et al., 2009). MAAEZ is also facilitated by counselors who are active 12-step members, which was a key component of Susie's practice (Kaskutas et al., 2009).

### ***12-Step Artmaking***

All the participants discussed art interventions that may aid clients in working on specific steps. This practice of using art to facilitate step work can also be found in the art protocols developed by Holt & Kaiser (2009), Krebs (2008), Julliard (1995), and Lorenz et al. (2022). Judy also talked about primarily concentrating on the first three steps, which was similar to Holt & Kaiser (2009), whose protocols prepared clients for step one, and Julliard

(1995) and Krebs (2008), whose interventions followed the first three steps. This similarity was likely because art therapists primarily treated clients who were early in their recovery journeys. It also may indicate a demand for more art interventions that focus on the middle and latter steps.

Collage was the most common 12-step art intervention utilized by study participants and was frequently used in the art protocols of Holt & Kaiser (2009), Krebs (2008), and Julliard (1995). This may be because, as the study participants noted, clients with substance use disorders can be particularly resistant, and collage is a very accessible medium. Collage may also be well suited for cognitively sorting through issues of control, pros and cons of drug use, and unmanageability.

### ***Familiarity with 12-Step Recovery***

Darla and Megan spoke the most about their experiences as non-12-step members within 12-step-focused treatment centers. Their challenges with connecting to 12-step-focused colleagues, clients, and the agency were validated by existing literature. 12-step-oriented treatment centers are more likely to hire clinicians who are in recovery and are more likely to refer clients to 12-step groups (Fenster, 2006; Glassman et al., 2022; Humphreys, 1997).

Darla also experienced the phenomenon of appearing less credible to clients because she was not in recovery (Dennis et al., 2013). Her lack of shared background made her appear less familiar with 12-step, and therefore less credible to her clients (Dennis et al., 2013). She also talked about learning about 12-step by being immersed in it at a treatment center, but also appeared to be the least familiar 12-step. This was described by Chappel & DuPont (1999) and Laudet & White (2005) as a phenomenon in which clinicians believe they are more familiar with 12-step than they actually are because they are surrounded by 12-step

“lore,” but are unfamiliar with how it is interpreted within 12-step practice. They concluded that this leads to widespread misunderstandings.

### *Attitudes and Beliefs about 12-Step Recovery*

This study found that the participating art therapists, except for Darla, generally had positive perceptions of 12-step and all were likely to refer clients to 12-step meetings, which aligns with the conclusions of Fenster (2006), Humphreys (1997), and Laudet & White (2005). The participants in this study also expressed negative perceptions of 12-step that have been previously identified in the literature, including that people can become dependent on it, that it lacks professionalism, and that it is religious (Chappel & DuPont, 1999; Laudet & White, 2005). However, the participants did not strongly endorse some negative perceptions that have been previously identified, including that 12-step is too intense for some people, that members spread bad advice, that it is limited to only one substance, and that it is only useful in early recovery (Chappel & DuPont, 1999; Laudet & White, 2005).

The participants in this study also did not hold strong beliefs about how client characteristics and identities affected their referral practices. Most stated that they would refer most clients to 12-step. They also believed that personality, willingness, and meeting culture were more influential on a client’s fit with 12-step than their identity factors. This was significantly different from the findings of previous research, which found that factors such as age, employment status, housing status, previous 12-step history, religious beliefs, addiction severity, and psychiatric conditions affected referral practices to 12-step groups (Humphreys, 1997; Laudet & White, 2005). I believe this divergence may be due to the strong person-centered values of the art therapists in this study. They encouraged their clients to at least try 12-step and to shop around for meetings but would also respect their autonomy in finding the best fit.

### *Art Therapist Identity and Cultural Competency*

I found evidence that art therapists who were active 12-step members were more likely to integrate 12-step feelings and philosophy into both their professional and personal identities, whereas non-12-step-art therapists more clearly separated their personal and professional identities. This means that art therapists who are part of the 12-step community walk the talk, which can quickly build trust and rapport with their clients because of their perceived insider expertise. This bond can extend outside of the formal therapeutic relationship as well because both client and therapist belong to the same community. However, art therapists who are in recovery also must work harder at maintaining ethical boundaries and are more likely to experience countertransference. Susie shared that through her work in CODA, “What I’ve learned is practicing my words, practicing how to set, and state, and then maintain healthy boundaries, some days much easier than others.” (p. 9, lines 22-23)

As the participants observed, art therapists who are not 12-step members may have to work harder and longer to build this same level of trust with clients. Even if they are extremely familiar with 12-step professionally, they will not have the same lived experience of being addicted nor the felt sense of identifying as an addict or alcoholic in a 12-step meeting.

In my conversations with Mariah Pisarsic (personal communication, October 28, 2023) an alumnus colleague, we realized that this issue can be conceptualized within the framework of cultural competency and humility. The 12-step community is a unique subculture that is in many ways counter-cultural to mainstream culture in the United States. It is more collectivist than individualistic, which can be seen in the first AA tradition: “Our



common welfare should come first; personal recovery depends upon AA unity.” (*The Twelve Traditions of Alcoholics Anonymous (Short Form)* | *Alcoholics Anonymous*, n.d.)

Twelve-Step was described by Bill W., the founder of AA, as “benign anarchy” (A.A. General Service Conference, 2021) in part because every AA group (defined as a meeting of just two or more alcoholics) is autonomous except in matters that affect the entire fellowship (*The Twelve Traditions of Alcoholics Anonymous (Short Form)* | *Alcoholics Anonymous*, n.d.). 12-step is also non-capitalistic, it actively avoids making a profit and does not align itself with any other organization or institution.

This subculture is also defined by unique slogans, rituals, events, symbols, camaraderie, shared experience, mutual aid, and service. Many people freely offer resources to each other, and it is not uncommon for people to find employment, housing, and transportation within the fellowship. There is also a profound sense of belongingness and understanding. I can go to a meeting anywhere in the world and feel like I am home.

This is all to say that I believe non-12-step art therapists can be very successful in working with 12-step clients if they approach perceived resistance with an attitude of cultural humility. They can openly acknowledge that they may never fully understand the culture of 12-step while also demonstrating that they are open and eager to learn. I think that one of the best ways to learn is for art therapists to visit their local meetings and get an immersive sense of the atmosphere and culture.

### ***12-Step and Trauma***

Darla cited Dr. Gabor Maté as a source in her belief that addiction is a trauma-based disorder. While her theory closely aligned with Maté’s in this matter, they differed significantly in their attitudes towards 12-step. Maté (2010) admired many positive qualities in an AA meeting that he attended, including humility, serenity, gratitude, acceptance,

commitment, support, and authenticity. Although he initially feared attending as a non-alcoholic, he experienced acceptance and belonging for the shopping addiction that he was struggling with (Maté & Levine, 2010). He also observed an atmosphere of humor and camaraderie and felt at home with the high energy of the members (Maté & Levine, 2010). Although he was initially repelled by the concepts of surrender and higher power, he quickly re-interpreted these ideas for himself, which was similar to the interpretation practices of the participants. The difference in Darla's and Maté's attitudes may be due to the context in which they attended 12-step meetings. Maté went seeking help, while Darla stayed within a professional role. I believe Maté's writings on his experience show how 12-step and trauma-based approaches are not necessarily mutually exclusive of each other, they can be synergistic.

Darla's conclusion that 12-step would be effective if it were accompanied by trauma therapy is supported by the work of Jamie Marich (2020). Marich argued that rigid interpretations and practices of 12-step are potentially harmful to people with unresolved trauma and called on 12-step to become more trauma-informed. However, she also identified many parts of 12-step, including the culture, traditions, sponsorship, and steps themselves that can help people resolve and make meaning out of trauma.

Darla and Marich (2020) differ in another fundamental way. Darla viewed 12-step and therapy as being distinct and separate from each other, whereas Marich (2020) believed that they could be integrated. In addition to 12-step becoming more trauma-informed, Marich (2020) believed that therapists should become more familiar with 12-step, recognize its benefits and dangers, and integrate it into clinical practice. For example, she talked about how the personal inventory process could be done in therapy because there is no mandate that sharing personal inventories has to be done with a sponsor (Marich, 2020).

### **Alternative Explanation of Findings**

I cannot claim to be a purely objective researcher, my personal history and beliefs cannot be completely separated from my analysis of the data. However, I have taken steps, as outlined in the methodology section, to reduce how my biases influenced my interpretations. I am also operating from a constructivist paradigm to respect the differing realities of the research participants.

### ***Trustworthiness***

This has been a challenging project for me. At times I had strong emotional reactions to the content of this research. I attempted to capture these reactions in my notes and analytic memos and reflected on them with my thesis advisor who helped me broaden my perspective of the data. I have been highly critical of 12-step in my own life, but it was challenging to hear critiques being made by people who were not part of the 12-step community. It was similar to the emotional dynamic of “I’m the only one that’s allowed to be mean to my friends.” This was also impacted by the power differential between myself and the participants who were significantly more experienced and expert in the art therapy field than me yet were participants in a research project where I held more power as the researcher. But I also believe that my history and experience made me uniquely attuned to the nuances and important details present in these complex issues.

I built trustworthiness into the methodology of this study by creating neutral interview questions, not revealing my recovery status to participants before the interviews and documenting my emotional responses within the transcripts and analytic memos. I discussed countertransference reactions with Dr. Jayashree George and she reviewed two of my annotated transcripts and provided feedback on my interpretations. During the structural coding, I attempted to capture the exact words of participants and quoted their transcripts

throughout the results section. The values coding process was very rigorous, which enabled me to sort and prioritize the main ideas across all the transcripts. Additionally, many of my findings replicated existing research, which added validity and trustworthiness to my conclusions.

### **Study Limitations**

Although the participants' demographics do reflect the population of art therapists in the United States in that they were predominantly female, white, and older than 40 (Elkins & Deaver, 2015), these results cannot be generalized to the entire field. The participants in this study were also entirely non-religious, so this research did not capture the perspective of art therapists who practice organized religion. The participants were also predominantly White, so issues of racial discrimination and oppression within 12-step, which certainly exists, were not reflected in the data. The participants were also entirely middle-aged or older, so there was little mention of how young people's meetings, which are a significant portion of 12-step fellowships, may impact perceptions and practices. While these were not specific focuses of the study, they also did not show up in the general familiarity with 12-step or their perceptions towards it.

Some practical constraints limited this study. I initially planned to transcribe and begin analysis of each transcript before the next interview. This would have allowed me to modify my interview questions on a cyclical basis to better hone in on significant topics. Unfortunately, the transcription process took me longer than I anticipated, so I was not able to finish each transcription before the next interview. If I were to do this again, I would have scheduled the interviews further apart so that I would have enough time to finish the transcriptions.

I also initially planned to conduct participant checks by reaching back out to the interview participants after my analysis to confirm that my interpretations of the data accurately reflected their perspectives. However, my coding procedures took longer to complete than anticipated, so I ran out of time to complete this step.

### **Future Research**

I believe this study could act as a starting point to more broadly apply this research question to art therapists in the United States. The themes and results could inform the construction of quantitative surveys, which would be used to collect data from a larger sample size. This type of study could produce more generalizable conclusions about where the art therapy field stands on this issue.

Future research could address how different addiction treatment settings and populations may impact the types of art materials utilized. For example, some art materials or interventions may be more common in adolescent and youth contexts versus adult addiction treatment. There are also the safety considerations of different settings. State hospitals and prisons are likely to be more restrictive in the types of art materials that can be used in addiction treatment.

Future research could address how different addiction treatment settings and populations may impact the types of images and words that are associated with 12-step. There may be some common associations that are embedded in the popular stereotypes of 12-step. But there also may be some that are unique to certain populations and treatment settings. Examining the similarities and differences in associations may identify preconceived notions about 12-step that act as additional barriers. Working with these images in the context of art therapy could also be useful in addressing barriers that clients in 12-step may be experiencing.

Finally, more research could be done on how/if art therapists are taught about 12-step recovery. This pedagogical theme emerged from the interviews but fell outside of the scope of this research. Graduate training programs were cited as a primary source of 12-step information by research participants. Three of the participants were also art therapy educators and they discussed methods they used in teaching substance abuse. The beliefs, attitudes, and associations identified in this study are likely passed down through these training programs. Modifying how this subject is taught could help the field become familiar with 12-step and learn how to integrate it into art therapy practices.

### **Conclusions**

This study found that art therapists appeared to integrate 12-step into clinical practice using art making, that art therapists generally appeared to have positive views of 12-step recovery, and that art therapists were likely to refer clients to 12-step meetings in addition to alternative support groups. The participants with high 12-step familiarity had more positive opinions about 12-step and more deeply integrated it into clinical practice. The study participants viewed physical and cultural accessibility as one of the primary strengths of the 12-step approach to recovery. The one participant who was an active 12-step member was more comfortable with integrating her personal and professional experience to build an authentic rapport with clients. Finally, there appeared to be a separation between the trauma-focused theory of addiction and 12-step recovery. I agree with Jamie Marich (2020) that integrating trauma-informed practice with 12-step recovery is an important growth area in the art therapy field.

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**APPENDIX A**

**EXAMPLE OF A TRANSCRIPT PAGE WITH VALUES CODING**

- 1 **A3:** So that I kind of see **green vines** all around me and all around that idea that **growth can**  
 2 **happen in a variety of ways, right?**<sup>1</sup> **12-step programs are absolutely one of them**<sup>3</sup>. **And if**  
 3 **people want that structure**<sup>4</sup>, those **steps can be so helpful with guiding people**<sup>5</sup>. I do also, this is  
 4 **gonna go back to one of your earlier questions, I did learn that it's so effective to work them in**  
 5 **order**<sup>6</sup>  
 6 **DB:** Right, right.  
 7 **A3:** Right? **And so I try to encourage that.**<sup>7</sup> I try to, because some people, that's another that's  
 8 another, what were you asking, if there's some misnomers or misinformation?  
 9 **DB:** Yeah.  
 10 **A3:** Some of my young recovery folks in early recovery will say, **"well, I'm just gonna start in**  
 11 **step four."**<sup>8</sup>  
 12 **DB:** Yeah, right!  
 13 **A3:** **"My sponsor told me I could start at step..."**<sup>9</sup> And I really give them **kudos for giving any**  
 14 **step a try**<sup>10</sup>. But then I say, **"have you heard that the steps were designed in a certain fashion,**  
 15 **to work them in succession, has anyone mentioned that?"**<sup>11</sup>  
 16 **DB:** Yeah.  
 17 **A3:** So, you know, so anyway, I see **green**<sup>12</sup> and yes, it's probably because of what I'm looking at  
 18 out the windows, but also because I do believe as an art therapist, **growth is ever available to**  
 19 **folks, if they want it**<sup>13</sup>.  
 20  
 21 **DB:** Yeah, another word that kind of stuck out to me that you said was the "action" based. How  
 22 do you feel like that plays a role in 12-step recovery?  
 23 **A3:** That **people have to get off their own heinies and get there, right**<sup>14</sup>? Or tune in if it's over  
 24 Zoom, or **they have to take some action to help themselves**<sup>15</sup>. **It is not going to fall upon them**<sup>16</sup>.  
 25 And so yeah, that **it is action-based**<sup>17</sup> and **action oriented**<sup>18</sup> on a **daily**<sup>19</sup>.  
 26 **DB:** Yeah.  
 27 **A3:** And **so** as we might get, and as I might, build more **rapport**<sup>20</sup> with people, I might become  
 28 more **strong in reminding them this will be a daily choice**<sup>21</sup>, this **will be daily work**<sup>22</sup>. This will,  
 29 **just like we get up and we brush our teeth every day**<sup>23</sup>, if we **wanna keep these really nice...**  
 30 **DB:** **Mhmm.**  
 31 **A3:** **...we're gonna also want to nurture our heart, our mind, our soul toward what we do want**  
 32 **in our recovery**<sup>24</sup>. And that might involve **reviewing something in the Big Book**<sup>25</sup>, that might  
 33 **reviewing pulling out a handout from one of your therapist, blah blah blah. But action, yes,**<sup>26</sup>  
 34 **daily meditation**<sup>27</sup>, putting on **music that gets you in a more Zen space**<sup>28</sup>. Yep, all of that, **action.**<sup>29</sup>

<sup>1</sup> AS: Green vines

<sup>2</sup> V: Multiple pathways

<sup>3</sup> V: 12 is valid pathway

<sup>4</sup> B: 12 is structured

<sup>5</sup> AT: Steps help guide

<sup>6</sup> B: Work steps in order

<sup>7</sup> B: Work steps in order

<sup>8</sup> B: Some want to skip steps

<sup>9</sup> B: Some want to skip steps

<sup>10</sup> V: Trying step work

<sup>11</sup> B: Work steps in order

<sup>12</sup> AS: Green

<sup>13</sup> B: Growth always available

<sup>14</sup> AT: 12 is program of action

<sup>15</sup> AT: 12 is program of action

<sup>16</sup> AT: Change requires action

<sup>17</sup> AT: 12 is program of action

<sup>18</sup> AT: 12 is program of action

<sup>19</sup> AT: Recovery is daily

<sup>20</sup> V: Rapport

<sup>21</sup> AT: Recovery is daily

<sup>22</sup> AT: Recovery is daily

<sup>23</sup> AS: Teeth brushing

<sup>24</sup> V: Wholistic recovery

<sup>25</sup> V: Big Book

<sup>26</sup> AT: 12 is program of action

<sup>27</sup> V: Meditation

<sup>28</sup> V: Mindful music

<sup>29</sup> AT: 12 is program of action

**APPENDIX B**

**EXAMPLE OF A SPREADSHEET FOR COMPILING VALUE CODES INTO  
THEMES**

|    | A   | B        | C | D                               | E        | F | G                         | H        | I | J                       | K        |
|----|---|----------|---|---------------------------------|----------|---|---------------------------|----------|---|-------------------------|----------|
| 1  | THEME 1: 12-Step is a Large, Accessible Community |          |   |                                 |          |   |                           |          |   |                         |          |
| 2  | Attitudes   | Quantity |   | Beliefs                         | Quantity |   | Values                    | Quantity |   | Associations            | Quantity |
| 3  | 12 is accessible                                  | 10       |   | Different fellowships           | 14       |   | Asking for support        | 12       |   | Coffee                  | 5        |
| 4  | 12 is most accessible                             | 6        |   | Geography matters               | 13       |   | Open mind                 | 6        |   | Circular arrangement    | 3        |
| 5  | Dependable fellowship                             | 6        |   | Meeting host bias               | 7        |   | Psychoeducation           | 6        |   | Smoking                 | 3        |
| 6  | 12 is well-known                                  | 5        |   | Meeting acceptance varies       | 7        |   | Group mutual support      | 4        |   | Group table             | 1        |
| 7  | Meetings are welcoming                            | 5        |   | 12 is gateway to support        | 5        |   | Heterarchy                | 4        |   | King Arthur's round tal | 1        |
| 8  | 12 is laid back                                   | 4        |   | MAT stigma in 12 step           | 5        |   | Holding space             | 4        |   | Nurturing               | 1        |
| 9  | 12 is established                                 | 3        |   | 12 is global                    | 4        |   | Outside support           | 4        |   | Smiling                 | 1        |
| 10 | 12 support is unique                              | 3        |   | Combining 12 and DBT            | 4        |   | Peer support              | 4        |   | Together                | 1        |
| 11 | 12 spirituality is open                           | 3        |   | I know local meetings           | 4        |   | Connection                | 3        |   |                         |          |
| 12 | 12 can dominate social life                       | 2        |   | Online meetings                 | 4        |   | Equity in groups          | 3        |   |                         |          |
| 13 | Belongingness                                     | 2        |   | Openness required for 12        | 4        |   | Meeting shopping          | 3        |   |                         |          |
| 14 | Online less intimidating                          | 2        |   | Openness to 12 increases        | 3        |   | Referrals to 12           | 3        |   |                         |          |
| 15 | Openness  | 2        |   | Pandemic shifted meetings       | 3        |   | Willingness               | 3        |   |                         |          |
| 16 | Women's 12 is wonderful                           | 2        |   | Reconnecting in 12              | 3        |   | Accessibility             | 2        |   |                         |          |
| 17 | Alternatives hard to access                       | 1        |   | Recovery needs community        | 3        |   | Accessible sources        | 2        |   |                         |          |
| 18 | 12 is community building                          | 1        |   | Virtual meetings                | 3        |   | Exploring asking for help | 2        |   |                         |          |
| 19 | 12 gateway to community                           | 1        |   | Women's meetings exist          | 3        |   | Exploring community       | 2        |   |                         |          |
| 20 | 12 group accessible                               | 1        |   | 12 group multiplied             | 2        |   | Accessible materials      | 1        |   |                         |          |
| 21 | 12 is approachable                                | 1        |   | 12 is free                      | 2        |   | Beach meetings            | 1        |   |                         |          |
| 22 | 12 is chill                                       | 1        |   | 12 is widely known              | 2        |   | Busing to meetings        | 1        |   |                         |          |
| 23 | 12 is ubiquitous                                  | 1        |   | 12 pros as ambassadors          | 2        |   | Community building        | 1        |   |                         |          |
| 24 | 12 meant for everybody                            | 1        |   | Community art grew              | 2        |   | Group connection          | 1        |   |                         |          |
| 25 | 12 reaches people                                 | 1        |   | Community is main factor        | 2        |   | Important in my commun    | 1        |   |                         |          |
| 26 | Happiness in community                            | 1        |   | Groups open and ongoing         | 2        |   | Murals                    | 1        |   |                         |          |
| 27 | Homey   | 1        |   | Isolation -> addiction          | 2        |   | Open heart                | 1        |   |                         |          |
| 28 | I like open spirituality                          | 1        |   | Meeting fit varies              | 2        |   | Open HP                   | 1        |   |                         |          |
| 29 | MAT controversial                                 | 1        |   | Meeting population varies       | 2        |   | Open mindset              | 1        |   |                         |          |
| 30 | Online meetings accessible                        | 1        |   | Social deficits -> addiction    | 2        |   | Openness to 12            | 1        |   |                         |          |
| 31 | Online meetings safer                             | 1        |   | Some groups allow visitors      | 2        |   | Removing barriers         | 1        |   |                         |          |
| 32 | Social anxiety affects referral                   | 1        |   | Speaker meetings                | 2        |   | Wholistic recovery        | 1        |   |                         |          |
| 33 | Some AA more dogmatic                             | 1        |   | Stigma has reduced              | 2        |   |                           |          |   |                         |          |
| 34 | Steps accessible                                  | 1        |   | 12 common foundation            | 1        |   |                           |          |   |                         |          |
| 35 | Steps help guide                                  | 1        |   | 12 expanded to department       | 1        |   |                           |          |   |                         |          |
| 36 | Virtual meetings are good fit                     | 1        |   | 12 groups open & ongoing        | 1        |   |                           |          |   |                         |          |
| 37 |   |          |   | 12 part of my community         | 1        |   |                           |          |   |                         |          |
| 38 |   |          |   | 12 under credited by therapists | 1        |   |                           |          |   |                         |          |
| 39 |   |          |   | 12 well established             | 1        |   |                           |          |   |                         |          |
| 40 |   |          |   | AA/NA are more popular          | 1        |   |                           |          |   |                         |          |
| A1 |   |          |   | AA/NA Attractions not promotion | 1        |   |                           |          |   |                         |          |