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# Self-Identified Atheists in 12-Step Substance Use Disorder Treatment and Aftercare

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# Walden University

College of Social and Behavioral Sciences

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Elizabeth Clare Bayley

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Walden University
2021

Abstract

Self-Identified Atheists in 12-Step Substance Use Disorder Treatment and Aftercare

by

Elizabeth Clare Bayley

MS, Walden University, 2014

BS, California State University Northridge, 1989

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Psychology

Walden University

May 2021

## Abstract

The Minnesota model is ubiquitous in the United States for the treatment of substance use disorder (SUD). The model uses 12 steps and is centered on a belief in god(s) or a higher power; however, it is anathema to an atheist worldview. Researchers have noted that atheists do not readily become involved with 12-step programs and tend to drop out; however, there had been no qualitative investigations of the lived experiences of atheists in 12-step SUD treatment. The purpose of this study was to determine whether 12-step SUD treatment was problematic for atheists. An integrated theoretical framework was used. Minority stress theory was combined stigmatized identity theory, cognitive dissonance theory, and social identity theory. The interpretative phenomenological analysis method was applied to data collected from a purposive sample of 13 atheists from across the United States who had voluntarily attended 12-step SUD treatment within the prior 3 years. Themes that emerged from the data included that the participants were cognizant of having a stigmatized identity and experienced discrimination because of their atheism. The majority of the participants were “out” as atheists, but some concealed their lack of belief due to fear of ostracism. Another finding in the data was the perception that treating staff held a bias towards 12-step SUD programs and did not refer clients to alternatives. Most of the participants were unable to reconcile their lack of belief with the 12-step programs and dropped out soon after discharge. Some participants found secular mutual aid groups more consonant and, in turn, more helpful. Atheists with SUDs may benefit from the results of this study with better treatment outcomes that may arise from increased awareness and understanding of their needs. Positive social change may result from the lower SUD burden afforded by better treatment outcomes.

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# Dedication

For Mom and Dad, my favorite atheists.

## Acknowledgments

I would like to thank my Committee Chair Dr. Tracy Marsh for her support, patience, and encouragement, as well as gentle nudging when needed. I would also like to thank my Second Committee Member Dr. Matthew Hertenstein. Your course sparked my interest in social psychology, and you were an important contributor to my research plan. To Dr. Jean Kallie, my stalwart cheerleader, friend, confidante, and partner in crime, I can never thank you enough on paper -- just know that your love and support meant the world through the long process of the dissertation. You told me to go for it, and I did. Thank you to Dr. Clinton Weyand -- you inspired me to go back to school and changed my life. A heartfelt thank you to Dr. Mohammad and Vickie. Without you, this would not have been possible. Thank you to Mom and Dad, who have believed in me my whole life. Aside from the obvious, without growing up around your hard work and intellectual curiosity, I would not have been able to do this, nor would I have wanted to. Finally, to my erstwhile beloved Ivan, who passed the torch to my sweet Ali. Thank you both for being wonderful cats and discerning companions throughout the years.

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# Chapter 1: Introduction to the Study

In October 2014, Barry Hazle won $1.9 million from the State of California, settling a lawsuit for violating his civil rights ("Hazle v. Crofoot," 2014). Hazle, a lifelong atheist, received parole on the condition that he attend a 12-step SUD treatment program. Initially, Hazle had asked to attend a non-12-step, secular SUD treatment program, but none was available in his area. Not wanting to be sent back to prison, Hazle complied but registered an objection to his parole officer. Three days later, Hazle was arrested and sent back to prison for 100 days for violating his parole ("Hazle v. Crofoot," 2014; Walsh, 2014). The United States Court of Appeals, Ninth Circuit, decided in Hazle's favor. The court, citing "uncommonly settled case law," held that the parole officer had violated Mr. Hazle's civil rights. The Establishment Clause of the First Amendment prohibits the government from coercing an individual to attend a religion-based SUD treatment program (see"Hazle v. Crofoot," 2014, p. 1; "Inouye v. Kemna," 2007; "Kerr v. Farrey," 1996).

Mr. Hazle's case is an extreme example of how problematic it can be for atheists to attend faith-based, 12-step programs such as AA. The religious connotations of AA are objectionable to atheists who, by definition, lack a belief in god(s). The language of AA is replete with the word "God" with a capital "G." Five of the 12 steps of AA refer to god explicitly, and the use of "His" and "He" implies god in several others (AA, 1939).

For the atheist, formal 12-step oriented treatment is akin to a faith-based program because most addiction counselors have achieved sobriety in 12-step mutual-aid groups and proselytize the 12-step philosophy and slogans (Bergman & DeLucia, 2014). Some

treatment staff verbally express gratitude to god while they are at work. There is significant pressure from peers and staff to embrace the 12-step philosophy and implication that a person may not succeed in achieving long-lasting sobriety without it (Peele, Bufe, & Brodsky, 2000). The overarching message is that the 12-step program works for everyone, and it is the client's fault if they fail because they were not motivated or was in denial (Peele et al., 2000).

Researchers have cited the religiosity of AA as a barrier to participation for atheists (Kelly et al., 2010). The position of AA is that it is a "spiritual," but not "religious" program, and adherents can construct a personal "higher power" (Alcoholics Anonymous, 2001). Case law in the United States has nullified this disclaimer. Courts have characterized AA as a religious organization in cases involving violations of the Establishment Clause of the First Amendment (see "Cox v. United States," 2002; "Hazle v. Crofoot," 2014; "Inouye v. Kemna," 2007).

In this chapter, I present the background of the study, including an overview of extant literature related to the topic and the gap in the knowledge that I addressed by conducting the research. I also explain why the attainment of this knowledge has the potential to inform culturally-competent informed consent, assessment, and treatment plans in SUD treatment programs. The social implication of new knowledge could be SUD treatment that is more congruent with atheist beliefs and, in turn, more effective. More effective SUD treatment could lead to a reduction in the SUD burden on society.

## Background

Substance use disorders (SUDs) are psychiatric disorders listed in the *Diagnostic and Statistical Manual of Mental Disorders*, 5th edition (American Psychiatric Association, 2013). Someone meets the diagnostic criteria for SUD when they are suffering clinically significant impairment because of the abuse of alcohol, other drugs, or both (American Psychiatric Association, 2013). Impairment can be physical, such as health problems, and it can be functional, such as failure to meet responsibilities at work, school, or at home.

In 2016 in the United States, approximately 21 million people aged 12 or over needed treatment for SUD (Substance Abuse and Mental Health Services Administration [SAMHSA], 2017). This number represents 1 in 13 people or 8% of the population over 12 years old (SAMHSA, 2017). Young adults (ages 18 to 25) were afflicted at twice the overall rate, at 1 in 7 people, or 14% (SAMHSA, 2017). Only 10% of all those afflicted received SUD treatment.

According to Roman and Johnson (2004), 75% of privately funded SUD treatment programs use the 12-step model, and 66% require attendance at 12-step meetings (Roman & Johnson, 2004, p. 22). Researchers have shown that 12-step facilitation is no more effective than evidence-based modalitie,s such as cognitive behavioral therapy, motivational interviewing, or medication-assisted treatment (Higgins & Green, 2011; Montalto, 2015; Project MATCH Research Group, 1998b).

The Minnesota model is the quintessential 12-step SUD treatment protocol. One of the characteristics of the Minnesota model is the employment of counselors who have successfully resolved their SUD with a 12-step program. Novotna et al. (2013) found that such lived experience can bias treatment decisions because counselors believe lived experience is more credible than research evidence. Counselor bias may affect their awareness of non-12-step mutual-aid groups and the use of evidence-based modalities, such as motivational interviewing or cognitive behavioral therapy (Novotna et al., 2013).

Additionally, Sue, Arredondo, and McDavis (1992) cautioned that "counselors who are unaware of the bias for differences that occur between them and their culturally different clients are likely to impute negative characteristics" (p. 69). In the SUD treatment context, counselors may impute negative reasons for atheist clients' reluctance to embrace the 12 steps, such as denial, lack of motivation, or willfulness (Novotna et al., 2013).

Meier and Davis (2010) found that counselors need to be aware of their stereotypes and biases. Otherwise, the therapeutic alliance may suffer. Counselor bias could lead to the misunderstanding of family dynamics, misdiagnoses, and ineffective interventions (Meier & Davis, 2010). Counselors may also have difficulties conceptualizing presenting problems when they have biases (Guanipa & Woolley, 2000).

In the SUD treatment context, counselor bias can manifest as resistance to the adoption of evidence-based modalities, such as motivational interviewing, cognitive behavioral therapy, dialectical behavioral therapy, and medication-assisted treatment (SAMHSA, 2017; Weisner & Hay, 2015). Bias towards the 12-step modality may cause

treatment staff to unwittingly misinform the public about the existence and effectiveness of secular alternatives to 12-step SUD treatment and support groups. Laudet (2003) conducted a survey of SUD counselors for referrals for "clients who did not want to attend AA." The results showed that 47% of the counselors stated non-12-step approaches were ineffective, 45% stated AA was the only approach, and 8% said there were helpful alternative approaches (Laudet, 2003).

AA was founded in 1935 by a few members of the Oxford Group, a Christian revivalist organization in the 1930s (Kurtz, 1979). The founders suffered from alcoholism and were trying to stay abstinent by attending Oxford Group meetings. Many of the members wanted to focus on abstinence, so they decided to form a specialized support group for alcoholics, which became AA (Kurtz, 1979). These founders adapted the Oxford Group's *Five Procedures*: "Giving in to god, Listening to god's Direction, Checking for Guidance, Achieving Restitution, and Sharing" (Walters, 2002, p. 54) as a framework for the 12 steps. I discuss the 12 steps in general here and go into more detail in Chapter 2.

The 12 steps of Alcoholics Anonymous (AA) are a series of actions and prayers that include surrendering to god or a higher power, examining past behavior, confessing misdeeds to another person, making amends, reflecting every day on behavior, apologizing instantly for any wrongdoing, praying, and proselytizing and service (Alcoholics Anonymous, 1939). The culmination of the 12-step process is a spiritual awakening/ religious conversion that may be undesirable to the atheist whose identity stems from an absence of, or rejection of, a belief in god(s) (Alcoholics Anonymous,

2001; Brewster, Robinson, Sandil, Esposito, & Geiger, 2014; LeDrew, 2013). Atheists, by definition, do not believe in god(s). Hence, the notion that sobriety is dependent on a belief in and submission to a god or higher power is anathema to the atheist.

Clients in 12-step SUD treatment programs learn how to find 12-step meetings and how to get a 12-step sponsor before they leave treatment. A sponsor is someone who has completed the 12 steps and is willing to help someone else go through the process. Aftercare directives usually include attendance at 12-step mutual-aid groups and continued sponsorship (Kelly, 2003). Sometimes, aftercare involves living at a structured sober living home where attendance at 12-step meetings is mandatory.

There have been several studies on the impact of religiosity on participation in AA. One study of predictor variables of SUD treatment outcome involved participants at the Veterans Administration who were 1-year postinpatient 12-step treatment at the Veterans Administration (Kelly, Kahler, & Humphreys,, 2010). Kelly et al. (2010) found that lacking a religious preference significantly correlated with a poor outcome. Craig, Krishna, and Poniarski (1997) revealed similar findings in a study with Native Americans and recommended alternative treatment modalities for clients who would feel alienated by the religious overtones of AA.

In another study, Galanter (2006) found that atheists were less likely to fit in with 12-step mutual-aid groups because, although some atheists are spiritual, it might be difficult to feel the same sense of fellowship and belonging experienced by religious adherents in 12-step mutual-aid groups. A sense of belonging reinforced involvement with 12-step mutual-aid groups (Galanter, 2006).

Atkins Jr and Hawdon (2007) had similar findings in their national survey of mutual-aid groups for addiction. Atkins Jr and Hawdon (2007) found that religiosity of the respondents was one fundamental difference between participants of 12-step versus secular groups. Religious respondents were more likely to take part in the 12-step groups and Women for Sobriety, and the nonreligious respondents were significantly less likely to join 12-step groups. Religiosity had little impact on participation in one secular group, SMART Recovery, but did correlate with a decreased involvement in Secular Organizations for Sobriety (Atkins Jr & Hawdon, 2007).

Similar to Atkins Jr and Hawdon (2007), Borras et al. (2010) found 12-step groups problematic for nonreligious individuals and recommended referring these clients to alternative mutual-aid groups that are more compatible with their worldview. Moreover, Kelly et al. (2010) performed a factor analysis and found that the most significant reasons participants dropped out of AA were comorbid psychiatric diagnoses and spiritual concerns. The researchers developed a questionnaire based on the study results called REASONS for use as a screening tool for a referral to 12-step or non-12 step mutual-help groups (Kelly et al., 2010).

There are special AA groups for agnostics and atheists (C. R. , 2017). Non-12-step, secular mutual-aid groups may be viable alternatives for atheists who object to the religiosity of the 12 steps (Bergman & DeLucia, 2014; Tusa & Burgholzer, 2013). I discuss these alternatives in Chapter 2.

Atheists have a marginalized identity in the United States and are subject to stigma and discrimination in everyday life (Brewster, Hammer, Sawyer, Eklund, &

Palamar, 2016; Brewster, Velez, Foster, Esposito, & Robinson,2016). In the context of 12-step SUD treatment where religiosity is highly salient, atheists may decide to conceal their stigmatized identity, a similar phenomenon to members of a sexual minority having to decide when and with whom to "come out of the closet" (Brewster, Velez, et al., 2016). According to studies supporting minority stress theory, people with stigmatized identities suffer increased psychological distress because of their minority status (Meyer, 2003). It is essential to learn whether this occurs with atheists in 12-step SUD treatment and aftercare to inform SUD treatment professionals so that atheists do not feel misunderstood or dismissed. Increased knowledge about atheists' SUD treatment experiences could inform clinicians' provision of ethical, informed consent and evidence-based treatment that could be more attuned to atheist preferences and, in turn, be more effective. This research will also inform public policymakers and criminal justice professionals about the needs of atheists in SUD treatment.

Clinicians are beholden to ethical requirements to choose treatment modalities that accommodate a client's worldview, an essential part of evidence-based practice (American Psychological Association, 2017). For clinicians to become evidence-based practitioners, they screen for client preferences and values when assessing clients for admissibility to their SUD treatment programs. The prevailing assumption is that 12-step programs work for everyone (Peele et al., 2000). This assumption leads to a bias towards 12-step programs and the admission of atheists to 12-step SUD treatment programs and aftercare contraindicated for this population.

The overarching ethical standard for the practice of psychology is to “do no harm” (American Psychological Association, 2017). A goal of this study is to illuminate any psychological distress the atheist may feel while attending 12-step SUD treatment and aftercare. Studies have shown that potential triggers for distress are 12-step meetings with group prayer; treatment staff invalidation of the atheist worldview; and deciding whether to conceal their stigmatized identity, or "come out" to staff, peers, and lay 12-step adherents (Chaudoir & Quinn, 2016; Cloud, 2017; Kelly, Bergman, Hoeppner, Vilsaint, & White, 2017).

There are social implications of understanding the atheist experience in 12-step SUD treatment and aftercare. Once the needs of atheists in SUD treatment are better understood, SUD treatment and aftercare may become more effective, and possibly less distressing. Also, a better understanding of atheist needs in SUD treatment and aftercare can aid clinicians in the provision of culturally-competent informed consent and evidence-based practice. If these factors result in more atheists completing treatment, the burden of SUD on families, businesses, and society-at-large may go down. Families may become more stable and less violent, and crimes associated with SUD could go down, including a reduction in the prevalence of impaired driving.

If the needs of atheists were better understood, there might be more referrals for atheists to non-12-step mutual-aid groups such as the Secular Organization for Sobriety, Smart Recovery, or Women for Sobriety. More compatible referrals may lead to improved compliance and better SUD treatment outcomes, reducing the societal burden of addiction in the United States

**Problem Statement**

The problem I addressed in the research was the lack of qualitative knowledge about the lived experience of atheists in 12-step SUD treatment and aftercare. This problem was necessary to address because of the religiosity of the 12-steps as a barrier to atheist participation in 12-step groups and because most of the SUD treatment programs in the United States use the 12-step model (see Kelly et al., 2010). Also, it was essential to discover whether atheists experienced any adverse effects, including psychological distress, due to the burden of having to manage their stigmatized identity in an environment where religion is highly salient. This knowledge can facilitate ethical, informed consent procedures for atheists entering 12-step SUD treatment and aftercare. Knowledge of atheists' needs in SUD treatment can aid in the provision of ethical, culturally competent, evidence-based practice.

Researchers have shown that atheists have a low affiliation rate in 12-step SUD treatment aftercare, which consists of 12-step meeting attendance, step-work, and obtaining a sponsor (Tonigan, Miller, & Schermer, 2002). Because the hallmark of the atheist identity is disbelief in god, any expectation that atheists embrace the 12-step philosophy, the foundation of which is the belief in a god(s) or a higher power, is a denial or an invalidation of the atheist worldview.

Furthermore, there is a stigma towards atheists in the United States (Edgell, Hartmann, Stewart, & Gerteis, 2016). In situations where religiosity is salient, like 12-step SUD treatment and aftercare, atheists must manage their stigmatized identity (Quinn & Chaudoir, 2009; Quinn et al., 2014). As with individuals who have sexual minority

status, atheists may choose to "come out" as atheists or conceal their atheism. Either way, the management of a stigmatized identity is often correlated with psychological distress (Chaudoir & Quinn, 2016; Quinn & Earnshaw, 2013).

The extant research literature on 12-step SUD treatment and aftercare included a small body of quantitative research into atheist affiliation and attrition (Pagano, White, Kelly, Stout, & Tonigan, 2013; Tonigan et al., 2002). These studies offered quantitative evidence of a low level of involvement of atheists in 12-step SUD treatment and aftercare but did not capture the subjective experiences of atheists. Additionally, despite evidence that atheists have a stigmatized identity and experience discrimination, it is not known whether atheists suffer any adverse psychological effects while undergoing 12-step SUD treatment and aftercare (Brewster, Velez, et al., 2016). I addressed this gap by investigating how self-identified atheists felt while undergoing 12-step SUD treatment and aftercare.

## Purpose

The purpose of this qualitative study was to heighten awareness and understanding of the lived experiences of self-identified atheists attending 12-step SUD treatment and aftercare. I used inductive reasoning and the interpretative phenomenological analysis (IPA) approach (see Smith & Eatough, 2007). The IPA approach is appropriate for research problems that require the investigator to understand the subjective experiences of the participants, while at the same time setting aside personal biases and beliefs (Moustakas, 1994).

I conducted written interviews with self-identified atheists who had voluntarily undergone 12-step SUD treatment and aftercare in the preceding 3 years. By using open-ended questions to capture the rich detail of the participants' experiences, I developed a thematic understanding of the results by coding the responses to elucidate themes that appeared (see Creswell, 2016).

The results of this study offer insight into the subjective experiences of atheists during 12-step SUD treatment and aftercare. Such insight can inform SUD treatment professionals and other stakeholders in providing ethical, informed consent and SUD treatment and aftercare that accommodate atheists' unique treatment needs.

## Research Question

The goal of this study was to develop a richly detailed, comprehensive understanding of the lived experiences of self-identified atheists in 12-step SUD treatment and aftercare. To that end, I presented an exploratory question. Exploratory questions investigate phenomena that are not well understood (Creswell, 2013).

The overarching exploratory question was as follows: What are the lived experiences of atheists in 12-step SUD treatment and aftercare?

## Theoretical Framework

The theoretical framework for this study was an integrated model, with minority stress theory as the overarching theme (see Meyer, 2003). Extant research supported the use of several compatible theories to explain the experiences of atheists in 12-step SUD treatment and aftercare: the management of a stigmatized identity theory by Goffman (1963), cognitive dissonance theory by Festinger (1957), and the rejection-identification

model (Branscombe, Schmitt, & Harvey, 1999) of social identity theory by Tajfel and Turner (1986).

## Minority Stress Theory

Minority stress theory posits that undue stress related to marginalized status correlates with psychological distress (Meyer, 2003). Minority stress theory is the lens through which researchers have studied the psychological health of sexual minorities (Brewster, Velez, et al., 2016). According to Meyer (2003), examples of experiences that are minority stressors are discrimination, prejudice, the expectation of stigma, and concealment of marginalized identity. Atheists have minority stressors due to their marginalized status in the United States (Brewster, Hammer, et al., 2016). Minority stressors correlate to adverse mental health outcomes such as psychological distress, depression, and anxiety (Chaudoir & Quinn, 2016).

When self-identified atheists embark on 12-step SUD treatment, they enter an environment where the salience of their atheist identity as "other" heightens. There may also be feelings of guilt and shame for recent behavior leading up to the treatment episode. From this vulnerable stance, self-identified atheists may experience frequent reference to a higher power or god and pressure to embrace the religion-based 12-step philosophy, which heightens awareness of their marginalized status and increases the anticipation of stigma (Quinn et al., 2014).

## Cognitive Dissonance Theory

The second theory I used in this study was the Festinger (1957) theory of cognitive dissonance. Cognitive dissonance refers to the psychological distress that arises

from the internal conflict of holding two incompatible beliefs (Cooper, 2007). The self-identified atheist does not believe in god. When told the 12-step program is the only path to sobriety, a person may experience psychological discomfort that they will seek to reduce (Cooper, 2007).

Within the cognitive dissonance theoretical framework, the atheist may be able to reduce dissonance by altering their attitude towards the 12-step philosophy (Cooper, 2007). They may deem that AA's overtly Protestant components, such as the Lord's prayer at meetings, are not a barrier for participation and attempt to fit in or seek out specialized 12-step meetings for atheists and agnostics. They may convince themselves that the 12-step program is not too religious, and it is possible to accept parts of the program without fully embracing the idea of divine intervention. The individual may conclude that the benefit derived from receiving the social support of the 12-step group members is worth the cost of changing their attitude (Cooper, 2007). Paradoxically, the cost of changing their attitude may eventually include the feeling of hypocrisy (Yousaf & Gobet, 2013).

Hypocrisy is profoundly disturbing for people whose identity centers around the forsaken value or belief. According to Yousaf and Gobet (2013), there are negative emotional and attitudinal consequences of religious hypocrisy within the cognitive dissonance paradigm. Participants experienced guilt and shame for behaving contrary to their beliefs. Guilt and shame could lead to depression and maladaptive coping skills, such as alcohol or drug use (Yousaf & Gobet, 2013).

In another arm of their study, Yousaf and Gobet (2013) found that participants used a different mechanism to relieve their dissonant state than a change of their attitude. In this case, the participants became more committed to their belief system. Atheists in 12-step SUD treatment may experience dissonance from the pressure to accept a belief that is contrary to their worldview. To relieve the dissonance, the atheist may become more committed to their nonbelief and reject the 12-step philosophy.

Individuals who grew up in atheist families may bristle at being told they must be open to the possibility of the existence of a god or divine intervention and may reject this notion (Simonson, 2011; Zimmerman, Smith, Simonson, & Myers, 2015). Self-identified atheists with a religious upbringing have already gone through the potentially painful and unpopular process of deconversion and the rejection of the existence of god. According to Hunsberger and Altemeyer (2006), atheists perceive their atheism as the result of critical thinking and independent assessment of religion. Atheists and agnostics ranked higher than all religious groups in the Pew Forum's "What Americans Know About Religion" survey , indicating that atheists have learned about the world's religions and have analyzed religious claims (Pew Research Center, 2019). There is a narrative of critical free-thought that forms the atheist identity (Fitzgerald, 2003; Zimmerman et al., 2015). Any attempt to change the atheist belief system, such as SUD treatment staff or AA peers asking atheist clients to keep an open mind about the existence of a god or a higher power, is dismissive and invalidates the atheist worldview (Garneau, 2012; Her, 2017; Sue, 2010). Such a cavalier attitude towards the atheist's beliefs could lead to resentment and hostility towards 12-step proponents and possible lasting psychological distress.

**Rejection-Identification Model**

The rejection-identification model is rooted in social identity theory (Branscombe, Fernandez, Gomez, & Cronin, 2012; Tajfel & Turner, 1986). The rejection-identification model explains the ways members of outgroups protect and keep their psychological well-being in the face of discrimination and prejudice from members of the ingroup. The rejection-identification model describes the strengthening of the outgroup members' identity in reaction to negative interactions with members of the ingroup (Branscombe et al., 2012). For example, atheists may join atheist activist groups as a reaction to a vitriolic speech by fundamentalist Christian groups. For the self-identified atheist in 12-step SUD treatment and aftercare, the rejection-identification model of social identity theory may explain the atheist who rejects the 12-step philosophy, bolsters their identification with the atheist identity, and develops hostility to treatment staff and members of the 12-step community. This outcome may lead to a negative psychological state such as depression and possibly to maladaptive coping mechanisms.

**Management of Spoiled Identity**

The historically high percentage of Christians in the United States has led to Christian privilege and, in turn, the marginalization of atheists and other religious minorities (Blumenfeld, 2009). Christian privilege is the unearned advantage Christians have in the United States. An example of Christian privilege is the ability to take religious holidays off with pay because companies in the United States usually provide paid holidays on the religious holidays of the Christian faith (Riswold, 2015).

Atheists are one of the least trusted and most stigmatized groups in the United States (Edgell et al., 2016). As such, atheists experience discrimination, invalidation, and prejudice (Cragun, Kosmin, Keysar, Hammer, & Nielsen, 2012). Minority stress may cause atheists to conceal their worldview to avoid invasive and judgmental remarks by SUD treatment staff and lay members of AA. This concealment and attendant distress are consistent with extant research on the management of spoiled identity theory, which can explain this type of study data (Elliott & Doane, 2015; Quinn et al., 2014). As with the aforementioned theoretical outcomes, the self-identified atheist may experience psychological distress in 12-step SUD treatment and aftercare (Chaudoir & Quinn, 2016).

## Nature of the Study

A qualitative study provided an in-depth understanding of the subjective experiences of atheists in 12-step SUD treatment and aftercare (see Creswell, 2016). I used the IPA approach to conduct this study (see Smith & Eatough, 2007). Researchers use this approach to transcend, or set aside, personal experience and bias (Smith & Eatough, 2007). The interview data provided detailed descriptions of this phenomenon, giving information that quantitative methods cannot provide.

## Definitions

*12-step mutual-aid groups:* Community support groups such as AA, which are open to the public at no cost (Borkman, 2008; Orlowski, 2017). These groups hold weekly meetings that adhere to a standardized format (Creswell, 2013; Wiechelt, 2015).

*12-step SUD treatment and aftercare:* A term used to describe a specialized SUD treatment program based on the 12 steps of AA, and the accompanying postdischarge

directives that support the client's recovery maintenance (White, 2014). The level of care of the treatment episode may be residential, partial hospitalization, or intensive outpatient (SAMHSA, 2018). Aftercare usually consists of regular attendance at 12-step meetings, obtaining a sponsor, and working the steps (Miller, Sorensen, Selzer, & Brigham, 2006). Aftercare may include medication, psychotherapy, and sober living (Miller et al., 2006).

*Counselor bias:* The tendency to favor one treatment modality over another (Hunter, 2001). In this case, counselor gender bias occurs when counselors favor 12-step mutual-aid groups as the best choice for clients to the extent that they are either not aware of or are misinformed about alternatives.

S*ober living:* A group home where residents must stay sober, get a sponsor, and attend 12-step meetings (Polcin, Korcha, Bond, & Galloway, 2010). Sober living is a transitional step between SUD treatment and independent living (Cloud, Rowan, Wulff, & Golder, 2008).

*Sponsor:* A person who coaches one or several members of a 12-step program such as AA (Young, 2013). The sponsor has usually been sober for more time than the person whom they sponsor and helps them to complete the 12 steps (Young, 2013).

*Theist* : A person who has a belief in god(s) (Hitzeman & Wastell, 2017).

*Treatment staff* : A term used in this study to denote paraprofessionals in SUD treatment facilities such as residential advisers or addiction counselors (White, 2014). Treatment staff are usually in recovery and are hired for their knowledge of the 12-step philosophy and practices (White, 2014).

## Assumptions

This study held several assumptions. First, I assumed that participants self-identified as atheists in their everyday lives. Second, I assumed that the participants were truthful about having undergone 12-step SUD treatment and aftercare, including five 12-step meetings, within the last 3 years. Lastly, I assumed that participants were honest in their responses to questions about experiences, thoughts, and feelings. These assumptions were necessary because I could not independently confirm the veracity of the participants' responses.

## Scope and Delimitations

This study included self-identified atheists in the United States. They were age 18 and over, underwent voluntary 12-step SUD treatment and aftercare within the 3 years before October 2018, and attended at least five 12-step meetings. I focused on self-identified atheists because people who identify as not believing in a god are sure of their beliefs (see Abbott, 2017) as opposed to agnostics and other religious "nones" who may have believed in god but chose not to adhere to any specific religious practices. Researchers have shown that people who are less sure about their belief in god become more convinced about god's existence after spending time in 12-step mutual-aid groups and 12-step SUD treatment (Tonigan et al., 2002). I excluded participants who did not identify as an atheist.

Qualitative researchers do not strive for the transferability of results because the focus of the qualitative inquiry is to investigate a small, nonrandom sample of a population who have the first-hand experience with a phenomenon (Creswell, 2013). In

this study, I conducted interviews using open-ended questions to obtain detailed data that I analyzed for common themes that led to meaningful conclusions (see Creswell, 2016). Although this study resulted in dense data about self-identified atheists' lived experiences in 12-step SUD treatment and aftercare in the United States, the results are not transferable to all atheists' subjective experiences in 12-step SUD treatment and aftercare. I recommend that further researchers use the themes from my study to construct an instrument to measure this phenomenon in a large sample, with significant effects that can be generalized to the atheist population.

## Limitations

This study had several limitations. Because the sample was a small number of self-identified atheists aged 18 and over who had undergone voluntary 12-step SUD treatment and aftercare and attended at least five 12-step meetings, the findings are not transferable to any other populations. The geographical scope was within the United States, and the experiences and attendant narratives of participants do not apply to atheists in all regions of the United States. The prevalence of atheism varies widely by region, and the social dialog surrounding atheism differs as well.

As an exploratory study, results do not yield quantitative data to analyze for statistical significance. Rather, I intended the study results to complement quantitative data already in the literature so that the whole picture of the atheist experience in 12-step SUD treatment and aftercare could appear. Only then can a meaningful dialog take place among stakeholders in the SUD field.

I was aware of a personal bias I held against the use of 12-step SUD treatment for atheists. I used bracketing to address this bias so that it did not affect the results of the study. Bracketing is a form of compartmentalization, wherein the researcher strives to take a fresh perspective by setting aside their experiences throughout the research process (Creswell, 2016; Hamill & Sinclair, 2010; Husserl, 1931). I used journaling to bracket my experience and bias (see Hamill & Sinclair, 2010; Husserl, 1931). I journaled throughout the process of collecting and analyzing my data, as well as when I wrote up the results and conclusion. As an additional precaution to assure objectivity, before I gathered data, I submitted interview questions to SUD treatment experts and my doctoral research committee to confirm neutrality of wording and screen for "leading" questions. Another method of ensuring my objectivity was to use member checking. The transcripts were sent to the corresponding participant so that they could confirm that I captured the meaning of their interview responses.

## Significance

I conducted this research to fill a gap in understanding the subjective experiences of atheists in 12-step SUD treatment and aftercare. This project is important because atheists are an underrepresented population in psychological research, even in the realm of SUD treatment research, where spirituality is an overriding theme. There is quantitative evidence that atheists are likely to disengage with 12-step mutual-aid groups, but there was no research to date that described how atheists subjectively experience 12-step mutual-aid groups (see Kelly et al., 2010; Tonigan et al., 2002). It was essential to know how self-identified atheists experience 12-step SUD treatment and aftercare

because the 12-step philosophy is incongruent with the atheist worldview and, in turn, a potential source of distress. The SUD treatment clinicians need to know if self-identified atheists experience psychological distress during 12-step SUD treatment and aftercare.

Insights from this study build on prior knowledge about atheists undergoing 12-step SUD treatment and aftercare, including whether the experience is psychologically distressing. The study also serves to inform SUD treatment programs, clinicians, policy-makers, criminal justice professionals, and other stakeholders in the SUD treatment field. The goal was to use the knowledge from the study to inform the provision of ethical, culturally competent, inclusive, and affirmative experiences for atheists in SUD treatment and aftercare.

## Summary

SUD is a significant public health crisis in the United States. Treatment for SUD must be effective, multiculturally competent, and not cause the sufferer added distress. Most SUD treatment and aftercare programs in the United States center around the 12-step philosophy. The 12-step philosophy uses religious concepts such as surrender, submission to god's will, confession, atonement, proselytizing, and religious conversion to aid sufferers in their recovery. Atheists are not well-suited to 12-step SUD treatment and aftercare because they do not have a belief in god.

I conducted this study to explore the lived experiences of atheists in 12-step SUD treatment and aftercare. I used a qualitative method, specifically the IPA approach, to extract rich detail about what the atheists experienced and how they felt during the process.

The most helpful theoretical framework for analyzing and explaining the resulting interview data was an integrated, pan-theoretical model with minority stress theory as the conceptual lens. There were three theoretical trajectories for the atheist in the context of 12-step SUD treatment and aftercare, based on my analysis of extant literature. These were (a) management of stigmatized identity theory (Goffman, 1963), (b) the rejection identification model (Branscombe et al., 2012) of social identity theory (Tajfel & Turner, 1986), and (c) cognitive dissonance theory (Festinger, 1957)

In Chapter 2, I give a detailed review of the extant literature surrounding atheism, SUD treatment and aftercare, and theories. In Chapter 3, I describe the method used in the study, including the recruitment of participants and data collection methods. In Chapter 4, I describe the results of my study.  In Chapter 5, I analyze my findings, present the limitations of the study, make recommendations for future research. Addictionally I discuss the social change and clinical implications of my findings.

# Chapter 2: Literature Review

## Introduction

The purpose of this study was to investigate the lived experience of atheists in 12-step SUD treatment and mutual-aid groups, such as AA. The 12-step philosophy is anathema to the atheist because they lack a belief in a god or a higher power (Alcoholics Anonymous, 1939; Lopez Gaston, Best, Day, & White, 2010; Sahker, 2016). Atheists reject the basic tenets of 12-step programs: that sobriety is dependent on a relationship with a higher power, or god; that one must turn their will and life over to god; and that a spiritual awakening, or religious conversion, will result from diligent completion of the 12 steps (Alcoholics Anonymous, 1939; Brewster et al., 2014).

SUD is a significant public health problem in the United States. According to the National Institute of Drug Abuse (2019), the annual costs to society of lost productivity, health care, and criminal justice are about $740 billion. An individual suffering from SUD faces profoundly damaging consequences to their health, family, career, and even death. At 67,397 in 2018, drug overdose is the most common cause of injury death, having surpassed car accidents (Sehgal, 2020).

Every year, approximately 9% of the United States population meet the DSM-5 diagnostic criteria for a SUD (Lipari, Park-Lee, & Van Horn, 2016). Of these, 20.8 million people, only 10%, or 2.2 million individuals, received any treatment (Lipari et al., 2016). Treatment options are outdated. The most prevalent treatment philosophy in the United States is the 12-step approach, widely adopted in 1939. Roman and Johnson (2004), in their National Treatment Center Study, found that between 75% and 93% of all

SUD treatment programs use the 12-step philosophy. In cases where the 12-step approach may be contraindicated or problematic, clinicians must respond by referring clients to alternative modalities for treatment and aftercare.

Clinicians have an ethical duty to provide patients with culturally competent, evidence-based practices (American Psychological Association, 2017; Weisner & Hay, 2015), the current standard of patient care (Weisner & Hay, 2015; Witbrodt et al., 2014). Client preference and characteristics are necessary components of evidence-based practice (Weisner & Hay, 2015). In the context of SUD treatment, clinicians are beholden to assess each client's spiritual beliefs and preferences to develop a compatible treatment and aftercare plan (CASA Columbia, 2012).

In the United States, 40% of atheists are aged 18 to 30 (Keysar, 2014; Pew Research Center, 2015). Individuals in this age group also account for 35 to 40% of all SUD treatment admissions (SAMHSA, 2016). There is a need for SUD treatment and aftercare that is compatible with atheists' needs, including 12-step alternatives (Kelch, 2014; Kelly et al., 2010; Pagano et al., 2013).

Extant quantitative studies have shown that atheists have a low affiliation rate with 12-step groups, such as AA (Kelly & Moos, 2003; Tonigan et al., 2002). However, there were no data to indicate whether atheists suffer any psychological distress while in treatment. Nor were there any data on the management of the stigmatized atheist identity in a religious setting, or whether atheists experience pressure to accept the 12-step philosophy (Elliott & Doane, 2015). Before this study, there was no qualitative study that addressed the subjective experiences of atheists in 12-step SUD treatment and aftercare.

This qualitative study provided the rich detail necessary to understand how atheists experience 12-step SUD treatment and aftercare. Information from this study may inform clinical providers, public policy architects, criminal justice professionals, and other stakeholders in SUD treatment and aftercare.

## Literature Search Strategy

I retrieved journal articles for this review from online aggregate databases. I used the following databases to search for articles: Thoreau, Google Scholar, PsycINFO, and SocINFO. My searches included the following keywords: *atheism, atheist, atheist discrimination, microaggressions, religious microaggressions, nonreligion, 12-step, Alcoholics Anonymous, 12-step alternative, 12-step referral, clinician attitudes 12-step, 12-step affiliation, atheist, 12-step and religiosity, cognitive dissonance theory, social identity theory, rejection-identification, minority stress theory, religious minority, SUD treatment, addiction treatment,* and *SUD mutual-aid groups.*

I also used Google Scholar to perform citation chaining on articles having ten or more citations. Citation chaining is the process of inspecting a group of articles that all cite a popular, previously published article. The technique can quickly identify articles cited most often in later publications and to capture related new research. My criteria for including articles for inspection were published in the last 5 years and subsequently cited five or more times.

## Theoretical Framework

The theoretical framework for this study was an integrated model of social psychology theories, with minority stress theory as the overarching theme (see Meyer,

1995). Extant research supports the use of several compatible theories to explain experiences of self-identified atheists in 12-step SUD treatment and aftercare. I combined minority stress theory with each of the following theories individually: management of stigmatized identity theory by Goffman (1963), cognitive dissonance theory by Festinger (1957), and the rejection identification model of social identity theory by Branscombe et al. (1999) and Tajfel and Turner (1986).

Based on these three different combinations, I proposed three different behavioral trajectories with three similar outcomes. The atheist's membership in a marginalized group causes psychological distress on a day-to-day basis. It affects behavior in the context of the presentation of self to others, intergroup behavior, and cognitive dissonance. Together these theories helped to conceptualize scenarios for self-identified atheists in 12-step SUD treatment and aftercare. Each predicted a psychologically distressing chain of events leading to maladaptive coping mechanisms and the potential for relapse to SUD symptoms.

**Minority Stress Theory**

Meyer (1995) developed minority stress theory to explain the higher incidence of mental health disorders among sexual minority populations due to chronic stressors from living in a heteronormative culture that was often homophobic and hostile. Among these stressors were discrimination, stigma, and prejudice that caused mental health problems. Atheists are a religious minority and, as such, are vulnerable to similar stigma, prejudice, and discrimination.

The social cost of identifying as an atheist may compel the atheist to conceal their stigmatized identity and then selectively disclosure their atheism to others (Quinn et al., 2014). This phenomenon is similar to that experienced by a member of a sexual minority, choosing whether to stay *in the closet* or *come out* (Cloud, 2017; Elliott & Doane, 2015). In deciding to come out, the atheist risks alienation and discrimination from peers, family members, and coworkers (Cloud, 2017; Quinn & Earnshaw, 2011). Over time, the effort of managing a stigmatized concealed identity results in psychological distress (Edgell et al., 2016; Goffman, 1963).

**Cognitive Dissonance Theory**

Festinger's (1957) theory of cognitive dissonance purported that an individual will experience psychological discomfort when they face cognitions: attitudes, beliefs, or behaviors that do not align with their core beliefs or values. According to the theory, the individual will seek to reduce discomfort and restore balance. For example, cognitive dissonance occurs when a person knows that smoking cigarettes causes cancer but continues smoking. In this situation, the smoker may reduce their psychological discomfort by justifying or minimizing their behavior to reduce their psychological distress (Brewster, Velez, et al., 2016; Lindeman & Lipsanen, 2016).

Yousaf and Gobet (2013) found that if dissonance involves attitudes or beliefs that are central to the self-concept, the result was attitude reinforcing and strengthening, rather than a reconciliation of dissonant beliefs or attitudes. Yousaf and Gobet researched the emotional and attitudinal consequences of personal attitude-behavior discrepancies using a religious version of the hypocrisy paradigm. The hypocrisy paradigm is the gap

between belief and behavior. Participants ($N = 206$) felt hypocritical for advocating specific religious behaviors that they had not recently engaged to their satisfaction (Yousaf & Gobet, 2013). According to Yousaf and Gobet, higher levels of self-reported guilt and shame compared to the control condition were reported in Experiment 1, and Experiment 2 further showed that a religious self-affirmation task reduced the guilt and shame. In Experiment 3, participants increased religious attitudes after feeling the distress of cognitive dissonance, and both religious and nonreligious self-affirmation tasks eliminated this effect. The findings provided evidence that dissonance induced through religious hypocrisy could result in guilt and shame as well as an attitude bolstering effect, as opposed to the attitude reconciliation effect that was prevalent in previous dissonance research. (Yousaf & Gobet, 2013). In the context of 12-step SUD treatment and aftercare, cognitive dissonance arising from atheists' participation in 12-step programs is a form of religious hypocrisy and could result in an attitude bolstering effect.

The direction of the attitude change as the result of hypocrisy depended on the complexity of the self (Yousaf & Gobet, 2013). Participants with high complexity bolstered their attitudes to reduce the dissonance, and participants with low complexity decreased the strength of their attitude to relieve the dissonant feeling of hypocrisy. In the context of SUD treatment, I proposed that atheists experience cognitive dissonance when they hear claims that 12-step programs are spiritual but not religious. The Christian language of the textbooks, the reliance on prayer, and religious practices contradicted these claims. I proposed that the result could be self-confirmation of attitude and belief (see Yousaf & Gobet, 2013).

The cognitive dissonance literature supports a scenario where the religious behavior of AA (e.g., prayer, confession, proselytizing) may cause the atheist to choose to adjust their perception of the 12-step philosophy as offensive to relieve the dissonant state to receive approval, social support, and a sense of belongingr hand, Another outcome, supported by the cognitive dissonance literature, is the atheist experiencing psychological distress because their worldview is invalidated by clinicians or staff who insist they try to embrace the 12-step philosophy and attend 12-step meetings (Galanter & Post, 2014; Tonigan et al., 2002; Vederhus, Laudet, Kristensen, & Clausen, 2010).

Most counselors and technicians who work in Minnesota model SUD treatment programs attribute their recovery to participation in 12-step programs (Novotna et al., 2013). Of all the employees at a treatment center, counselors and technicians spend the most time with clients and, in 12-step SUD treatment programs, help to facilitate (or mandate) client affiliation with 12-step programs. Twelve-step affiliation manifests as attending meetings, working with a sponsor, holding a service commitment, attending special events, and eventually serving as a sponsor (mentor) to new members. Researchers have found that due to their success with 12-step mutual-aid groups, counselors and technicians tended to hold a personal bias towards 12-step mutual aid groups (Novotna et al., 2013). Staff bias towards 12-step programs may indicate to clients that 12-step programs are the most effective, or only available, SUD mutual-aid groups. I aimed to discover if the atheist client could experience cognitive dissonance because the 12-step philosophy was inherently anathema to their worldview, while at the same time,

the treatment staff's message is that sustainable recovery is possible only through the 12-step program (see Festinger, 1957; Festinger & Carlsmith, 1959).

**Rejection-Identification Model**

Branscombe et al. (1999) developed the rejection-identification model as a continuation of s*ocial identity theory* (Tajfel & Turner, 1979). Social identity theory described intergroup behavior of groups based on members' social identity. The rejection-identification model predicted that members of an ingroup would increase the strength of identification with and loyalty to other ingroup members and express negativity towards members of the outgroup (Branscombe et al., 2012).

According to Branscombe et al. (1999), the rejection-identification model experienced discrimination attributed to prejudice correlated with a strengthening identification with the in-group. Scholars have applied the rejection-identification model to several minorities: Latinos, African Americans, multiracial individuals, and international students, and found the model mediated the adverse effects of the rejection and the maintenance of self-esteem (Giamo, Schmitt, & Outten, 2012; Ramos, Cassidy, Reicher, & Haslam, 2012).

Branscombe et al. (1999) found that when African Americans experienced protracted rejection from an outgroup and attributed the rejection to outgroup prejudice, participants maintain their self-esteem by strengthening identification with their in-group. Branscombe et al. also found that along with identifying more strongly with their ingroup, African Americans had a more negative attitude towards the outgroup. I

proposed that atheists are a marginalized group in the United States and are subject to similar stereotypes, stigma, prejudice, and discrimination.

**Management of a Stigmatized Identity**

According to Tajfel and Turner (1979), social identity theory groups were a significant source of pride and self-esteem for their members, providing a sense of social identity and belonging in the social mosaic. *Ingroup* was the term used for a group with which an individual does identify, and *outgroup* designated a group with which an individual does not identify, or the "other" (Tajfel & Turner, 1986). The rejection-identification model of social identity theory purported that a stronger identification with the ingroup reduced harmful effects of prejudice and discrimination to the individual's self-image and self-esteem (Branscombe et al., 2012; Doane & Elliott, 2015)

Well-supported findings in the social psychology literature showed atheists are a stigmatized group in the United States (Brewster, Hammer, et al., 2016; Edgell et al., 2016; Zuckerman, Galen, & Pasquale, 2016). I proposed that in settings where the atheist identity is highly salient, as in a faith-based SUD treatment program, an individual may conceal their atheism (see Elliott & Doane, 2015). It followed that over time, the effort to try to manage a stigmatized concealed identity could result in psychological distress (Edgell et al., 2016; Goffman, 1963).

I applied the rejection-identification model to understand the reaction of atheists to prejudice and discrimination due to their worldview. I wanted to find out whether, in the context of 12-step SUD treatment, if adherents to the 12-step philosophy invalidated or denounced the atheist client's beliefs, the atheist client would identify more strongly

with their in-group and develop hostility toward proponents of the 12-step philosophy, including treatment staff or laypersons (Gervais, 2013). I proposed the likelihood of an atheistic client affiliating with 12-step groups under these circumstances would down and that it may be imperative that atheists be offered alternative SUD treatment modalities and aftercare at the beginning of treatment.

## Atheists

### Definition of Atheism

Scholars of atheism have cited Cliteur (2009, p. 1) as a useful and inclusive definition of atheism: "an absence of belief in the existence of a God or gods" (Brewster et al., 2014; Bullivant & Ruse, 2013; Cliteur, 2010; Zuckerman et al., 2016). Atheists tend not to believe in the existence of supernatural beings, miracles, karma, immortal souls, reincarnation, or the afterlife (Bullivant & Ruse, 2013; Farias, 2013). Another important aspect of the atheist worldview is the rejection of the idea of divine intervention.

Research showed that self-identified atheists had a firmer stance on the existence of god or gods when compared to agnostics (Bullivant & Ruse, 2013; Robele, 2015). Agnostics were apathetic about the existence of god and not convinced either way or who have not made up their minds (Bullivant & Ruse, 2013; Zuckerman et al., 2016). Cliteur (2010) purported the best way to avoid controversy was to consider the definition of atheist separately from any motives to identify as an atheist. For example, a self-identified atheist who grew up in a religious household may want to rebel against their parents.

**Prevalence of Atheism**

The United States is one of the most religious nations in the world (WIN-Gallup International, 2012). The Pew Religious Landscape Study quantified religiosity in the United States in 2007 and 2014 (Pew Research Center, 2008, 2015). In 2014, Pew researchers surveyed 35,071 adults by telephone, asking about their religious beliefs, the frequency of prayer, and the frequency of religious service attendance. Findings showed that the population of the United States became less religious between 2007 and 2014.

In 2007, 95% of all adults in the United States believed in god, and 83% identified as religiously affiliated (Pew Research Center, 2008). In 2014, adults who believed in god decreased to 89%, and those who identified as religiously affiliated decreased to 77% (Pew Research Center, 2015). Conversely, the proportion of adults in the United States who identified as *unaffiliated* increased from 16% in 2007 to 23% in 2014. The proportion of adults of all ages who self-identified as an *atheist* was between 5% and 7% in 2014. For the 18-30 years age group, the proportion was much higher, at 40% (Pew Research Center, 2015).

The atheist population in the United States is an equivalent size when compared to other small minority groups but lacks the same visibility and acceptance. For example, people who identify as a sexual minority make up 3% to 4% of the population (Dahlhamer, Galinsky, Joestl, & Ward, 2016); Asian-Americans are between 5% and 6% (U.S. Census Bureau, 2015); and the percent of the population who identify as Jewish is about 2% (Pew Research Center, 2015). The highest density of atheists in the United

States is in the Northeast (Pew Research Center, 2015). The lowest density of atheists is in the South (Pew Research Center, 2015).

**Academic Scholarship on Atheism**

Atheists were an understudied population until the beginning of the 21st century. Brewster et al. (2014) conducted a meta-analysis of 100 social science research articles on atheism published between 2001 and 2012 and found the rate of publication increased from zero articles in 2001 to twenty articles in 2012. One-third of these studies were in the field of psychology or counseling (Brewster et al., 2014). Cragun (2016) performed a similar review of three journals dedicated to the sociology of religion and found a scarcity of articles on atheists and the nonreligious until the 2000s. There is a small body of research on the nonreligious as a discrete category, rather than as a residual of the majority religious categories (Bullivant & Lee, 2012).

Investigators have studied atheists in psychology, religious studies, sociology, and political science, and developed instruments to measure phenomena specific to the atheist experience. Examples are the Theistic/Atheistic Strength of Worldview Scale (Robele, 2015), the Dimensions of Secularity Scale (Schnell, 2015), The Development and Validation of the Scale of Atheist Microaggressions (Pagano, Jr., 2015), and the Measure of Atheist Discrimination Experiences (Brewster, Hammer, et al., 2016).

Scholars of atheism have established a few organizations and a journal dedicated to new social science research on atheists and the nonreligious (Bullivant & Lee, 2012). The Institute for the Study of Secularism in Society and Culture (ISSSC) is a research and teaching facility founded in 2005 by Dr. Barry Kosmin, at Trinity College,

Connecticut (www.trincoll.edu/Academics/centers/isssc). In 2008, Dr. Lois Lee founded The Nonreligion and Secularity Research Network (https://nonreligionandsecularity.wordpress.com), and the multidisciplinary, peer-reviewed Journal of Secularism and Nonreligion, in 2011, at University College, London (https://secularismandnonreligion.org). Dr. Ryan Cragun created The Atheist Research Collaborative (ARC) at the University of Tampa. It is a website devoted to social science research on atheism and nonreligion (www.atheistresearch.org)

**Atheism and Wellbeing**

Many researchers reported a positive correlation between religion and spirituality (R/S), and physical and psychosocial well-being. (Greenfield, Vaillant, & Marks, 2009; Seeman, Dubin, & Seeman, 2003; Waite & Lehrer, 2004). However, critics asserted the methodology of many such studies contained confounding variables, poor construct validity, and problematic sampling methods (Brewster et al., 2014; Cragun, D., Cragun, R., Nathan, Sumerau, & Nowakowski, 2016; Galen & Kloet, 2011; Hwang, Hammer, & Cragun, 2011; Sloan & Bagiella, 2002).

Confounding variables are elements of a study that could be alternative explanations for a correlation between variables. For example, the beneficial effect of R/S on health could be due to the social aspects of going to church. The health benefits found in a study of religious people could be related to the participants' social engagement with members of a congregation or social pressure to adopt healthy lifestyle habits (Hwang et al., 2011). These variables would have to be controlled for in the experimental design

before the researchers could assert a positive correlation between R/S and health (Hwang, 2013).

The independent variable, religiosity, is hard to measure (Baumann & Pajonk, 2014). Often, researchers use proxy variables to measure religiosity. For instance, a question may ask the participant how often they perform religious activities such as *attending worship* or *pray* (Hwang, 2013). Researchers found evidence of self-presentation bias in respondents who inflate their self-reported frequency of church attendance (Hadaway, Marler, & Chaves, 1998). Also, there is the possibility of respondents attending church or praying for non-religious reasons such as seeing friends and socializing, or preserving family harmony (Hadaway et al., 1998; Hwang et al., 2011). People may pray with selfish motivations like the enrichment of personal wealth or divine intervention to achieve the desired outcome.

Worship services are not customary in all religions. The operationalization of religiosity would be invalid for minority religions such as Buddhism. The proxy variables of mainstream religions would misclassify a Buddhist as *nonreligious.* Hence, the measurement of health benefits of religion and spirituality would only be valid for Christian and Jewish participants (Hwang et al., 2011).

Sloan and Bagiella (2002) found the sampling methods problematic in the R/S health studies they reviewed. Investigators used volunteer sampling by recruiting participants at churches, which skewed the results. In his study of AA, Tonigan et al. (2002) found measures of religiosity problematic. The validity of measuring religiosity on a continuum requires the assumption that everyone is religious to a degree. This

assumption is flawed because the atheist worldview is not equal to a zero score on a continuum of religiosity (Hwang, 2013).

There are a small number of research articles on the relationship between atheism and physical and psychological well-being. Horning, Davis, Stirrat, and Cornwell (2011) collected data from a sample of 134 believing and nonbelieving adults aged 55 or over with mixed results. They found no difference between believing participants and nonbelieving participants on measures of well-being, social support, or locus of control. Horning et al. (2011) found different coping mechanisms among the participants; believers used religion to cope while nonbelievers used humor and mind-altering substances.

Robele (2015) set out to see if the strength of a belief system was related to subjective well-being. Study results showed a curvilinear relationship between the strength of belief or nonbelief and wellness. People who were not sure of their beliefs were less happy than those with strong atheist worldviews or a firm belief in god (Mochon, Norton, & Ariely, 2011; Robele, 2015). To operationalize the strength of the construct *of the worldview of atheists and strength of belief of theists*, Robele (2015) developed the Theistic-Atheistic Strength of Worldview Scale.

**The Atheist Identity**

Atheists in the United States tend to be young (aged 18-30), male, white, highly educated, live in Western or Northeastern states, politically liberal, and tolerant of other minorities (Bainbridge, 2005; Baker & Smith, 2009a; Kosmin & Keysar, 2009, 2013). The difference in gender proportions could be due to women, often single parents,

wanting to provide their children with the social support of the church. Bainbridge (2005) found that lower levels of social obligation (i.e., single, childless) positively correlate with atheism

**Stigma and Discrimination Against Atheists**

Atheists are one of the most stigmatized groups in American society (Edgell, Gerteis, & Hartmann, 2006; Edgell et al., 2016; Potter, 2015). Individuals with a stigmatized identity sometimes conceal their beliefs (i.e., stay in the closet*)*. Potter (2015) conducted a study of atheists in a city in the Midwest, considered a relatively religious area. Of the 538 participants, Potter (2015) found that 78% of his sample were in the closet about their atheism, 40% had received unfair treatment, 38% experienced discrimination, and 52% experienced occasional conflict with family and friends.

National surveys in the United States consistently reported atheists as the least liked members of society (Edgell et al., 2006; Edgell et al., 2016). Edgell et al. (2006) found atheists were the people respondents would be *least* likely to want their children to marry (47.6%), less popular than Muslims (33.3%) just a few years after the 9/11 terrorist attacks.

Ten years later, the results were similar for atheists as potential family members (43.7%) (Edgell et al., 2016). However, the *most* disliked group was now Muslims, whose disapproval rating was much higher than in 2006 (48.9%) (Edgell et al., 2016). Notably, the 2014 survey participants were less tolerant of *all* minority groups than in 2006 (Edgell et al., 2016). For instance, for an item worded: *This Group Does Not Agree*

*with My Vision of American Society*, endorsements for gay individuals went up from 22.6% in 2006 to 29.4% in 2014 (Edgell et al., 2016) .

In the United States, discrimination against atheists is found in all sectors of society: education, government, healthcare, employment, and criminal justice (Edgell et al., 2016). In Tennessee, an atheistic woman sued Citigroup, who fired her for disruptive behavior. Two Baptist coworkers became hostile when they found out she was an official of the Tennessee Atheist Alliance (Ghumman, Ryan, Barclay, & Markel, 2013). They harassed her by putting a religious picture on her computer and moving to sit far away from her. In a settlement, the atheistic woman was awarded $250,000 for wrongful termination and religious discrimination (Ghumman et al., 2013)

In California, a parole board forced Barry Hazle, Jr. to attend a 12-step based program as a condition of his release. Hazle, a lifelong atheist, had requested a secular treatment program, and none were available in his area. Hazle attended the 12-step program, which required him to acknowledge a higher power. When Hazle refused, the program staff reported him to his parole officer, and his parole officer revoked his parole, forcing Hazle to spend 100 more days in prison. Hazle won a lawsuit against California, which paid $1.9 million to Hazle for violating his civil rights and wrongful imprisonment. The United States Court of Appeals for the Ninth Circuit found the 12-step treatment to be religiously based. By requiring Hazle to attend, the state violated Mr. Hazle's constitutional rights ("Hazle v. Crofoot," 2014). The Court put the lower courts on notice that making parolees attend 12-step programs was unconstitutional.

Research showed atheists would be unlikely to win an election. A 2012 nationwide poll found that 43% of the United States population would not vote for an otherwise qualified atheist candidate (Jones, 2012). Seven states have constitutional clauses precluding individuals who do not believe in god, from holding public office: Texas, Tennessee, Arkansas, Mississippi, Pennsylvania, Maryland, and North Carolina. Nonbelievers were the most numerous voting bloc in the 2016 United States General Election (Ingraham, 2016; Pew Research Center, 2015).

Medical professionals were sometimes discriminatory and dismissive towards atheists. Hammer, Cragun, Hwang, and Smith (2012) found that one in seven hospitalized atheists had visiting clergy, even after they requested no supernatural intervention. In a separate study of atheists' preferences for end-of-life interventions, Smith-Stoner (2007) surveyed 88 self-identified atheists. The participants wanted a "good death" (p.1), including clinicians' respect for their non-belief, particularly regarding prayer or references to deities. The researchers found that even though atheists had requested no divine intervention, their requests were ignored by hospital staff who proselytized and subjected the atheists to unwanted prayers (Smith-Stoner, 2007).

In a study of atheists receiving medical care for spinal-cord injuries, Hwang (2008) found the participants felt they had been discriminated against and had concealed their atheist identity. Participants' atheist identity was invalidated by hospital staff who suggested atheism was just a phase brought on by anger with god. Participants also reported being told that if they prayed to god, their injury may be cured (Hwang, 2008).

Furnham, Meader, and McClelland (1998) investigated the factors that affected healthcare workers'' decisions in creating a ranked waitlist for kidney patients' access to dialysis. The participants were 167 members of the hospital staff (100 female, 67 male). The participants were predominantly Christian (46%). Twenty-five percent were Hindu, 14% were atheist, 11% were Muslim, and 4% were Sikh. The participants took a survey based on 16 hypothetical waitlist patients. As regards demographics, the hypothetical patients all possessed different combinations of religious beliefs, income, level of alcohol consumed, and religion. The researchers hypothesized that in vignettes containing Christian patients, participants would choose Christians over atheists because of ingroup favoritism. The results showed that participants favored females over males, nondrinkers over drinkers, poor over rich, and Christians over atheists. Christian participants ranked individuals who drank alcohol as more deserving than atheists, an interesting result which exemplifies the prejudice atheists encounter (Furnham et al., 1998).

Gervais (2013) investigated why atheists are so unpopular in the United States. The study found that the public viewed atheists as untrustworthy. This perception appears to stem from atheists' rejection of a watchful god and lack of concern about potential punishment for immoral behavior (Gervais, 2013). Simpson and Rios (2016) found that Christians believed atheists were flouting authority by dismissing the Ten Commandments. Atheist stereotypes include criminal, unsatisfactory conduct, unhappiness; left-wing; evil; angry; militant; and anti-religion, lacking a moral compass, living less meaningful lives, and less trustworthy (Cragun, et al., 2012; Edgell et al.,

2016; Simonson, 2011; Simpson & Rios, 2016; Wright & Nichols, 2014; Zuckerman et al., 2016).

To understand the nature of these stereotypes (Simpson & Rios, 2016) set out to investigate how atheists and Christians view each other's moral values. They used the moral foundations' theory as a framework (Graham et al., 2011a). Moral foundations theory posits there are innate, universal, psychological systems that form intuitive ethics that guide behavior (Graham et al., 2011a). There are five main moral foundations: care, fairness, loyalty, authority, and sanctity. Simpson and Rios (2016) used the Moral Foundations Questionnaire (Graham et al., 2011b) to collect their data.

Using the Moral Foundations Questionnaire, participants endorsed moral values from three different perspectives: participants' own, a *typical atheist,* and a *typical Christian.* (Graham et al., 2011b). The results showed that atheists believed their ingroup endorsed *fairness/justice* values more than Christians (Simpson & Rios, 2016). Christians believed their ingroup endorsed *all* moral values more than atheists. Each group held inaccurate stereotypes about their respective outgroup's values.

In another Simpson and Rios (2016) study, participants responded to open-ended questions about the outgroup's morality. Atheists typically described Christians more negatively than Christians described atheists, regardless of the moral foundation of concern (Simpson & Rios, 2016). Christians' negative impressions drew primarily from the *authority* foundation, as atheists were flouting the authority of the Ten Commandments. Both groups drew heavily from the *care* foundation in both their positive and negative depictions (Simpson & Rios, 2016).

Cook, Cottrell, and Webster (2015) conducted two experiments to find out how perceived threats to values correlated with prejudice against atheists. In the first experiment, they found that participants scored atheist groups as posing a significantly more significant threat to values and elicited greater moral disgust than other groups also perceived to pose a threat to held values, such as LGBT or Muslim groups (Cook et al., 2015). In experiment two, one group of randomly selected participants read a news story with a value threat priming details of moral decline. In contrast, the control group read the same story without the value threat priming. Following the values-threat prime, participants reported increased adverse effects and higher discriminatory intentions toward atheists, but not toward students or other groups such as LGBT or people who have HIV. The results of the two experiments suggest that perceptions of threats to values are associated with, and negatively affect, anti-atheist prejudice (Cook et al., 2015).

**Atheist Identity Formation and Management**

Many development trajectories lead to the atheist identity (Baker & Robbins, 2012). Baker and Robbins (2012) found that atheists had nonreligious parents, a non-religious spouse, and a non-religious social network. Atheists raised in a religious family exit their religion through a process of deconversion, the rejection of a culturally normative belief in god (Smith, 2011). Deconversion takes place when the theist individual meets new people with different beliefs and alternate explanations for reality (Zimmerman et al., 2015). The theist individual begins to question their beliefs, finally reaffirming or rejecting the theist worldview. In the United States, identifying as an

atheist is a costly choice because there is a stigma attached to the atheist identity (Smith, 2011).

Mueller (2012) conducted a qualitative study on atheist students at a rural, midsized public university with an enrollment of 16,000. There were 16 participants (10 men); 15 participants were undergraduates, and one was a graduate student. Criteria for participation were: self-identification as an atheist, and between ages 18 and 26, inclusive. Mueller (2012) conducted two hour-long interviews with each subject, analyzed, and coded the data. Three central themes appeared: (a) going from faith to reason, (b) finding meaning in life, and (c) living on the margins of society.

In most cases, participants grew up in religious families, and curiosity gave way to growing doubt and cynicism towards the Biblical explanation of life. Some participants chose an academic specialty oriented to logical thought and reason, with scientific evidence supplanting their childhood explanations of the world (Mueller, 2012).

Mueller (2012) found the student atheists managed their stigmatized identities in several ways. Some chose to blend in, and others discussed and challenged their stigmatization. On-campus, there were no organizations for atheist students to congregate, exchange views, or educate other students about atheism. The students used the terms "being closeted" and "coming out" in their recounting n deciding to reveal their identity to other students (Mueller, 2012).

**Microaggressions**

In addition to overt discrimination, atheists experience more subtle forms of prejudice called microaggressions (Nadal, Issa, Griffin, Hamit, & Lyons, 2010; Sue et al.,

2007). Microaggressions are "the brief and commonplace daily verbal, behavioral, and environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative racial, gender, sexual orientation, and religious slights and insults to the target person or group" (Sue et al., 2007, p. 217).

The term microaggressions first appeared in a book titled Television and Education (Pierce, Carew, Pierce-Gonzalez, & Wills, 1978). Pierce, et al., (1978) devised a method for coding the content of all the television commercials aired over three primetime television nights on the three top networks at the time, ABC, NBC, and CBS. The results showed that the commercials showed excessive negative images of blacks. The researchers concluded the commercials contained subtle messages of racism, which were "subtle, stunning, often automatic, and nonverbal exchanges that were put-downs of blacks by offenders" (Pierce et al., 1978, p. 66). Pierce et al. (1978) coined the term for the offense of microaggressions. Sue et al. (2007) later used the term to name the subtle forms of discrimination they found in a metanalytic study of aversive racism.

Aversive racism is one type of contemporary racism wherein the perpetrator avoids contact with the marginalized individual or denies having a bias. The concepts of color blindness and privilege (e.g., White privilege) are related to aversive racism in that the perpetrator is unaware of their bias and will deny it. The perpetrator has no awareness of the unearned advantages they enjoy in life. Examples of White privilege are: being able to drive without being pulled over; going to a department store without being followed; knowing there will always be the makeup that matches their complexion, going

through security at the airport without people staring or being subject to a search for no reason.

Sue et al. (2007) created a taxonomy of three microaggression types: micro assault, microinsult, and microinvalidation. Offenses are categorized based on the act's severity, the intentions of the perpetrator, and the themes of the underlying message (Nadal et al., 2010).

A micro assault is the most blatant kind of microaggression. These are conscious, intentionally malicious verbal or non-verbal attacks, which hurt the victim (Sue et al., 2007). Microassaults may take the form of violent name-calling, teasing and bullying, catcalling women, refusing service to an LGBT customer, or physical violence (Sue et al., 2007). Another example would be imitating a person who has involuntary muscle movements (e g., cerebral palsy) or calling them spastic (Nadal, 2008).

Microinsults tend to be unconscious behavior or remarks that are rude, insensitive, and put down a victim's heritage or identity (Sue et al., 2007). An example would be a security officer following an African American around a store, conveying an assumption of criminality (Nadal, 2008). Another example is a teacher telling a Latino student they are a credit to their race.

As with microinsults, microinvalidations are often unconscious (Sue et al., 2007). These are communications that negate, nullify, or exclude the psychological thoughts, feelings, or experiential reality of a member of a marginalized, oppressed group. An example would be a comment regarding a shopkeeper's refusal to sell a wedding dress to a lesbian, "why doesn't she go to another store?" This comment would invalidate the

lesbian's experience of discrimination. Alternatively, as relates to the present study, telling an atheist to think of god as "Good, Orderly, Direction" or to use a doorknob as their higher power and informing the atheist that they can opt-out of the group prayer at the end of the 12-step meeting invalidates the atheist identity. The fact that an individual can excuse themselves does not obscure the obligatory nature of praying, nor does it mitigate the acute social pressure upon the individual to conform to the group's rituals.

Given the subtle nature of microaggressions, the perpetrator may be oblivious to having issued the offending acts or words. Likewise, the victim may not be aware of the cumulative effects of microaggressions on their psychological health (Nadal, 2008; Nadal et al., 2011; Sue et al., 2007). In their study of racial microaggressions, Sue et al. (2007) found adverse reactions such as sadness, frustration, anger, and doubt. In another study, participants reported feelings of alienation, uneasiness, and confusion as to how to respond to enactors (Sethi & Williams, 2016). Negative emotions increase stress levels and, over time, have a lasting negative impact on health (Nadal et al., 2011).

In a clinical setting, microaggressions compromised the therapeutic alliance between the clinician and the client. The therapeutic alliance accounts for the largest amount of variance in psychotherapeutic outcomes (Moyers & Miller, 2013). Psychotherapeutic research literature supports a positive correlation between the increase in premature termination of treatment and damage to the therapeutic alliance (Moyers & Miller, 2013; Sue et al., 2007).

Microaggressions tend to happen outside of awareness, and clinicians need education as to the manifestations. Everyone has implicit biases and prejudices acquired

during the socialization process. An example of a microinvalidation is when a white counselor asks a person of color: "Where are you from?" and the person of color answers, "I was born in Los Angeles." but the counselor is not satisfied, so he asks: "No, where are you really from?". The counselor denies the reality of the client as a citizen and damages rapport building (Sue et al., 2007). The client may not return for a second session to get the help they need from the counselor.

Patients suffer psychological distress from the cumulative effects of daily microaggressions. It has been ten years since Sue et al. (2007) published their seminal article. There have been studies of microaggressions against ethnic minorities (Sue, 2010), racial minorities (Nadal, 2008, 2011; Sue et al., 2007), sexual minorities (Nadal et al., 2011; Shelton & Delgado-Romero, 2011), people with disabilities (Keller & Galgay, 2010) gender identification minorities (Nadal, 2008), individuals with more than one marginalized identity (Balsam, Molina, Beadnell, Simoni, & Walters, 2011), and people with mental illness (Gonzales, Davidoff, Nadal, & Yanos, 2015).

Nadal et al. (2010) compiled a taxonomy of religious microaggressions. There are six categories: “endorsing religious stereotypes, exoticization, pathology of different religious groups, assumption of one's own religious identity as the norm, assumption of religious homogeneity, and denial of religious prejudice" (Nadal et al., 2010, p. 297).

Some examples of endorsing religious stereotypes are to angrily call someone a "cheap Jew," call a Sikh wearing a turban a "towelhead," or ask a Christian, "what would Jesus do?" (Nadal et al., 2010, p. 298). These are conscious attempts to hurt the victim, so they fall into the subcategory of a micro assault (Nadal et al., 2010; Pagano, Jr., 2015).

An example of exoticization is a non-Sikh individual asking a Sikh man many questions about his turban and religious practices. The Sikh individual may be offended because the non-Sikh assumed it is acceptable to ask questions about a sacred part of somebody's identity (Nadal et al., 2010; Pagano, Jr., 2015). Another example is a non-Hindu couple incorporating Hindu traditions into their wedding. The message is: Hindu rituals are exotic; it is acceptable to co-opt sacred Hindu rituals for non-Hindu purposes (Nadal et al., 2010; Pagano, Jr., 2015).

The pathologizing of different religious groups occurs when a perpetrator implies there is something wrong with an individual's worldview (Nadal et al., 2010; Pagano, Jr., 2015). For example: if a Christian asks an atheist, "Why don't you believe in god? Are you angry at god? Did something happen?" Alternatively, "How do you handle the death of a loved one if you do not believe in a higher power?". Questions of this type send the message that the atheist's way of looking at the world is wrong, and there has to be a reason for someone not to believe in god (Nadal et al., 2010; Pagano, Jr., 2015).

Environmental microinsults include the assumption of one's religious identity as normal. Christo-normative examples in the United States are: "In God, We Trust" printed on the currency, the yearly National Christmas Tree and White House decorations, and the annual Easter Egg Roll at the White House. The message sent to underrepresented religious groups is "Christianity is the norm." In clinical settings, if religious quotes from the Bible, Torah, or Qu'ran are on display, they are microinsults to atheists and other religiously unaffiliated clients (Nadal et al., 2010; Pagano, Jr., 2015).

Next is the *assumption of religious homogeneity*, or the assumption that everyone in the religion or that adheres to a worldview is the same (Nadal et al., 2010; Pagano, Jr., 2015). An example of an assumption of religious homogeneity is a perpetrator exclaiming, "Wow, a Jew with blonde hair! Did you convert?"Alternatively, "You are too nice to be an atheist! They are so angry about everything!"

The last category in religious microaggressions is the *denial of religious prejudice* (Nadal, 2008; Pagano, Jr., 2015). An example of this would be if the perpetrator said: "I do not care that you are an atheist, I get along with everyone." In the context of the 12-step program, the addiction literature suggests the use of "a doorknob as your higher power" or "John is an atheist, and he has been in AA for 25 years! You will come to believe in a higher power in time". The message is, "it does not matter what your worldview is; the 12-steps are for everyone!" The preceding comments are also microinvalidations (Nadal et al., 2010).

Studies have found that being the recipient of microaggressions is correlated with a lower quality of life over time (Pagano, Jr., 2015; Sue et al., 2007). The atheist who experiences microaggressions in their daily life needs SUD treatment staff and clinicians who affirm their worldview and strive to provide treatment modalities that are congruent with the same.

## Alcoholics Anonymous

### History of AA

AA is the original 12-step mutual aid group for individuals suffering from alcoholism. AA began in 1935 when Bill Wilson and Dr. Bob Holbrook left the Oxford

Group (Kurtz, 1979). The Oxford Group was a Christian temperance movement whose members supported each other in their efforts to stay sober (Kurtz, 1979). Members of the Oxford Group underwent a process of surrender, self-examination, acknowledgment of character defects, confession of wrongdoing, restitution, and commitment to leading a moralistic life (Eng, 2016).

Wilson and Holbrook had been able to remain sober in the Oxford Group, but they disliked its rigidity (Eng, 2016). The two men formed a new group, AA, which they designed to be more flexible while keeping the original Oxford Group's Christian orientation. New members of AA had to surrender, submit their will to a higher power, admit to character defects, confess wrongdoing, atone for harm to others, pray, proselytize, serve others, and commit to a virtuous life (Humphreys, Blodgett, & Wagner, 2014).

In 1941, Jack Alexander wrote an article for the Saturday Evening Post about the phenomenon of AA, giving the fledgling group national publicity (Alexander, 1941). From then on, individuals suffering from alcoholism, and their loved ones, could discreetly write to the New York office to order literature and find meetings with other afflicted individuals (Alcoholics Anonymous, 1939). Meetings were local, and each meeting had the autonomy to choose a meeting time, format, and venue. The entire organization was self-governed under the guidance of 12 principles called traditions.

Wilson and Holbrook published the first edition of Alcoholics Anonymous: The Story of How More than One Hundred Men Have Recovered from Alcoholism (aka The Big Book of Alcoholics Anonymous) in 1939. The text explained the disease concept of

alcoholism, provided instructions for the 12 steps, offered education and advice to family members and employers, and provided testimonials (Alcoholics Anonymous, 1939). A companion book, Twelve Steps and Twelve Traditions, published in 1952, contained descriptions and analysis of the components of the program of AA (Alcoholics Anonymous, 1952).

As of 2016, AA had an estimated two million members worldwide, and hundreds of thousands of people credit AA with helping them achieve long-term sobriety (Emrick & Beresford, 2016). Adapted versions of AA are available for individuals suffering from dependence on substances other than alcohol. Examples are Nicotine Anonymous, Methamphetamine Anonymous, Cocaine Anonymous, and Narcotics Anonymous. There are 12-step programs for compulsive behavioral problems such as Gamblers Anonymous, Codependents Anonymous, and Overeaters Anonymous (Pickard, Laudet, & Grahovac, 2013).

**AA as a Faith-Based Organization**

The literature of AA claims the 12-step program is "a spiritual remedy" (Alcoholics Anonymous, 1939, p. xvi) and "not a religious program" (Alcoholics Anonymous; 2001, p. xx). A complete discussion of the difference between spiritual and religious is beyond the scope of this literature review. However, I will briefly define each term as these can be nebulous concepts.

Spirituality can be difficult to define without specifying the context as human or theological. The U.S. Army published a practical definition as part of the development of the Spiritual Fitness Scale of the Comprehensive Soldier Fitness program (Hwang, 2013).

The Army's pragmatic definition of spirituality in the human, as opposed to theological context, was "the continuous journey people take to discover and realize their spirit, that is, their essential selves" (Pargament & Sweeney, 2011, p. 59).

The Oxford English Dictionary definition of religion is "Action or conduct indicating a belief in, obedience to, and reverence for a god, gods, or similar superhuman power; the performance of religious rites or observances" (Religion, 2020). The following passages from AA have language more reminiscent of Judeo-Christian doctrine than in aid of a journey of discovery. References to obedience and reverence for god are religious. Six of the 12 steps and various oft-used prayers include the word god and references to Him and His (Alcoholics Anonymous, 1939).

**The Twelve Steps**

The 12 steps of AA (1939) read as follows:

1. Admitted we were powerless over alcohol and that our lives had become unmanageable.
2. Came to believe 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 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 all our shortcomings.

8. Made a list of all those we had harmed and became willing to make amends to them all.
9. Make 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 we 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 the 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 alcoholics and practice these principles in all our affairs. (pp. 59-60)

The third step prayer follows:

God, I offer myself to Thee-To build with me and to do with me as Thou wilt. Relieve me of the bondage of self, that I may better do Thy will. Take away my difficulties, that victory over them may bear witness to those I would help of Thy Power, Thy Love, and Thy Way of life. May I do Thy will always! Amen. (p. 63)

The following is the seventh step prayer:

My Creator, I am now willing that you should have all of me, good and bad. I pray that you now remove from me every single defect of character which stands in the way of my usefulness to you and my fellows. Grant me strength, as I go out from here, to do your bidding. Amen. (p. 76)

Twelve-step meetings are autonomous and may select the readings and prayers of their choice. In the Los Angeles region of Southern California, the majority use the Lord's Prayer, from the Bible, to close the meeting. The Lord's Prayer is:

Our Father, which art in heaven. Hallowed be thy Name, Thy Kingdom come, thy will be done on earth, as it is in heaven. Give us this day our daily bread. And forgive us our trespasses as we forgive them that trespass against us. And lead us not into temptation but deliver us from evil. For thine is the kingdom, the power, and the glory, Forever and ever. Amen. (Mat. 6.9–13; Luke 11.2–4, King James Version)

**AA Literature**

Each meeting begins with a reading from Chapter 5 preamble of *The Big Book of Alcoholics Anonymous*(1939):

Rarely have we seen a person fail who has thoroughly followed our path. Those who do not recover are people who cannot or will not completely give themselves to this simple program, usually men and women who are constitutionally incapable of being honest with themselves. They are not at fault; they seem to have been born that way. They are naturally incapable of grasping and developing a manner of living which demands rigorous honesty. Their chances are less than average. There are those too, who suffer from grave emotional and mental disorders, but many of them do recover if they have the capacity to be honest. Our stories disclose in a general way what we used to be like, what happened, and what we are like now. If you have decided you want what we have and are willing to go to any length to get it – then you are ready to take certain steps. Without help it is too much for us. But there is One who has all the power – that

One is God. May you find Him now! We asked His protection and care with complete abandon. (pp. 58-59)

The text of the preamble suggests there is something inherently wrong with any person who does not stay sober after completing the 12 steps. Either the person is unwilling, or "incapable" of being honest or "suffer from grave emotional and mental disorders" (Alcoholics Anonymous, 1939, pp. 58-59). The passage separates AA members into an "us" ingroup and a "them" outgroup, where the well and willing ingroup has stayed sober by embracing and surrendering to god.

In the chapter devoted to step two in the *Twelve Steps and Twelve Traditions*, an unflattering description of the atheist follows:

Let's look first at the case of the one who says he won't believe – the belligerent one. He is in a state of mind which can be described only as savage. His whole philosophy of life, in which he so gloried, is threatened. It's bad enough, he thinks, to admit alcohol has him down for keeps. But now, still smarting from that admission, he is faced with something really impossible. How he does cherish the thought that man, risen so majestically from a single cell in the primordial ooze, is the spearhead of evolution and, therefore, the only god that his universe knows! [sic] Must he renounce all this to save himself? (p. 25)

**Clinician Referral to AA**

The lay population may intuitively believe that people who go to AA drink less alcohol and experience fewer consequences in their health and social lives (McKellar, Stewart, & Humphreys, 2003). Between 75-90% of specialist SUD treatment programs

promote AA as an adjunct to treatment. (Mohammad, 2018; Roman & Johnson, 2004). Referrals to AA come from all sectors of society, such as mental health professionals, school counselors, medical professionals, employee assistance programs, clergy, law enforcement, and judicial personnel.

In his study of clinicians' referrals to mutual aid groups in the United States, Kelch (2014) developed twelve *best practices for patient referral.* One of the recommendations was for clinicians to be mindful of the many other routes to recovery than 12-step that offer the same benefits of support in the maintenance of sobriety (Kelch, 2014). Two other "best practices" call for clinicians to have a working knowledge of both 12-step and non-12-step mutual aid groups, as well as the necessity of educating all clients of the many trajectories recovery can take (Kelch, 2014).

**AA Affiliation and Attrition**

There were several studies on affiliation and attrition in the 12-step mutual-aid recovery group literature (Atkins Jr & Hawdon, 2007; Montalto, 2015; Pagano et al., 2013; Tonigan et al., 2002). Kelly et al. (2010) found the most frequently cited reasons for discontinuing 12-step participation were (a) identifying as other than religious or spiritual, and (b) having a co-occurring disorder. Pagano et al. (2013) found two key dimensions accounted for a sizeable portion of outcome variance, (a) camaraderie, and (b) the program content.

Kelly and Moos (2003) investigated the prevalence and factors that led to participant drop-out from 12-step mutual aid groups in the twelve months following treatment. The study included 2,778 male participants, of whom 91% (2,518) identified

as having attended 12-step groups either in the three months before or during treatment. At the twelve-month mark, 40% of the participants had dropped out. Low motivation to stop drinking, low religiosity, and less prior 12-step involvement were the three highest risk factors for attrition.

**AA Efficacy**

The self-published success rate of AA in 1976 was 75% (Alcoholics Anonymous, 2001, p. xx) . "Fifty percent of initiates got sober right away, 25% got sober after some relapses, and the remaining 25% showed some improvement" (Alcoholics Anonymous, 2001, p. xx). AA publishes the results of member surveys, but the data are not scientifically valid.

The scholarly literature contained mixed results for AA efficacy. Some controlled studies found evidence of a weak correlation between AA and reduced drinking at follow-up compared to non-attendees (Emrick, Tonigan, Montgomery, & Little, 1993; McKellar et al., 2003; Moos, 2008; Tonigan, Toscova, & Miller, 1996).

To date, experimental studies have not established a causal relationship between 12-step mutual aid group involvement and improved recovery outcomes (Mendola & Gibson, 2016). There were methodological limitations inherent in conducting controlled experiments with 12-step participation as the independent variable (Mendola & Gibson, 2016). Limitations include the absence of recordkeeping, anonymity of participants, a self-selection bias, a wide range of variation among AA groups, and there was an ethical barrier to the use of control groups (Mendola & Gibson, 2016).

In studies with correlational results, there was controversy surrounding the self-selection bias present. Self-selection bias confounds experiments in that it was not possible to know whether a participant who goes to AA was more motivated to change than other participants and if a positive outcome was partially attributable to their extra motivation to stay sober.

According to Montalto (2015), AA works because it provides a psychosocial framework wherein the individual focuses on their psychological limitations (e.g., self-regulation) in a group setting. The effect was a type of group therapy intended for work on self-destructive patterns of behavior and attitudes. Group norms encouraged members to surrender to a higher power and practice altruism (Montalto, 2015). Also, participants who stayed sober were proud of their accomplishments and developed a strong bond with other members over time. They were happy to attend meetings. Members who have relapsed may be ashamed to face the group and stop attending altogether.

Moos and Timko (2008) studied the long-term effects of the swiftness with which AA participation began and the length of participation of 473 treatment-naive participants who suffered from alcohol use disorders. The researchers measured outcomes at one-year and eight- years. The results showed participants who were affiliated with AA within six months of first seeking help and who participated longer had better SUD outcomes than participants who entered AA more than six months from first seeking help. The latter group had outcomes that were no better than the outcomes for participants who did not go to AA at all (Moos & Timko, 2008).

**Project MATCH**

The National Institute on Alcohol Abuse and Alcoholism (NIAAA) began the study "Matching Alcoholism Treatments to Client Heterogeneity" (Project MATCH) in 1989. The study was the "largest and most statistically powerful clinical trial of psychotherapies ever undertaken" (National Institute on Alcohol Abuse and Alcoholism, 1996, p. 1). Project MATCH lasted eight years and included 1,726 patients at multiple Veterans Administration sites in the United States (Project MATCH Research Group, 1998a). Most of the participants were men (76%). There were two clinical populations: outpatients and aftercare patients (Project MATCH Research Group, 1998a).

Project MATCH researchers investigated whether matching treatment modalities to client attributes would result in better outcomes. For example, low-motivation patients would do well if treated with motivational enhancement therapy because of the focus on developing and maintaining motivation (Longabaugh & Wirtz, 2001).

There was 21 participant attributes matched with three evidence-based, manualized treatment modalities: Cognitive Behavioral Coping Skills Therapy (CBT) by Monti, Abrams, Kadden & Cooney (1989), Motivational Enhancement Therapy (MET) by William R. Miller (1995), and Twelve-Step Facilitation (TSF) by Nowinski and Carroll (1995). It should be noted the TSF protocol consisted of 12 individual therapy sessions, wherein a therapist encouraged a participant to become involved in the 12-step community by attending meetings, getting a sponsor, and completing the 12-steps.

One hypothesis was that the religious clients (operationalized as beliefs and practices) would derive a larger benefit from a treatment that incorporated spiritual

themes and practices (Connors, Tonigan, & Miller, 2001). Researchers hypothesized participants scoring high for religious beliefs and behaviors would have better outcomes from TSF than participants low in religiosity. There was no hypothesis of the relationship between religious beliefs and behaviors and benefits derived by religious participants in the CBT or MET conditions.

The results of Project MATCH did not support the study hypotheses for the 20 attributes tested in either the aftercare or outpatient samples. There was no statistically significant difference between the drinking outcomes of participants in the three treatment modalities at the 1-year follow-up and the 3-year follow-up (Longabaugh & Wirtz, 2001; Project MATCH Research Group, 1998b).

**Atheists, Agnostics, and AA**

Tonigan et al. (2002) conducted a retrospective study of religiosity and AA using Project MATCH data sets for the outpatient ($N = 952$) and aftercare ($N = 774$) samples. The researchers aimed to clarify mixed findings in the literature about the importance of religious beliefs in predicting AA affiliation.

The RBB was a 13-item questionnaire used to assign a quantitative score for each participant's level of religiosity. The first item was his or her religious identity: (a) atheist; (b) agnostic; (c) unsure; (d) spiritual, and (e) religious. The next six items asked clients to endorse the score for the frequency of religious behaviors in the past year on an 8-point Likert scale. The psychometric evaluation of the RBB scale was good. The scale measured two factors: God Consciousness and Formal Practices. The test-retest reliability was excellent, and the scale had excellent internal consistency. The test-retest correlation

over a three-day interval was .97, and internal item consistency for joint study arms (outpatient and aftercare) at intake was .86.

Tonigan et al. (2002) hypothesized that religious clients with behaviors such as reading scripture, prayer, meditation, and direct experiences of god would accept the therapeutic focus of TSF more readily than clients with low levels of religious practices. Hence, high scoring RBB clients would report higher rates of AA attendance and involvement during the 12-week study and result in better drinking outcomes and favorable reports of the client-therapist therapeutic alliance.

The results did not support the hypothesis that high pretreatment RBB scores would correlate positively with posttreatment drinking outcomes. TSF was significantly more likely to foster pre-post changes in participant god beliefs, and atheists and agnostics attended AA significantly less often throughout follow-up on clients who self-identified as spiritual and religious.

AA attendance, however, was significantly associated with increased abstinence and reductions in drinking intensity regardless of god-belief (Tonigan et al., 2002). Finally, there were no differences in percent days abstinence and drinking intensity between the atheist and agnostic versus spiritual and religious clients, but clients unsure about their god-belief reported significantly higher drinking frequency than the other groups.

Belief in god was relatively unimportant in deriving AA-related benefits. However, atheist clients were less likely to begin and sustain AA attendance when compared to spiritual and religious clients (Tonigan et al., 2002). Researchers

recommended that clinicians recognize the atheist reluctance to affiliate with AA when encouraging AA participation.

The findings of Tonigan et al. (2002) provided quantitative evidence of the low AA affiliation typical of atheists in 12-step SUD treatment and aftercare. The derivation of AA-related benefit, regardless of belief, showed the presence of a non-spiritual mechanism of action driving behavior change. It was possible that some atheists experienced a sense of social acceptance and belonging at AA meetings, which relieved the severity of their cognitive dissonance. Another possibility was that some atheists concealed their stigmatized identities to avoid intrusive questions or comments.

**The REASONS Study**

Kelly et al. (2010) developed the REASONS questionnaire to screen clients as to the suitability of referral to 12-step mutual aid groups. The instrument served to research the barriers to participation in 12-step groups and to inform 12-step facilitation efforts and identify clients who would prefer non-12-step mutual-help groups, such as SMART Recovery (Kelly et al., 2010).

Another goal of the study was to reflect the experience of the VA participants and the SUD population in general. The study included veterans at the VA Palo Alto Health System SUD treatment program. There were sixty male participants between the ages of 18 and 65, whose mean age was 49, and the group was 41% African American (Kelly et al., 2010).

The instrument they developed was the REASONS assessment tool. The 30 items were from eight domains generated in a staff focus group on the barriers to participating

in the 12-step program (Kelly et al., 2010). Barriers were: client lacked motivation or did not perceive a need to participate; spiritual/religious component was unacceptable to the client; the client had social anxiety making attendance at meetings intolerable; client lacked transportation or other logistical problems; the client did not like members; client disliked meeting format or content; the client was ill; and the client was reluctant to discuss co-morbid psychiatric diagnosis in a group setting (Kelly et al., 2010). There were seven face-valid and internally consistent subscales and 24 items to analyze the results (Kelly et al., 2010). The instrument asked for a response on a 7-point Likert scale, each point the degree to which the respondent agrees. Drop-out was no attendance for three months.

Exploratory factor analysis resulted in two dimensions that accounted for 49% of the variance. (p. 321). These dimensions were: social fellowship and program content. The highest subscale endorsement was the client's belief that they do not need MHG and lack of motivation, and social anxiety, which would be present regardless of the type of mutual-help group. On the other hand, the psychiatric barrier (disclosing disorder and taking medication) and the spiritual barrier were deemed specific to the 12-step mutual-help group and accounted for a significant portion of the variance (Kelly et al., 2010). Kelly et al. (2010) recommended that clinicians refer clients with high scores on these subscales to secular mutual aid groups or use the information to focus 12-step facilitation efforts.

The authors stated the REASONS questionnaire had excellent psychometric properties and could serve as an assessment tool to help clinicians focus their 12-step

facilitation efforts and screen clients for referrals to non-12-step mutual aid groups (Kelly et al., 2010). The limitations of this study included a small sample size, and all participants were male. Men tend to have more severe addictions and also more co-occurring physical and psychiatric conditions (Kelly et al., 2010). Hence, the researchers cautioned against generalizing the results to females, non-VA populations, and adolescents (Kelly et al., 2010).

## Alternatives to 12-Step Mutual Aid Groups

Atheist clients are unlikely to sustain involvement with 12-step mutual-aid groups. There are secular alternatives available throughout the United States as in-person and online support groups. These secular alternatives were a better fit for atheist individuals (Zemore, Kaskutas, Mericle, & Hemberg, 2017). Attendees tended to be less religious than in 12-step groups.

The major non-12-step mutual-aid groups are Women for Sobriety (WFS), Self-Management and Recovery Training (SMART), Refuge Recovery, Secular Organization for Sobriety (SOS). Each of these alternatives offers group cohesion and group alliance factors that create change (see Sotskova, Woodin, & Cyr, 2016).

### Women for Sobriety

Women for Sobriety (WFS) is an abstinence-based, secular recovery organization for women. It was formed in 1975 as an alternative to the 12-step mutual-aid program (Fenner & Gifford, 2012). The WFS members believe that the core principles of the 12-step philosophy: powerlessness and the turning over of one’s will to god, are countertherapeutic for women (Fenner & Gifford, 2012). The organization's founder,

sociologist Dr. Jean Kirkpatrick, believed women's needs for recovery support were different than for men (Fenner & Gifford, 2012). WFS is a non-professional, self-and mutual-help organization (Fenner & Gifford, 2012). Volunteers lead meetings after training and certification by WFS (Fenner & Gifford, 2012). I was not able to find any scholarly research on WFS effectiveness.

**SMART Recovery**

SMART Recovery is a secular alternative to 12-step mutual-aid groups (Horvath & Yeterian, 2012). SMART began in the 1990s by SUD treatment professionals who were frustrated with the lack of alternatives for mutual-aid group referrals (Horvath & Yeterian, 2012). SMART members use evidence-based modalities: rational emotive behavioral therapy (REBT), cognitive-behavioral therapy (CBT), and motivational enhancement skills (Horvath & Yeterian, 2012). Attendees learn these skills via free, face-to-face, and online meetings (Beck et al., 2017; Miller, 1995). According to Horvath and Yeterian (2012), as of May 2012, SMART Recovery had 690 groups throughout the world. Most face-to-face meetings are in the United States, the United Kingdom, and Australia. Each meeting has a trained volunteer facilitator who leads attendees in a review of the week and how they applied the coping skills taught in the SMART Four-Point curriculum (Horvath & Yeterian, 2012). Participants do not label themselves as alcoholics or addicts, and there is no expectation of abstinence or lifetime participation (Horvath & Yeterian, 2012).

There was limited research on SMART's effectiveness. Atkins Jr and Hawdon (2007) found a positive relationship between the amount of participation in mutual-aid

groups, including SMART, and length of continuous abstinence. The correlation held for all types of mutual-aid groups, showing participation in SMART Recovery may be as helpful as participation in other mutual aid groups.

Brooks and Penn (2003) compared SMART and 12-step based intensive outpatient (IOP) treatment for patients with dual diagnoses. Results indicated that SMART was less effective than 12-step based IOP for the reduction of alcohol use but useful for improving employment and medical problems. However, methodological problems limited the study's internal and external validity.

Beck et al. (2017) conducted a meta-analysis of twelve studies on SMART. Three of the studies were assessments of SMART effectiveness. The analysis found positive effects of alcohol use disorder. However, because of the small sample sizes and non-standardized methods, the researchers were unable to conclude as to the efficacy of SMART. Beck et al. (2017) recommended further research to assess the utility of SMART as mutual-aid recovery support.

**Secular Organization for Sobriety**

The Secular Organization for Sobriety (SOS) began in 1986 (Connors & Dermen, 1996). The group's founder, James Christopher, was a disaffected former member of the 12-step group who sought to get rid of the religious elements of mutual-aid groups (Connors & Dermen,1996). There are SOS meetings across the United States and online. SOS is a support group, a source of education on relapse prevention methods, and the process of addiction in the brain and body (Connors & Dermen, 1996).

**Comparison Studies**

Zemore et al. (2017) conducted a cross-sectional study comparison study of 12-step group attendees to alternative mutual-aid group attendees. The researchers sought to find out if there were differences between 12-step and non-12-step attendees' characteristics, participation, group cohesion, and satisfaction. Researchers collected baseline profile and participation data for 651 participants using online surveys, as the first step in a longitudinal contrast study. All participants had a lifetime alcohol use disorder (AUD), were over 18, lived in the United States, and reported attending one or more 12-step group meetings or one or more alternative group meetings within the last 30 days. The non-12-step groups included in the study were WFS, LifeRing, and SMART.

Results showed equal levels of participation in both 12-step and alternative groups, despite lower in-person participation by alternative group attendees (Zemore et al., 2017). Compared with 12-step attendees, alternative groups' attendees were less religious and higher on education and income. The WFS and LifeRing participants were more likely to be married, older, and lower on the severity of psychiatric and SUDs. LifeRing and SMART participants were least likely to endorse abstinence as a goal. There were higher levels of group cohesion and satisfaction reported by all non-12-step group attendees.

Zemore et al. (2017) also examined how demographic and clinical differences might affect group engagement by looking at whether and how the primary group modified the associations between participant characteristics and mutual-aid group involvement. A series of regressions determined whether the associations between

primary group involvement and religious self-identification, education, age, drug severity, psychiatric severity, and recovery goal interacted with participants' primary group (coded 12-step or alternative). There were significant interactions between the primary group and three variables: religious self-identification ($p < .01$), age ($p = .08$), and recovery goal ($p<.001$). Attendees of 12-step groups were strongly associated with religious/spiritual (vs. other) identification (B = .28, $p < .001$), older age (B = .17, $p < .05$), and abstinence (vs. other) recovery goal (B = 39, $p < .001$). Among members of the alternatives, neither religious identification nor age correlated with involvement, and having an abstinence goal was more weakly associated with involvement (B = .15, $p <.01$).

These results supported clinician referral for those who are non-religious/spiritual, or who did not have total abstinence as their goal, to non-12-step alternatives. Other factors, such as education level, drug severity, or psychiatric severity, did not predict involvement. These results indicated that these other factors were not as relevant to referral. Higher satisfaction in alternative secular groups was a critical finding, as mutual-aid group attendance correlated with positive SUD outcomes (Horvath & Yeterian, 2012).

Horvath and Yeterian (2012) concluded that referral to non-12-step mutual-aid groups should occur at the beginning of SUD treatment so atheist clients can become accustomed to attending meetings before discharge.

## 12-Step Mutual-Aid Groups in Secular Countries

Humphreys (2004) examination of the role of AA in secular countries illuminated the influence of highly religious culture, the United States, on SUD treatment and aftercare. Humphreys (2004) researched mutual-aid groups in the developed world and published his findings in his book, *Circles of Recover*y: *Self-Help Organizations for Addictions*.

In religious countries like the United States, Iceland, and Mexico, there was a high percentage of patients referred to 12 step mutual aid groups. There was also a high level of 12-step integration in formal SUD treatment, with meetings on program facilities and mandatory participation in 12-step meetings (Humphreys, 2004). Patients completed 12-step written assignments, went to local meetings, and obtained a sponsor, who, once vetted, can take the patient off-site for 12-step meetings.

On the other hand, the United Kingdom, France, and Sweden are secular and had minimal 12-step integration into formal SUD treatment programs, and a low frequency of referral to 12-step groups as an adjunct to treatment (Humphreys, 2004). In a study of SUD treatment staff referral to mutual aid groups in the United Kingdom, 5% of client referrals were to 12-step groups, with religiosity cited as the primary barrier to referral (Day, Gaston, Furlong, Murali, & Copello, 2005; Humphreys, 2004).

In Japan, where only 10% of the population is Christian, there is a mutual-aid group for alcoholism, *The Way of Abstinence,* or *danshudo*. These meetings are for the entire family. (Chenhall & Oka, 2016). Members sign in, donate a small sum, and share the story of how alcohol has affected their lives. Members' abstinent status is otherwise

private, and they will give a physiological reason for refusing alcohol in public. There are abstinence schools, recreational activities, and special groups for female or unmarried alcoholics (Chenhall & Oka, 2016).

In summary, in relatively secular countries, there is a low involvement with AA after treatment, low incidence of referral to 12-step mutual-aid groups, and a low level of integration of the 12-step model in professional SUD treatment programs (Humphreys, 2004). The United States varies from region to region as regards religiosity and the availability of non-12-step alternatives.

## Summary

Extant literature provided ample quantitative evidence of atheists' reluctance to participate in 12-step mutual aid groups (Connors et al., 2001; Tonigan et al., 2002). Additionally, quantitative data showed that atheists preferred secular mutual-aid groups (Zemore et al., 2017). I did not find any qualitative studies that investigated the subjective experiences of atheists in 12-step oriented treatment and aftercare. The goal of this study was to add to the knowledge in the field about atheists' experience in 12-step SUD treatment and aftercare so that clinicians can provide ethical, informed SUD treatment. Using the rich detail of qualitative data, I was able to convey nuances of the atheist experience unavailable from quantitative studies.

This study was an examination of the lived experiences of adult atheists in 12-step SUD treatment programs in the United States. As is characteristic of a qualitative study, the data I collected was the atheists' subjective experiences, which is not generalizable to the wider atheist population. The 12-step programs are ubiquitous in SUD treatment

facilities and correctional institutions in the United States. The ethical clinician provides evidence-based practice as laid out by Spring (2007), which requires an assessment of, and accommodation to, the client's beliefs and preferences (American Psychological Association, 2017).

# Chapter 3: Research Method

## Introduction

The purpose of this study was to investigate how self-identified atheists experience 12-step SUD treatment and aftercare, given the 12-step philosophy is faith-based and, as such, is anathema to the atheist worldview. In this chapter, I present a description of the research design and its rationale, the role of the researcher, participation criteria, and sampling methods. Next, I include a description of data collection and analysis procedures, verification of trustworthiness strategies, and ethical concerns. FinallyI discuss the implications of this study, the interpretation of the results, and the ways I will disseminate findings.

## Rationale for Qualitative Research Design and Methods

### Research Question

The research question I investigated in this study was as follows: What are the lived experiences of self-identified atheists in 12-step SUD treatment and aftercare? This study adds new knowledge to the field of SUD treatment, in that I did not find research into how an atheist feels during 12-step SUD treatment facility and aftercare, given that the 12-step philosophy is incongruent with the atheist worldview.

### Data Collection

I collected data by sending a set of open-ended questions to the participants. I had originally intended to ask the open-ended questions in a live interview to build rapport, promote discussion, and probe emerging themes. However, I could not conduct the interviews because of equipment failure. I sent the open-ended questions via an

asynchronous email instead. A limitation was that I did not have the flexibility to probe responses in real-time. I address this limitation in Chapter 5.

**Literature Gap**

In the preceding chapter, I presented a review of the scholarly and scientific literature about self-identified atheists in a highly religious country, the United States, and the attendant stigma and discrimination (see Edgell et al., 2016). I also reviewed the extant scholarly literature on 12-step SUD treatment and mutual-aid groups, insomuch as the articles related to factors predictive of personal affiliation or attrition, 12-step philosophy, religious language as presented in AA lay texts, and the efficacy of 12-step and alternative modalities for SUD.

Extant academic literature included that quantitative evidence of atheists' attrition from 12-step meeting attendance and religiosity were barriers to participation in 12-step programs. I did not find any studies that elicited atheists' experiences in 12-step treatment and aftercare. The nature, or essence, of the atheist's experiences with 12-step modalities, was not known (Husserl, 1931). Hence, this study aimed to fill a crucial gap in knowledge. Gaining an understanding of the subjective experiences of atheists was meant to heighten awareness of this phenomenon among SUD treatment providers (see Creswell, 2013).

The most appropriate method to obtain the detailed information needed to answer the research question was the qualitative research design with an IPA approach (see Creswell, 2013). Study participants told their stories and shared their subjective perceptions of 12-step modalities, illuminating all aspects of their experiences. The

qualitative method is appropriate when seeking an understanding of how and why phenomena occur (Barbour, 2000). Another reason to choose the qualitative research method was my ability to interview participants about phenomena that took place in a natural setting instead of the controlled environment that is customary for quantitative research studies (see Schensul, Schensul, & LeCompte, 1999).

**Interpretative Phenomenological Analysis**

The IPA approach seeks to uncover the essence of phenomena shared by all research participants (Smith, Jarman, & Osborn, 1999; Van Manen, 1990; Vivar, McQueen, Whyte, & Armayor, 2007). The IPA approach was well-suited to this study, in which I sought to gain highly detailed descriptions of atheists' experiences in 12-step SUD treatment and aftercare. I elicited themes shared by all participants and developed the depth of understanding needed to inform providers who seek to serve the atheist community.

**Positive Social Change**

This qualitative IPA study of atheists in 12-step SUD treatment adds to the existing body of scholarly literature about this phenomenon. As such, it can help to inform the planning, development, and practice of SUD treatment and aftercare programs. Secondly, it provides a foundation for research into atheists' experiences with alternative SUD treatment modalities and mutual-aid groups. Finally, because this study has the potential to be a catalyst for change in the perception of atheists by SUD treatment providers and improve the care of atheists in SUD treatment and aftercare, it meets the Walden University mission of positive social change.

## The Role of the Researcher

One of the defining characteristics of a qualitative research study is the role of the researcher as the key instrument in data collection (Creswell, 2013). The qualitative researcher conducts interviews, makes observations, and examines other sources of qualitative data, such as photographs and journals (Creswell, 2013). Interviews with participants consist of open-ended questions and are flexible so that the researcher may probe for more information when appropriate and valuable to ensure all constructs related to the phenomena are captured (Creswell, 2016).

As I was a crucial research instrument, I took steps to monitor my objectivity throughout the research process. I had personal experience with my topic, and the reader is entitled to know my background and why I chose to investigate these phenomena. Hence, the following disclosure of relevant personal history.

I am a lifelong atheist, and I have been in recovery from a SUD since 2006. My experience in 12-step SUD treatment was psychologically distressing because of the incongruence of being an atheist in a faith-based program. Treatment staff, peers, and members of the 12-step community were dismissive towards my worldview and assured me that I would "come to believe" in a god of my understanding or a higher power.

After completing treatment, I spent several months in a transitional living home where there was a mandate to attend several AA meetings each week and obtain an AA sponsor. This requirement was distressing for me because I felt alienated by the religious overtones of the meetings, the AA dogma, and the recitation of the Lord's Prayer. As a reluctant participant, I experienced cognitive dissonance and feelings of hypocrisy and

inauthenticity. Eventually, I relapsed and entered a non-12-step treatment program with evidence-based psychotherapy. Psychotherapy and medication-assisted treatment were effective in the long-term management of my disease, and my SUD is now in remission.

**Research Ethics**

Throughout my psychotherapy, I developed a passion for psychology and enrolled in graduate school. I now work as a clinician at a 12-step SUD treatment facility, but I did not recruit anyone I know personally or professionally as participants. Anyone who knew me could not take part in the study. I explained that for ethical reasons, participants had to be previously unknown to me, but I was happy to show them the final report. I referred interested participants to the Atheist Research Collaborative (www.atheistresearch.org), where recruitment for other atheist research studies are ongoing.

Research ethics require the investigator to protect the privacy and confidentiality of participants. Client confidentiality is a fundamental tenet in the field of psychology, an ethical mandate of the American Psychological Association (American Psychological Association, 2017) and a federal law (42 CFR § 2.52). I assigned each participant a unique pseudonym to identify them in the study documentation. I removed all identifying information from the data. Should I encounter one of the participants in the future, I will protect their privacy by behaving as though they were a stranger. The participant may choose whether they want to acknowledge me in public, if at all.

If a study participant enters SUD treatment at the facility where I work, I will not acknowledge that they are known to me to protect their confidentiality. I will tell my

supervisor that, for personal reasons, I cannot be their counselor. Such precautions will serve to prevent researcher bias and a dual relationship, as described in the APA Code of Ethical Conduct (American Psychological Association, 2017).

**Researcher Bias**

Because I had a negative personal experience with the phenomenon I studied, I had to set aside any bias I had developed. Husserl (1931) considered the suspension of judgment, or *epoché*, a critical requirement of phenomenological research. To successfully attain epoché, the researcher must bracket their assumptions, judgments, foreknowledge, and bias related to the phenomenon. Bracketing is a term that originated in mathematics that refers to the setting aside of mathematical expression (Sorsa, Kiikkala, & Åstedt-Kurki, 2015). In phenomenological research, the term refers to setting aside any preexisting subjective perceptions of the researcher (Husserl, 1931; Moustakas, 1994).

Bracketing strengthens the validity of the study, in that it ensures the descriptions of the participants' experiences are free of researcher bias (Creswell, 2016; Husserl, 1931). There are steps I performed to improve my awareness of bias during the research. One step was to keep a reflexive journal throughout the entire research project, writing down everything I knew about the phenomenon at the beginning so that my issues were brought to the forefront (see Sorsa et al., 2015). I set my issues, values, and culture aside while conducting the research. Occasionally I revisited the journal to sustain my awareness and add recent revelations, thus helping to ensure the validity of the

participants' data (see Vagle, 2014; Weber, Lomax, & Pargament, 2017). I maintained a reflexive journal throughout the research project.

## Methodology

### Population

The population I studied was self-identified atheists 18 and over who voluntarily attended 12-step oriented SUD treatment and aftercare within the 3 years before October 2018 and attended at least five 12-step meetings in the United States. The percentage of self-identified atheists in the United States is between 3% and 20% (Gervais & Najle, 2018; Pew Research Center, 2015).

### Sampling Strategy

In this study, I explored the lived experiences of self-identified atheists over 18 years old. They had at least one voluntary 12-step SUD treatment and aftercare episode, including attendance at five or more 12-step meetings in the 3 years before October 2018. I limited the population to self-identified atheists, as opposed to including participants who identify with other religiously unaffiliated terms. The criterion that participants were self-identified atheists served to select participants who had a salient atheist identity (see Moore & Leach, 2016). I required participants to have been in treatment voluntarily because involuntary treatment would be experienced differently due to factors unrelated to the research question.

I used purposive and snowball sampling methods to recruit participants. Purposive sampling is when the researcher solicits participants that meet specific criteria (Creswell, 2013). Snowball sampling involves obtaining referrals from participants to

others who meet the participation criteria. Creswell (2013) recommended a sample size of 10 for a qualitative design with a phenomenological approach. However, the final size of the sample is the number of interviews it took to reach saturation (Johnston, Wallis, Oprescu, & Gray, 2017; Mason, 2010). To recognize the saturation point, I analyzed the data after each questionnaire. When a questionnaire yielded no new themes, I had arrived at the saturation point and solicited no more participants.

**Participant Recruitment**

I used purposeful sampling and snowball sampling to recruit participants in the United States. My recruiting strategy was a three-step process. First, I distributed a link on Amazon's Mechanical Turk (MTurk) to an invitation letter to take part in the study (Appendix A). The letter described the study and the requirements of participation, the amount the participant would receive at each stage of the study, deposited in their MTurk account. At the end of the invitation letter, there were *Yes* or *No* fields for the participant to indicate whether they would like to participate in the study. Clicking on Yes would direct the participant to the informed consent form with contact information for questions. The mechanism for establishing informed consent was when respondents answered "yes" to the following question: Do you consent to participate in this study? When the participant consented thus, the Demographic Information Survey appeared (Appendix B). I used SurveyMonkey's skip question logic to disqualify respondents who did not meet the demographic criteria. After providing a disqualifying response, such as answering "no" to the question: "Are you 18 years old or over," the participant landed on a disqualification page, exiting the survey.

The first survey took respondents less than five minutes to complete. Afterward, I had a pool of potential participants who were 18 and over, self-identified as an atheist, and did not know me. Each respondent was paid $1.00 via their MTurk worker account.

Qualified participants then landed on a second qualifying survey, the Substance Use Disorder Questionnaire (Appendix C), which screened for the remaining participation criteria: attended voluntary 12-step SUD treatment and aftercare, attended at least five 12-step meetings, within the last three years, in the United States. Each respondent was paid $3.00 via their MTurk worker account.

I continued the first two steps of the recruitment process until I had 20 participants who met all study criteria. I sent each wave of recruitment surveys to 500 MTurk workers. Each wave was accessible to workers for one week. MTurk had an option to exclude workers who have responded already; I used this to make sure no worker participated twice.

I asked the participants who met the study criteria for an email address, so I could send a questionnaire to them. I told each participant I would protect their privacy by using a pseudonym assigned to their email. I offered a $25 token of gratitude, deposited in their MTurk account, regardless of whether they were able to complete the entire study.

I sent the questionnaires via email. I was not able to conduct the interviews in real-time, so I could not probe for additional information and retain flexibility. I will address this limitation in Chapter Five.

When each questionnaire was complete and sent back to me, I asked the participants if they knew anyone who would meet the criteria to take part in my study. If they did know such a person, I asked the participant to facilitate said person's participation by providing them with my contact details. This process is known as snowball sampling, a recruitment technique for studying hard to reach populations.

**Mechanical Turk**

MTurk is a popular crowdsourcing platform that has about 250,000 virtual "workers" (i.e., potential participants) who live in the United States (Springer, Vezich, Lindsey, & Martini, 2016). The MTurk platform is valuable to academic researchers because it is a way to reach thousands of potential participants in a very short time (Sheehan, 2018). MTurk is also low-cost when compared with traditional participant recruitment methods such as flyers and advertisements (Springer et al., 2016). MTurk participant data are reliable, valid, and more diverse than typical student samples utilized in research (Springer et al., 2016). Ethically, the use of the MTurk platform is sound, as participation is voluntary, anonymous, and participants receive fair compensation for their time.

Researchers, called "requesters," list their tasks on a dashboard that all potential participants can see. Participants complete tasks in exchange for a fee that is commensurate with the difficulty and time required, usually between $.50 and $1.00. The value for the researcher is to be able to screen a large population for study criteria in a short time. Researchers in the social sciences have been using this platform to find participants for their research studies for 20 years, and there is a body of literature

establishing the metrics as equal to, if not better than, an undergraduate student sample (Sheehan, 2018).

**Instrumentation**

I used a set of open-ended questions to collect my data. The overarching question for this study was: What are the lived experiences of atheists in 12-step SUD treatment and aftercare? The following is a list of the questions:

- Please describe your religious beliefs, if any, while growing up.
- Please describe your religious practices, if any, while growing up.
- What was your attitude towards atheism while growing up?
- How did your primary caregiver(s) feel about religion?
- How did your primary caregiver(s) feel towards atheism?
- Was there a time when you changed your religious beliefs? If so, please explain.
- How, if at all, did your family and friends react when you began to identify as an atheist?
- Have you ever chosen to conceal your atheism?

  If so, what was (were) the circumstances?
- Why do you think you chose to conceal your atheism at that time?
- How do you define atheism?
- How do you feel about religion?
- Do the people in your life know that you identify as an atheist?

- Have you ever received positive or negative experiences because of your atheist identity? Please explain.
- How important is being an atheist to you? Please describe how and why atheism is important to you?
- Do you belong to any atheist groups or organizations?
- If so, please explain what the group is and why you belong?
- Is there anything else you would like to say regarding your atheist identity?
- Is there anything you would like others to know about what atheism is or is not?
- What did you know about the 12-step philosophy before you entered treatment?
- How did you choose the 12-step SUD treatment you attended?
- Were you asked about your religious beliefs during your admission assessment?
- Did you tell your therapist/program staff that you were an atheist?
- How did your therapist/program staff respond to your atheist identity, if at all?
- Were there any non-12-step options for treatment in your area? If so, what were these?
- How long were you in treatment?
- What was your experience like in treatment?
- What were the positive aspects of 12-step treatment?
- What were the negative aspects of 12-step treatment?

- How often did you attend 12-step meetings during treatment?
- How did you experience these meetings?
- What were the positive or negative aspects of the meetings?
- Did you complete any steps in treatment? Please explain which steps and how these were integrated into the treatment program?
- Did you get a 12-step sponsor during treatment?
- What was your discharge plan?
- Did you move into sober living after treatment?
- Did you attend 12-step meetings after treatment? If so, which meetings were they? How often and how long did you attend? If not, please explain why?
- Are you attending 12-step meetings now?
- Overall, what impact, if any, did your identity as an atheist have on your treatment and aftercare experience? What impact, if any, did your identity as an atheist have on your attendance at 12-step meetings?

## Ethical Considerations

### Informed Consent

I provided potential participants with an informed consent form describing the study and its purpose, and my role as the data collection instrument. The informed consent contained a description of the study and the participation criteria. Participants were informed that they may withdraw from the study at any time without penalty or forfeiting the $25 token of gratitude. I sent each participant a digital copy of the informed consent form for their review. I answered questions and then asked the participant to

click on the consent form. Once the informed consent procedure concluded, I sent the questionnaires.

**Protection of Confidentiality**

The protection of participants from harm was a priority throughout this study (American Psychological Association, 2017; Festinger & Carlsmith, 1959). Confidentiality is a fundamental tenet in the field of psychology, an ethical mandate of the American Psychological Association (American Psychological Association, 2017), and is a federal law (42 CFR § 2.52). I assigned participants pseudonyms for identification in all study documentation. All emails and participant information are kept on an external hard drive and deleted from the first storage device. I will store the external hard drive in my safe deposit box, at Wells Fargo Bank, for seven years. After seven years, I will destroy all study data.

**Participant Autonomy**

Researchers are responsible for establishing the agency of each prospective participant, making sure they are  autonomous, with the capacity to understand the potential harm, risks, and benefits, and to make the decision to participate based on these factors (American Psychological Association, 2017). To that end, I assessed each participant for the ability to understand the study's purpose, the risks and benefits, and their agency to participate.

The Agency for Healthcare Research and Quality (AHRQ) recommends using a teach-back method to confirm participant comprehension of the consent documents. The teach-back method is an interactive educational process that allows the researcher to ask

the participant open-ended questions about: the goal of the research; the benefit and compensation to the participant; the risks of participating in the project; the voluntary nature of participation; the freedom of the participant to change their mind at any time; the confidentiality of the data; and how to contact the researcher or her supervisor. This process occurred after the participant had plenty of time to review the documents (Agency for Healthcare Research and Quality, 2009). I corrected any misinformation until the participant correctly answered the questions, demonstrating comprehension of the study. The teach-back method of assessing comprehension required practicing the informed consent process with colleagues as well as a checklist of essential elements of the study. All participants could understand the study protocol, so I excluded none.

**Participant Distress**

Although I was unable to monitor interview participants for emotional distress in real-time, I provided unconditional positive regard throughout the written communication and execution of the questionnaires. None of the participants reported emotional distress, and I reminded the participants they were free to withdraw from the study at any time without any penalty or loss of compensation. I provided all participants with referrals to a list of national mental health resources such as the Psychology Today Therapist Locator (www.psychologytoday.com/us) and the National Alliance for Mental Illness (NAMI), in case they needed support and to process distress experienced during their participation. The list of referrals appeared in the body of the consent form.

## Data Collection and Analysis

I gathered data by sending participants a set of open-ended questions (Appendix D). An expert panel reviewed the questions, as did my dissertation chair, committee member, University Reviewer, and Walden's Institutional Review Board. I conducted a mock interview with a co-worker who is a self-identified atheist and alumnus of 12-step SUD treatment. The mock interview took place when I was still planning to do live interviews. I changed my data collection method to open-ended questions via email when an external event destabilized my internet connection. When this occurred, I had to use asynchronous communication via email, which required only a brief internet connection.

I sent the questionnaires via email when requested, and instructed the participants to respond at times that were convenient to the participant. I was not able to take field notes, as recommended by Creswell (2013). The email questionnaires automatically generated a transcript of the questionnaires. I do not know how long the participants took to complete their responses.

Organizing data for each participant was entered into a Microsoft Excel® worksheet. One worksheet served to cross-reference each participant's pseudonym and email address. A second Excel® worksheet contained historical data such as contact dates, invitation, and questionnaire distribution dates, payment dates, and amounts.

### Data Analysis

To analyze the transcripts, I used code names derived from the theoretical framework of this study. According to Trochim and Donnelly (2006), theories that make up the lens through which a study and the attendant body of literature make up the

nomological network of the study. The theories presented in the preceding chapter were: cognitive dissonance theory (Festinger, 1957), minority stress theory (Meyer, 1995), rejection identification model (Branscombe et al., 1999) of social identity theory (Tajfel & Turner, 1986). I also used code names emanating from the 12-step philosophy and Christianity.

### Transcribing and Coding Procedures

I copied the text of each of the emailed questionnaires to a separate Word® 2016 file, saving each of the files as "(*pseudonym*).doc" on my laptop hard drive (Microsoft, 2016). I reviewed all of the questionnaire responses. I imported the transcripts to NVivo® 11 (QSR International, 2016), software used for the analysis, coding, and storage of data. I used index card sorting to review the categorization of data, as well as the participant's transcript for the resolution of discrepancies.

## Verification of Trustworthiness/Authenticity

Qualitative researchers use qualitative terms to denote the quantitative constructs of *validity* and *reliability* (Creswell & Miller, 2000). Qualitative researchers use the term *trustworthiness* to evaluate the quality of their research study. Characteristics that make up trustworthiness are credibility, transferability, dependability, and confirmability (Zimmerman et al., 2015). There are several strategies a researcher can employ to show the trustworthiness of their study.

### Credibility

*Member checking* is considered the "most crucial strategy for establishing credibility" (Lincoln & Guba, 1985, p. 314). The member checking procedure involves

participants confirming the interpretation of data is correct, and the narrative reflects their experience accurately. To enable the participants to examine my findings, I sent the transcripts and interpretations to each individual for their review (Creswell, 2016). I incorporated any feedback in the write-up of the results.

**Transferability**

Although qualitative studies are not generalizable in the same way as quantitative studies, the thick, rich descriptions of the participants' experiences allow the reader to assess for shared characteristics (Creswell & Miller, 2000; Zimmerman et al., 2015). In writing the narration, I prioritized the participants' words and ensured the descriptions held as much detail as possible. The goal was to transport the reader so that they can imagine themselves having the experience and find similarities to and for the participants' narrative to be plausible.

**Dependability**

To enhance the dependability of the study, I used an *audit trail* (Shenton, 2004). The goal of the audit trail is to enable the replication of the study. To which end, I will provide highly detailed documentation of the handling of the data at each stage (Lincoln & Guba, 1985; Shenton, 2004). I will describe the research question, research design, recruiting and interviews, theoretical origin of codes, coding procedure, emergent themes, and a final interpretation of the results. Shenton (2004) recommends a reflective appraisal of the project, wherein I will evaluate the effectiveness of the procedures undertaken in the study.

### Confirmability

Confirmability in qualitative research refers to the objectivity of the reporting of the investigator. The audit trail and reflexivity, as described above, are ways to strengthen the confirmability of the study. Other provisions I took to avoid bias include an admission of my beliefs and assumptions, a description of the study limitations and the effect of the limitations. The interview questions were reviewed for objectivity by experts, to decrease leading or biased phrasing.

## Conclusion

The purpose of conducting this study was to find out how atheists experience 12-step SUD treatment and aftercare. Treatment for SUD in the United States is overwhelmingly faith-based, and the choices for individuals who reject the 12-step philosophy are few. Informed consent includes a warning as to any risks, such as psychological distress, and must be provided to atheist clients before SUD treatment, whether 12-step oriented or not. I could not find any studies that researched the possible psychological distress of atheists in 12-step SUD treatment and aftercare. This research study attempted to fill that gap. I intend to distribute my findings to SUD treatment clinicians, consumers, researchers, policymakers, and criminal justice professionals.

# Chapter 4: Results

## Introduction

The purpose of this IPA study was to gain an in-depth understanding of the lived experience of self-identified atheists in 12-step SUD treatment and aftercare. The research question was as follows: What are the lived experiences of atheists in 12-step SUD treatment and aftercare?

The theoretical framework of this study was an integrated model of social psychology theories. The overarching theme was minority stress theory (Meyer, 1995), combined variously with cognitive dissonance theory (Festinger, 1957), management of stigmatized identity theory (Goffman, 1963), and the rejection identification model (Branscombe et al., 1999) of Tajfel's social identity theory (Tajfel & Turner, 1979).

In this chapter, I discuss the setting of the study, participant demographics, data collection, data analysis procedures, and the study results. I present the results by paraphrasing and directly quoting participants.

### Demographics

There were thirteen participants (*N* = 13). Seven identified as male and six identified as female. I invited participants who met the study inclusion criteria to participate. Criteria required to participate were the following: aged 18 or over, living in the United States, self-identified atheist, underwent voluntary 12-step SUD treatment and aftercare in the last 3 years (November 2015 to October 2018), attended a minimum of five 12-step meetings, and were not known to me.

**Sample Size**

The sample size of a study is considered an important factor for researchers to determine the success of a research study (O'Reilly & Parker, 2012). In quantitative studies, samples are random, and the adequacy of sample size can be estimated mathematically (Guest, Bunce, & Johnson, 2006). These sampling techniques increase the validity and reliability of study data. Future researchers can readily repeat the sampling process to replicate an experiment.

For most qualitative studies, the sample size is the number of participants it takes to reach the point of saturation. Saturation occurs when data collection is redundant because no new themes arise with each additional unit of data (e.g., interviews). The researcher hears themes repeated and decides to stop conducting interviews (Walker, 2012, p. 37).

There is some debate as to whether sample saturation is possible in all approaches of qualitative research and whether saturation is a necessary ingredient of measuring trustworthiness. An extensive discussion of the relationship between saturation, sample size, and data collection approach was beyond the scope of this paper (see Fusch & Ness, 2015; Guest et al., 2006; Hale, Treharne, & Kitas, 2008; O'Reilly & Parker, 2012).

The originators of IPA reject the notion that data saturation is a crucial indicator of trustworthiness or proper sample size (Smith, Flowers, & Larkin, 2009). Data saturation is not a prescribed aspect or goal of IPA (Hale et al., 2008; Smith et al., 2009). Instead, the IPA sample size is a function of the researcher's "commitment to the case study level of analysis and reporting; the richness of the individual cases; and the

organizational constraints one is operating under" (Smith et al., 2009, p. 51). The idiographic tenet of IPA is concerned with the rich and thick detail of the experience of a phenomenon (Hale et al., 2008; Smith et al., 2009). Participants can have all manner of reactions to a context, and the perception of one person can even change over time. Hence, true saturation is not possible because each human experience is unique.

The case study level of analysis is inherent in IPA. Each case (participant) is analyzed by meticulously reading and rereading the data. The goal is to delve into each participant's experience by analyzing and interpreting the narrative of their experience for meaning. This methodology is labor-intensive and time-consuming, and researchers with limited resources set the sample size to the manageability of the data. Hence, the sample size is a practical matter for the researcher with no right or wrong size (Wagstaff et al., 2014)

The sample size ($N = 13$) fit within my time, resource, and manageability constraints and provided detailed narratives of the phenomenon I was investigating. I decided 13 was a good sample size for my study.

**Data Collection and Setting**

I collected data during November and December 2018. The original plans for synchronous interviews via internet connectivity were not possible due to a regional natural disaster that disrupted Internet service. A revised data collection plan that relied upon asynchronous emailed interviewed questions was approved by the committee and Walden's Institutional Review Board.

I recruited participants using a two-part qualification survey on SurveyMonkey, via a link on Amazon's Mechanical Turk job board. Clicking on the link routed the participants to an informed consent form. The participants read the form, printed it out for their records, and clicked "yes" to give consent or "no" to exit the survey.

The participants who gave consent (*N* = 718) landed on the first qualifying survey. Participants who qualified in the first survey (*N* = 322) took the second qualifying survey. Those who met the study criteria (*N* = 179) sent an email to me to request the questionnaire. Thirty participants requested questionnaires, and I sent the questionnaires to them via email. I received 18 completed questionnaires via email. Of thesefive were disqualified because they did not meet study criteria. The final sample size was 13. The average length of the questionnaires was six pages.

To protect participants' privacy, I assigned each a pseudonym and copied their de-identified responses from the body of the email to a Word® file. The participants completed the questionnaires out of my presence, so the conditions of the settings were not known. I will address any resulting limitations in the next chapter.

There were small sums paid to participants, as tokens of gratitude, at each stage of recruitment and data collection; $1 for the first qualifying survey, $3 for the second qualifying survey, and $25 for completion of the questionnaire.

**Data Analysis**

I conducted the data analysis using IPA, as outlined by Smith et al. (2009). IPA is a qualitative research method dedicated to the study of how people make meaning of

major life experiences (Smith et al., 2009). IPA draws on concepts from three areas of philosophical knowledge: phenomenology, hermeneutics, and ideography.

Phenomenology is the descriptive approach in the study of experience developed by Husserl (1931), who argued that the basis of phenomenology is the careful examination of human experience. He was interested in finding a means by which someone might know their experience of a phenomenon with such a depth that they may be able to identify the essential qualities of the experience (Husserl, 1931). When a person self-consciously reflects on everyday experience by recalling images, sounds, or objects, they are phenomenological (Smith et al., 2009). By recognizing the basic components of the phenomenon, the researcher identifies the essential components of an in-depth description that captures the quintessential experience (Pietkiewicz & Smith, 2014). The researcher must consciously suspend or withhold preconceptions and refrain from any conclusion, a process known as bracketing, to capture a detailed description of the experience (Husserl, 1931).

Hermeneutic phenomenology, another influence on IPA, is the theory of interpretation (Smith et al., 2009). Heidegger, a student of Husserl's, diverged from Husserl's approach, moving away from the descriptive and towards the interpretive or hermeneutic (Finlay & Gough [Eds.], 2003). Hermeneutics goes beyond descriptions of experiences to look for meanings embedded in those experiences. These meanings may be hidden from the participants but can emerge from their narratives. Hermeneutics, therefore, is the discovery of meaning and achieving a sense of understanding by identifying, describing, and interpreting the everyday lived experience (Smith et al.,

2009). The researcher has expert knowledge that adds value to the meaning of the study. A second assumption is that bracketing is only ever partially accomplished (Smith et al., 2009). The result is a blend of the researcher's understanding of the phenomenon and the information generated from participants (Wojnar & Swanson, 2007).

Ideography, the third influence on IPA, is concerned with an in-depth analysis of each case (Smith et al., 2009). The researcher first examines the unique contexts of each case and emerging themes. Only then does the researcher complete a cross-case analysis looking for patterns, connections, or differences (Smith et al., 2009).

The analytic process of IPA is iterative and inductive. The researcher alternates between iterations of each participant's experience before moving to an examination of the similarities and differences across the participant group (Smith et al., 2009). There are six steps. Smith et al. (2009) guided novice researchers while emphasizing these steps are not prescriptive. As a novice researcher, I used the six steps to perform my data analysis.

Step 1 was reading and rereading each questionnaire. Per the IPA protocol, I read each questionnaire at least six times and analyzed the questionnaire line by line, and made notes in the margins.

Step 2 was conducting initial exploratory notetaking, including semantic and language content. This step was a continuation of notetaking on each questionnaire, but with more exploratory considerations.  For instance, I made notes about the use of emotional words, the pattern of speaking, the context of participants' concerns, and abstract concepts (see Smith et al., 2009). A larger number of lines of text were taken

together and analyzed for meaning (see Smith et al., 2009). I took notes in a separate handwritten notebook referring to lines of questionnaire when applicable.

Step 3 was developing emergent themes. After I read and annotated each questionnaire, I uploaded the Word® file containing the questionnaire QSR International's NVivo 12 Plus software. I set up a codebook in NVivo with superordinate themes (nodes) and themes developed from my interpretive notes and the text of the questionnaire (see Table 1).

Table 1

*Sample Coding of Excerpts in NVivo*

| Themes | Questionnaire excerpt |
|---|---|
| Node\12-step meetings\Theme\Sense of belonging & support | "… I really got to know everyone. People were open and honest about their addictions, what led them there, the obstacles they've faced, etc. Everyone helped each other out/open and honest." feeling deceptive due to concealment? |
| Node\12-step meetings\Theme\Universality of addiction and hope | "Having people with similar struggles I would say was a positive, you also have people that have been clean for a while as a sort of proof that it can be accomplished and stuck to provided you have the willpower, and that is what you really want."/ mother got sober in AA, could be identifying with a surrogate authority figure |
| Node\12-step meetings\Theme\Evangelizing lead to distrust | "…felt to me like I was having religion pushed into my face. I mean, every single day God this and Jesus that. I don't think many of them were real about their faith, anyway. I felt like they were hyping God up to sound and look good to the people in charge." /Weary of "god-talk," reaction distrust, suspicion, history of evangelizing in her childhood religion, stress from a concealed identity |
| Node\12-step meetings\Theme\Cognitive dissonance between 12-step philosophy and atheism. | Part of my problem is this powerlessness thing, too. We aren't powerless, and we're highly susceptible. To say we're powerless takes it out of our hands, and the higher power facilitates it and that I could do without. /Internal locus of control vs. divine intervention and submission to a higher power |

Step 4 was searching for connections across emergent themes. Another technique, numeration, was used to assess how often a theme appears in a participant's questionnaire. Numeration allows the researcher to gauge the relative importance of a theme to the participant. I set a threshold of three times for the theme to stand alone as a

code in NVivo. Then, on another pass through the data, I used abstraction to determine which themes were similar enough to be merged into one theme or remain separate (see Smith et al., 2009). Abstraction is the process of grouping together similar themes and renaming the cluster. I performed this task by printing a list of all the themes, cutting them into separate strips of paper, and then assembling groups into higher-order descriptions. In NVivo, the individual preliminary themes were merged into a new node with the new description, while keeping the preliminary themes as lower-level themes for future analysis (see Table 1).

Step 5 was repeat steps 1-4 for each participant. Step 6 was looking for patterns across participants. I collated the participants' shared themes by running queries in NVivo to run queries of participants' shared themes. If three or more participants shared a theme, then I determined whether the theme would be a subtheme (Smith et al., 2009). Table 2 contains a graphic representation of themes and subthemes. There were five main themes:

- Coming out as an atheist.
- Meaning of atheism.
- Experienced stigma and discrimination.
- Experience of treatment.
- Aftercare

Table 2

*Themes and Subthemes*

| Coming out as an atheist | Meaning of atheism | Experienced stigma and discrimination | Experience of treatment | Aftercare |
|---|---|---|---|---|
| Negative reaction | Defined as the absence of belief in god | Negative stereotypes & defensive othering | Choice of 12-step program | Alternatives to 12-steps found or sought |
| Neutral or positive reaction | Low centrality and salience | The public conflation of morality with belief in god. | Presentation of self, outness | Continued with 12-step meetings |
| Concealment of atheist identity | Low formal affiliation with other atheists | Public intolerant and misinformed | Staff bias and lack of referral. Universality and support of peers | Stopped attending meetings |
| Supportive atheist friends | Tolerance of others' religious beliefs | | Too much god-talk/paradox of isolation. | Difficulty with steps |
| Concealment at religious services | | | | Sponsorship |

## Evidence of Trustworthiness

The quality and value of qualitative research are called the *trustworthiness* of each study. Trustworthiness is akin to the concepts of *reliability* and *validity,* which are used in quantitative research to denote the quality of the study, instilling the confidence of the consumer/reader. The demonstration of trustworthiness must meet four criteria; credibility, transferability, dependability, and confirmability (Creswell, 2013)

### Credibility

Credibility conveys the truth of the study findings. Several techniques can establish a study's credibility, such as prolonged engagement, persistent observation, triangulation, peer debriefing, reflexive journaling, and member-checking (Amankwaa, 2016; Lincoln & Guba, 1985). In the current study, the choice of techniques employed to ensure credibility was dependent on feasibility, given my participants and my use of questionnaires as the only source of data. Hence, prolonged engagement, persistent observation, and triangulation techniques were not possible. I used member-checking and reflexive journaling to demonstrate the credibility of my findings.

Qualitative research scholars consider member checking "the most crucial technique for establishing credibility" (Lincoln & Guba, 1985, p. 314). I performed member-checking by sending each participant a copy of their questionnaire with an added column indicating the themes and subthemes that I developed. I requested confirmation that the questionnaire and similar themes reflected represented their experiences accurately. Most ($N$ = 9) of the participants sent a confirmation via email that they approved of my interpretation; four participants did not respond to my email.

I conducted bracketing by maintaining a written reflexive journal throughout the study. The goal of keeping the journal was to ensure the study results were an accurate reflection of the lived experiences of participants, free from bias.  When I was crafting the study questionnaire, I examined each of the questions and examined each for a potential source of personal bias. I identified language, which potentially reflected my bias, such as a "leading question" or a "yes or no" question. I changed the wording to reflect more neutral, open questions so that participants could answer authentically. I was also vigilant for any awareness, perception, or judgment that could lead to bias where participants' lived experiences differed from my own. I noted these instances to make sure I stayed committed to the goal of reflexive journaling, the accurate representation of the participants' lived experiences of the phenomenon under study.

An example of bias was my assumption that atheists consider atheism a very important part of their identity. I found that most ($N = 11$) of the participants did not consider atheism as very important or salient in their daily lives. I had to acknowledge that I had a bias because my atheism was an important and salient part of my identity, unlike most of my participants. My personal experience and consequent bias may have influenced my conceptual framework for this study. I will discuss this finding in Chapter Five.

**Transferability**

Historically, transferability has been associated with quantitative research and denoted as generalizability. Quantitative research studies use a large random sample and descriptive statistics, and consumers of the research rely on statistically significant results

as applicable to the whole population pool. On the other hand, qualitative research methods use a small sample and nonrandom sampling techniques such as purposive and snowball. Transferability in qualitative research is the degree to which the results of a study can be generalized to other contexts (Merriam & Tisdell, 2016). Study findings are not representative of the whole population pool. Instead, authors use *thick description* to paint a vivid picture for readers. Lincoln and Guba (1985) endorsed the use of participants' own words to develop themes and subthemes. Readers need as much information as possible to decide whether and how research results relate to other settings, situations, and people. It is the responsibility of the researcher to provide enough information to aid readers in deciding. I was provided with the rich detail of participants' experiences with atheism and 12-step SUD treatment and aftercare, enabling me to develop themes and subthemes.

**Dependability**

Dependability indicates the extent to which findings are consistent and replicable (Houghton, Casey, Shaw, & Murphy, 2013). The dependability criterion requires demonstrated that the researcher has made no mistakes in conceptualizing the study, collecting the data, interpreting the findings, and reporting the results (Houghton et al., 2013). The more consistent the researcher is throughout the research process, the more dependable the results are.

To strengthen the dependability of my study, I used an audit trail including raw data (completed questionnaires) and analysis notes in the margins, NVivo codebook, reports of NVivo queries, as well as any other documentation of the IPA process (Smith

et al., 1999). The audit trail serves to support the study's methodology and interpretative judgment (Houghton et al., 2013). Another function of the audit trail is to ensure readers could determine the rationale and reasoning for the study. I presented a comprehensive account of the iterative steps associated with the data analysis to facilitate the appraisal of its dependability (Sutherland & Chur□Hansen, 2014).

### Confirmability

Confirmability is the extent to which the findings of the study are neutral, "shaped by the respondents and not researcher bias, motivation, or interest" (Amankwaa, 2016, p. 121). The audit trail supports confirmability as it is a transparent account of the research process as generated throughout the study.

I used audit trails and researcher reflexivity to ensure confirmability, as discussed in previous sections. I also conducted member-checking to ensure the authenticity and accuracy of the data, and to facilitate replication or corroboration by others, the study provided a detailed description of the study's coding process. An explanation of the literature findings supported the study's research questions. I also retained copies of all correspondence with participants and other relevant parties (e.g., emails, IRB approval).

## Results

The purpose of this study was to investigate the lived experiences of atheists in 12-step substance use disorder treatment and aftercare. The overarching research question was, "What are the lived experiences of atheists in substance use treatment and aftercare?" My theoretical framework was an integration of social psychology theories: minority stress theory (Meyer, 1995), management of a concealable stigmatized identity

(Goffman, 1963), cognitive dissonance theory (Festinger, 1957), and the rejection identification model of social identity theory (Branscombe et al., 1999; Tajfel & Turner, 1979).

Five themes emerged from the analysis of the transcripts. These themes were as follows: (a) coming out as an atheist, (b) the meaning of atheism, (c) experienced stigma and discrimination, (d) experience of treatment, and (e) aftercare. From these five themes, 22 subthemes emerged (see Table 2).

**Theme: Coming Out as an Atheist**

The first set of questions collected data about the religiosity of the participant's family of origin and the experience of revealing their atheist identity in the context of their personal life. Research has demonstrated the stigmatization of atheists in the United States (Brewster et al., 2014; Edgell, 2017; Edgell et al., 2006). According to Goffman (1963) and Quinn et al. (2014), the decision to conceal a stigmatized identity is associated with factors such as the anticipation of a negative reaction or anticipated stigma and the salience of the identity in context (Stephenie R. Chaudoir & Quinn, 2016). The prior rejection or abuse after the disclosure of a stigmatized identity may result in anticipation of stigma and the concealment of atheism in highly religious contexts such as 12-step SUD treatment and aftercare (Abbott, 2017; Chaudoir & Quinn, 2010; Doane & Elliott, 2015; Scheitle, Corcoran, & Hudnall, 2018). In anticipation of performing the interpretation and analysis of data through the lens of my theoretical framework, I wanted to find out if the participants had experienced negative reactions from loved ones to their identification as atheists.

Coming out refers to the act of disclosure of a stigmatized, concealable identity to others (Abbott & Mollen, 2018; Zimmerman et al., 2015). The participants' decision to come out and the reactions of the participants' families varied depending on the family's religiosity.

**Subtheme: Negative reaction to coming out as an atheist.** Three participants (Michael, Steven, and Savannah) received a negative reaction from their families. The negative emotional terms used to describe the reactions were "devastated," "sad," "can't stand it," and "confused." Michael likened the family reaction to the "experience of Coming Out [*sic*] for some gay men/women." Both Michael and Steven described their families as dismissive of their identification as atheists, using terms such as "believed I was going through a phase" and "believed I would just grow out of it." Savannah said, "My mother was devastated and very upset. She pleaded with me to change my mind and asked me why I've turned away. Some of my family, however, have shunned me and don't speak to me at all." Steven only speaks about religion when his parents bring it up. He said,

> Basically, my family believed I would just grow out of it …. but just like I said, I don't argue about it. I will throw in a smart-aleck comment here or there when my parents yell at the TV news about things like abortion.

**Subtheme: Neutral or positive reaction to coming out as an atheist.** Six participants received a neutral or positive reaction from their families. For these families, atheism was completely normal. For instance, Dennis said, "Religion was never mentioned (at home) except in the context of history or art or both." William's parents

"didn't like my atheist stance," but they respected his personal beliefs and "never got angry or made it an issue." Eleanor's family was a "progressive, educated family; they didn't really have any prejudices towards atheism. We valued science and kept up with what NASA was doing. I couldn't rationalize the idea of miracles with the observations I had about the world." David's family was Catholic; he said,

> I told my parents I wanted to stop attending catechism. They asked why, and I told them I didn't believe any of it, that it was all made up. I remember my mother trying to convince me to keep at it, but in the end, I simply stopped going, and it was never a big deal.

Neither Margaret nor Valerie experienced any negativity. Valerie's family were atheists except for her father, who "passed away when I was 14; he was really the only family that I recall was not an atheist. My mother always said she didn't believe in a God or supreme being."

In Nicholas's family, there was a mixed reaction. His family were non-practicing Jews. At the time of Nicholas's coming out as atheist, his Dad was an atheist, too, and his mother did not hold any consistent beliefs. However, his stepmother "thought it was a pathway to hell, but so was being Jewish, so she wanted me to accept Christ (she would) yell at me and get abusive."

**Subtheme: Concealment of atheist identity.** Three participants (Christina, Kathleen, and Kevin) concealed their atheism. Christina said she conceals her atheism from her family as a "matter of convenience as …I see little reason for them to be worried about 'my mortal soul'…and I simply do not feel like having to hear about it…"

Kathleen concealed because she had a "fear of being stuck alone and alienated by those who love me…I fear being kicked out of the family."

**Subtheme: Supportive, nonjudgmental friends**. Most of the participants had friends who were atheists and did not experience any stigma in their immediate social circles. Eleanor said, "My friends were science nerds, and we all pretty much rejected the idea of religion at that time. I ended up dating and marrying atheists." Steven said, "…for the most part; my friends were all Atheists as well."

**Subtheme: Concealment at religious services**. Five of the participants attended religious services with loved ones. David was asked to conceal his atheism for his brother's Roman Catholic wedding and complied with his mother's wishes. Dennis, Kathleen, Michael, and Steven went to church to please romantic partners and family members. Kathleen stated she did not "sing or pray, and it was not noticed," and Dennis went to please his partner's parents.

Valerie co-parents with a man who is not an atheist. She said, "[child's] father knows that I am an atheist, he has asked for permission to have our …[child] attend church and at some point, be baptized by the church."

### Theme: Meaning of Atheism

In this section, the participants gave their definition of atheism. Clarifying the definition of atheism in the participants' own words ensured the sample was homogenous regarding nonbelief in god so that I could analyze the data through the lens of my theoretical framework. For example, the cognitive dissonance I proposed as a possible

finding would arise due to nonbelief in god vs. the 12-step program's heavy reliance on theism.

**Subtheme: Defined as the absence of belief in god.** Catherine said, "I would say I define it as a lack of personal belief in a divine deity, cosmic power, supreme being, etc." David said, "Quite simply, it is the lack of belief in a god, deity, or divine plan" Michael said, "I have strong disbelief in the existence of a God". Nicholas said, "The belief that there is no God or a similar entity if you can really call it a belief. It's more of a rational lack of belief in something that there's no good reason, to think exists [*sic*]". Savannah said, "Lack of belief in God or gods". Steven said, "As believing in the only fact, which in turn agrees with science". Valerie said, "As not believing in a God or supreme being". Dennis said, "For me, it just translates into an eternal unanswered question – is there a point to all this, or is it random? …there's never going to be an answer, so stop asking the question and do something else". Eleanor said, "A rational view that the universe is a vast place and there isn't some anthropomorphic godhead watching over the insignificant ape-humans who inhabit a dirtball on the edge of a tiny galaxy in the middle of 20 trillion other galaxies". Kathleen said, "You just are. I don't know why or where or what. I don't have those answers. There is no one big creator who put us all together and wrote all about it in a book or had special disciples write it down. I don't know what comes after either".

**Subtheme: Low centrality and low salience of atheist identity.** Two of the predictors of psychological distress in people with a concealed stigmatized identity are the centrality, or level of defining oneself by the stigmatized identity, and salience, the

frequency of thinking about the identity (Quinn et al., 2014). I asked participants: How important is your atheist identity to you? Most participants said their atheist identity is not that important, and they didn't consider it a defining characteristic. David said, "It is not important to me at all, aside from the fact that I expect to not be discriminated against as a result of it. Being an atheist isn't central to my being, no more than not believing in werewolves is essential to my being."

**Subtheme: Low formal affiliation with other atheists.** Atheist groups exist in the United States for many reasons. Some groups act as general support groups, especially in religious areas. Other atheist groups have a political bent to protect the separation of church and state (Mackey, 2019). I asked participants if they were affiliated with any atheist groups as evidence, in part, of the centrality of the participants' atheist identity. Only Eleanor and Steven answered affirmatively. Most participants just responded "no," but a few did expand their answers to explain they "didn't see a need for atheist groups" or "didn't want to be associated" with what they perceived as negative atheist behavior. One participant felt the public perception of atheists lumped everyone into the same group, when there are many types of people, from many different backgrounds, that identify as atheists. The perception of a couple of the participants (and the general public) is that atheist groups function is to proselytize and argue about the existence of god (Zuckerman, 2009)

**Subtheme: Tolerance of others 'religious beliefs.** I asked participants how they felt about religion to find out if there was any inherent negativity. The stereotype of the "New Atheist" is one of hostility and intolerance towards religions and religious people

(Baggett, 2019). The responses defied the stereotype and projected tolerance of others' beliefs. A few participants commented on the irony, saying it would be nice to receive the same respect in turn.

Savannah said, "I feel like it's a form of brainwashing to keep people from living how they really want to and to keep people from asking too many questions like why we exist and how?" Steven said, "I feel that if it gives people hope and they don't take it too far, it is a good way to teach people how to live. There are inherent good rules to live by in all good religions."

**Theme: Experienced Stigma and Discrimination**

I asked about the participants' experiences with members of the public due to their identification as atheists. Negative experiences could lead to anticipated stigma in the more religious setting of the 12-step SUD treatment. Almost all participants had experienced negative reactions due to their atheist identity.

**Subtheme: Negative stereotypes and defensive othering.** Some participants did not want to be associated with what they perceived as negative atheist behavior. These participants felt the public perception of atheists lumped everyone into the same group. Dennis cited an experience he had with a local shopkeeper, someone whom he thought would relate because of the man's own stigmatized religious identity. He recounted this story: "A Muslim owner of a convenience store in San Francisco once told me that only an idiot would be an atheist. He said that it would be better to be Jewish or Hindu. He was quite upset. I had known him for years; I had thought we could chat as friends. I was

wrong; the experience taught me to hold my cards closer to my chest with people that I don't know so well."

**Subtheme: Public conflation of morality with belief in god.** David overheard people talking about him at his workplace, which was "…owned and operated by evangelical Christians. I did overhear several conversations that referred to my 'godlessness' and 'immorality.' I found a new job as soon as I could."

**Subtheme: Public intolerant and misinformed.** Christina said, "…anyone who is religious usually simply does not understand. This could manifest in the form of questions out of confusion, sometimes even anger. I've seen a variety of responses mostly negative…". Eleanor lived in the Deep South and concealed her atheism because if anyone in her community found out she was an atheist the consequences were being ostracized from the community. She said, "Honestly, it can affect my job prospects, my child's friendship opportunities, and my side business success. I'm not telling these weirdos shit about my beliefs. Some of these people are downright deranged about their mission to the lord. You ought to read some of the comments on the local news. We have anti-evolution billboards on the side of the freeways. It's crazy town."

**Theme: Experience in Treatment**

**Subtheme: Choice of 12-step treatment.** Participants were asked how much they knew about the 12-step concept and program before treatment and how they chose their treatment program. The 12-step program was viewed by Eleanor as, "ubiquitous in popular culture." All participants reported having at least basic awareness of 12-step

mutual-help groups such as AA. Four participants (Dennis, David, Eleanor, and Kevin) credited their knowledge of AA to popular culture.

Dennis did not have a choice as to which program he would attend, as he had an ultimatum from his romantic partner. Kevin, Nicholas, and Steven were sent by their respective detoxification facilities. Valerie chose her program because they had available space, and it was covered by insurance.

David knew "a couple of people who had been through the program, so I had perhaps a slightly better idea of what it entailed than most people." Kathleen had a family history with AA. She reflected on this, and the program's requirement to give one's life over to a higher power, below:

William had a family history with AA, as well as a sense of foreboding over the higher power component. He spoke about accompanying his aunt to AA. "Well, when I was 16, my aunt went to rehab for drinking... I took her to AA meetings every day and got really involved in all that while I was there. So, when I decided I was done being a dope fiend, I already knew a lot of the vocabulary and concepts. I already knew the higher power stuff was going to be an issue, and it definitely was."

**Subtheme: Presentation of self -- outness in treatment.** Participants had to decide whether to disclose or conceal their atheist identity in treatment, important because, according to Chaudoir and Quinn (2016), anticipated stigma harms the trait-depressive. The results showed participants concealed and disclosed in almost equal numbers.

Seven of the participants disclosed their atheist identity in treatment, Christina, David, Michael, Savannah, Steven, Valerie, and William. There were varied reactions by staff. Savannah's experience was that they explained how she could use an alternative higher power to god, "They explained to me that while many 12 step programs are based on believing in a God, it doesn't necessarily have to be that way. ….as long as I give my problems to a greater power, whether it be the support group, nature, etc."

Christina said the staff was helpful, "They did not seem to be off-put, which was appreciated; after all, I came for help, not for judgment. I would say they were very helpful in working with me every step of the way."

**Subtheme: Staff bias and lack of referral**. David received a mixed reaction from staff: "Two of them took it in stride, while the third seemed perplexed as to how I would be able to recover without Jesus." Michael said the staff was "prepared with an answer…they said that there are many atheists in the program and that 12-step is not a conversion program. I didn't really believe them, but I was desperate for help, so I went ahead." Steven experienced staff members (except his therapist) trying to convert him. Steven reported, "I did (disclose), but quickly learned that there is no point in bringing it up with staff or fellow addicts. They will just see it as a chance to convert someone and would try to get me to read the bible, join sermons, and such. My therapist was very neutral about the whole thing. I suppose they are trained to do so."

Six participants, Dennis, Eleanor, Kathleen, Kevin, Nicholas, and Steven, concealed their identity in treatment. Margaret said she "was never asked at admission. Terms used to explain their decision to conceal their atheism were "fear of failing,"

"avoid distraction," "avoid mistreatment," "(avoid giving them) a chance to convert," "fudging."

**Subtheme: Universality and support of peers.** All the participants found hope and universality at the meetings. The participants agreed about the healing aspects of mutual support. David said, "Just knowing that you are not alone in your struggle can be a huge comfort."

**Subtheme: Too much god-talk and the paradox of isolation**. Paradoxically, most participants felt excluded at times because of the frequent god-talk and discussions about peers' reliance on their higher power and powerlessness. Savannah said "Sometimes, I felt it was too god oriented. Even though my therapist told me a higher power could be anything, for most people, it was God, and that made me feel left out at times."

**Theme: Aftercare**

**Subtheme: Found or sought an alternative to the 12-step program.** After treatment, four of the participants (David, Kathleen, William, Margaret) joined or sought non-12-step mutual-support groups. David found Rational Recovery, Kathleen joined Women for Sobriety, and William chose SMART and Refuge Recovery. Margaret said she would like to find an alternative to the 12-step program. Nicholas was interested in SMART recovery, but it was "a hassle" for him to attend while he was in treatment.

**Subtheme: Continued attending 12-step meetings.** Four participants (Michael, Dennis, Valerie, & Christina) still go to meetings between 2 and 3 times per week.

**Subtheme: Stopped attending 12-step meetings.** Nine of the participants stopped attending 12-step meetings (David, Eleanor, Kevin, Kathleen, Nicholas, Margaret, Savannah, Steven, and William). Of these, four switched to alternative programs (David, Kathleen, Nicholas, and William); Margaret would like to find an alternative to the 12-step program and believes "There is a lack of availability of a program that really is open to those without any religious beliefs." Steven, Savannah, Kevin, and Eleanor stopped going to meetings.

**Subtheme: Difficulty with the 12 steps.** Most participants had a difficult time working on the steps. Four participants finished all twelve (Christina, William, Savannah). Christina provided an excellent description of the process she used to adapt the 12 steps by using herself as her higher power.

Eleanor explained she got through a few of the steps using herself as a higher power, "I admitted that my life had become unmanageable …I asked for amends to my husband, who I had hurt. I took a personal inventory. The other steps were too magical thinking based on me. I have power over myself. I guess I am my own higher power." Kathleen found she "…honestly could not complete [the steps]for real."

**Subtheme: Sponsorship.** Participants were asked: Did you obtain a sponsor? A sponsor is someone who helps new members go through the 12 steps. Six participants formally obtained a sponsor (Dennis, Christina, Nicholas, Kevin, William, and Kathleen). Dennis's sponsor is a good friend that "…lives about half a mile away." Nicholas found a sponsor but "…we rarely spoke, and he was never important to me." Christina reported her sponsor was an atheist as well. "He helped me to take the general idea of the twelve

steps and turn them into what I needed them to be for me to be successful. We have remained friends to this day." Kevin is still in touch with his sponsor, who "is one of the things that I am most grateful for." William found his sponsor after a rocky start with his first sponsor, who was "an absolute prick about the higher power thing, so I ended up firing his ass and finding someone cooler." Kathleen said her sponsor was, "Someone I could never trust entirely. She would be quick to tell on me for any indiscretion at all. So, I never trusted her with anything.".

Seven participants did not obtain a sponsor (Valerie, Steven, David, Margaret, Michael, Eleanor). Valerie did not elaborate beyond "no" in her response. Steven stated he did not connect with anyone, "They tried, but I never called them or met with them. I guess I just never met one I liked enough to go for it with." David said, "I might have done so if I could have found someone who wasn't trying to force their religion down my throat. The last thing I wanted was yet another person telling me I was doomed to relapse unless I found Jesus." Margaret said, "I never claimed a particular person. I have a lot of support from friends, so if I had to, I could call them for support." and Michael did not want to have a sponsor that lived in another area: "The treatment center was some distance from my house, and I did not want to develop a sponsorship relationship with someone that I could not see face to face." Eleanor said, "No. I didn't want one. Again, I was just there to distract myself from physical cravings which I knew would subside."

**Discrepant Cases.** Kathleen and Eleanor had discrepant cases. Kathleen's case was discrepant because, unlike the rest of her cohort, she was hiding her atheism from her entire family. Kathleen kept her atheism concealed out of fear of rejection. Eleanor lived

in the bible belt, and she feared discrimination in her community. These two participants may have experienced minority stress (Brewster, Velez, et al., 2016; Meyer, 2003). I will discuss this in more detail in chapter five.

## Summary

The research question guiding this study was the following: What are the lived experiences of atheists in 12-step SUD treatment and aftercare. The sample consisted of 13 adults who self-identified as atheists who had undergone 12-step SUD treatment and aftercare in the last three years and attended at least five 12-step meetings. I recruited the participants from Amazon's Mechanical Turk job board. Participants completed qualifying surveys on SurveyMonkey and, after giving their consent, requested questionnaires which they completed and returned to me via email.

Five themes emerged from the analysis of the transcripts. These themes were: coming out as an atheist; the meaning of atheism; experienced stigma and discrimination; treatment experience; and aftercare: meetings, sponsorship, and steps. From these five themes, 25 subthemes emerged (see Table 2).

I found that most participants disclosed their atheism to family members and friends. For six ($N = 6$), the reaction was neutral or positive, and four ($N = 4$) had a negative reaction, including one case of abuse. Three ($N = 3$) participants concealed their atheism out of fear of rejection or to avoid causing. All participants had supportive friends who were either were atheists themselves or accepting of their atheism.

All participants defined atheism as a lack of belief in god. For most, atheism was not a central or salient part of their identity. Most reported experiencing difficulties with

stigma and discrimination due to common stereotypes of "angry," "militant," or "evil. Participants were mainly tolerant of others' religious beliefs and practices, and a few were interested in the philosophical, artistic, and historical aspects of the world religions. They also spoke of the harm and destruction associated with religion.

Participants had varying degrees of familiarity with 12-step programs before they went to treatment. Most knew about meetings and the steps from popular culture or knew someone with first-hand experience. Some participants had family members whose SUD was in remission due to participation in 12-step programs. Participants chose their treatment program because of insurance coverage, proximity to home, an ultimatum from a loved one, or as follow-on treatment after detox. Non-12-step alternatives were unknown among the sample with two exceptions.

About half of the participants disclosed their atheism upon admission to treatment. The staff at the treatment centers were usually helpful, helping participants to reconcile atheism with the higher power concept. A few participants experienced religious overtures from staff that were bothersome, such as pressure to attend a bible study. A staff member told one participant that he would never recover without religion. Participants spoke of being misunderstood by staff and lay members at meetings.

Participants concealed their atheism to minimize distractions while in treatment, or from fear of abuse or rejection. As part of the effort to hide their non-belief, some participants pretended to believe in god and became suspicious of the other clients' sincerity.

Most of the participants experienced a paradox in treatment. On the one hand, they felt a sense of universality and hope from knowing they were not alone, and others had overcome their substance use dependence. Conversely, participants felt isolation and cognitive dissonance when others talked about submission to god or a higher power. Participants spoke of a strong sense of agency and the difficulty of accepting the concept of divine intervention, which was anathema to their worldview. Only a few participants were able to reconcile their atheism with the philosophy of the 12-step program so that they could do the steps. Most were not able to do the steps because of their cognitive dissonance.

I found that most of the participants stopped attending 12-step meetings when they returned home. Some became involved in alternative programs, such as SMART, Refuge Recovery, or Women For Sobriety. Most participants reported keeping in touch with friends from treatment and were grateful for the support network.

In chapter five, I will provide an interpretation of the results through the lens of my theoretical framework, address implications for social change, recommendations, and conclusions. I will also discuss the limitations of the study and how this study can contribute to research in the field and clinical practice.

# Chapter 5: Discussion, Conclusions, and Recommendations

## Introduction

In this chapter, I present an analysis of the findings of my IPA study, which explored the lived experiences of self-identified atheists in 12-step SUD treatment and aftercare.

This study is important because between 75% and 90% of SUD treatment programs in the United States are 12-step oriented (Mohammad, 2018; Pagano, Jr., 2015; Roman & Johnson, 2004; SAMHSA, 2019a). The 12-step philosophy is anathema to atheists who, by definition, lack a belief in god (Bullivant, 2013). Extant studies of atheists in 12-step SUD treatment were quantitative and provided numeric evidence that atheists were unlikely to initiate and sustain involvement in 12-step programs (Kelly et al., 2010). However, the reasons for atheists' low affiliation and dropout were not studied qualitatively. I could not find any studies that explored what it felt like to be an atheist in 12-step SUD treatment and aftercare.

According to Gervais and Najle (2018), in 2018 the prevalence of atheists in the United States was approximately 20%. Gervais and Najle (2018) arrived at the 20% figure by using the unmatched count technique to adjust earlier telephone survey results of between 4% and 11% (Pew Research Center, 2015; WIN-Gallup International, 2012). The unmatched count technique is useful when the endorsement of items may be embarrassing or socially undesirable, such as admitting to cheating on an exam. Gervais and Najle suspected the earlier, lower percentages confounded by factors inherent in the measurement of atheists. One factor was the variety of definitions sometimes embraced

by atheists, such as agnostic, none, nonbeliever, and humanist (Bullivant & Ruse, 2013). Another is the social desirability factor wherein respondents avoid identifying with the stigmatized “atheist” label in favor of the less controversial “agnostic” or “none” designations (Edgell et al., 2016; Gervais & Najle, 2018; Quinn et al., 2014).

According to Pew Research Center (2015), young adults (aged 18 to 34) make up the largest segment of atheists in the United States: between 35% and 40%. Furthermore, approximately 40% of all SUD treatment admissions are young adults (SAMHSA, 2018). Logically, SUD treatment professionals regularly work with atheist clients.

Participation in mutual-aid groups as an adjunct to treatment is positively correlated with the number of days abstinent and negatively correlated with the length and severity of relapses (Tonigan, Connors, & Miller, 2003). If atheists are not able to tolerate the 12-step program, they will eventually drop out, increasing the risk of relapse (Tonigan et al., 2002). Hence, the SUD treatment episode is an opportunity for clinicians to introduce clients to non-12-step mutual-aid groups to increase the chances of long term participation and success (Moos & Timko, 2008). The culturally competent treatment of atheist clients requires treatment center staff to be well-versed in options for atheists, including the facilitation of secular mutual-aid group involvement.

## Purpose of the Study

The purpose of this study was to understand the lived experience of atheists in 12-step SUD treatment and aftercare. A small body of quantitative research showed that atheists were unlikely to affiliate with 12-step groups, such as AA (Kelly et al., 2010; Tonigan et al., 2002). However, how it felt for atheists to experience 12-step SUD

treatment and aftercare had not been studied. Such knowledge can inform the treatment and aftercare of atheists with SUD, for whom 12-step programs are contraindicated (Borras et al., 2010).

## Nature of the Study

I recruited a purposeful sample of 13 self-identified atheists who met study criteria. Study criteria were self-identified as an atheist, at least aged 18, lived in the United States, enrolled in voluntary 12-step SUD treatment in the United States within the last 3 years, and attended at least five 12-step meetings.

The participants gave informed consent and responded to a list of 38 open-ended questions via email (Appendix D). The open-ended questions gathered information on participants' experiences in 12-step SUD treatment and aftercare, as regards their atheist identity, and how it impacted their experience. I also asked about the participants' early experiences coming out as an atheist and managing their atheist identity amongst families, friends, and the public. The participants' characterization of these early experiences enabled me to analyze my findings within the conceptual framework of the study.

## Gaps in Research and Literature

Extant empirical research revealed that atheists did not readily participate in, or sustain involvement in, 12-step programs. Religiosity was an oft-cited barrier to participation (Pagano et al., 2013; Tonigan et al., 2002). I could not find any qualitative research on the subjective experience of atheists in 12-step SUD treatment and aftercare. Therefore, I sought to address this gap with this study.

The next section is a summary of my key findings and a discussion of the ways my findings are consistent with, not consistent with, or add to knowledge in the field of psychology by comparing the results to the existing peer-reviewed literature in Chapter 2.

## Summary of Key Findings

The research question guiding this study was as follows: What are the lived experiences of atheists in 12-step SUD treatment and aftercare?

The themes that emerged from the participants' responses fell into five groups: (a) coming out as an atheist, (b) meaning of atheism, (c) experienced stigma and discrimination, (d) experience of treatment, and (e) aftercare.

There were a few new additions and extensions of knowledge in the field. The level of outness in treatment was illuminating because some participants felt they had to hide their beliefs from the staff and their peers. To accomplish this, they behaved in contradiction to the tenet of authenticity and honesty much revered in the 12-step program. The participants either actively concealed or concealed through passive nondisclosure. Several concealing participants falsified their progress with the steps and avoiding the topic of god or a higher power in conversation. This type of concealment frequently occurred as group therapy is a hallmark of SUD treatment.

Some participants disclosed their nonbelief in hopes of eliminating distraction and receiving help to succeed in the program. Whether or not they concealed their atheism, participants reported becoming weary of the religious orientation of the program and the frequency of god-talk. Another effect of frequent god-talk was feeling excluded. The

exclusion was not found in the extant literature and was notable as loneliness has negative effects on psychological health.

Also of note was the lack of referral or education on alternatives to 12 steps. Many participants stopped attending the 12-step program and did not replace the structure with an alternative program. However, some participants retained their support group and friends after they had left the 12-step program.

## Interpretation of Findings

I grouped emergent themes to provide a view of the participants' experiences as an atheist before they went to treatment and how their atheist identity impacted their experience while in treatment and aftercare (see Table 3).

Table 3

*Themes and Subthemes*

| Coming out as an atheist | Meaning of atheism | Experienced stigma and discrimination | Experience of treatment | Aftercare |
|---|---|---|---|---|
| Negative reaction | Defined as the absence of belief in god | Negative stereotypes & defensive othering | Choice of 12-step treatment | Alternatives to 12-steps sought and found. |
| Neutral or positive reaction | Low centrality and salience | The public conflation of morality with a belief in god. | Presentation of self, outness | Continued with 12-step meetings |
| Concealment of atheist identity | Low formal affiliation with other atheists | Public intolerant and misinformed | Too much god-talk/paradox of isolation | Stopped attending all mutual-aid groups |
| Supportive atheist friends | Tolerance of others' religious beliefs | | Universality and support of peers | Difficulty with steps |
| Concealment at religious services | | | Staff bias/lack of referrals | Sponsorship |

**Theme: Coming Out as an Atheist**

**Subtheme: Negative reaction to coming out as an atheist.** Consistent with research by Abbott (2017), Cloud et al. (2008), Elliott and Doane (2015), Zimmerman et al. (2015), and Zylik (2019), the participants who grew up in a religious family experienced a difficult coming-out process, similar to coming-out experiences within the lesbian, gay, bisexual, transgender, queer and questioning community. Notably, families who respected the individuation of belief adapted to the disclosure, although not without difficulty. Participants' experiences were consistent with research by Zimmerman et al., who found family members (usually grandparents) expressed concern for the atheists' soul and the afterlife. These family members and two participants' religious schools used threats of Hell and proselytization to try to change participants' minds about leaving the religion. Zylik suggested that threats and proselytization are ultimately dismissive of a person's beliefs and can negatively affect well-being. Some of the participants in my study did report feelings of guilt for making their parents or grandparents worry; a few concealed their atheism from more religious family members to avoid causing worry.

**Subtheme –Neutral or positive reaction to coming out as an atheist.** Six participants were either never closeted or received a neutral or positive reaction from their families. This finding was consistent with research by Smith (2011) and Abbott (2017) who found that for atheists whose family of origin included atheist or secular parents, atheism was normative and coming-out was unnecessary.

**Subtheme: Concealment of atheist identity.** Atheism is a concealable identity, and extant research has demonstrated that if the social cost is too high, such as anticipated

stigma or discrimination, atheists did not readily reveal their nonbelief (Camacho, Reinka, & Quinn, 2020; Garneau, 2012; Goffman, 1963). For example, Garneau (2012) found in a study of atheists in the Midwest, a relatively religious area of the United States, that 78% of respondents actively concealed their atheism to avoid stigma or discrimination.

My findings were consistent with the abovementioned research. Three participants (Christina, Kathleen, and Kevin) concealed their atheism. Christina said she conceals her atheism from her family as a "matter of convenience as …I see little reason for them to be worried about 'my mortal soul'…and I simply do not feel like having to hear about it…" Kathleen concealed because she had a "fear of being stuck alone and alienated by those who love me…I fear being kicked out of the family."

**Subtheme: Concealment at religious services.** Consistent with the findings of Hammer et al. (2012), some participants were asked by family members to hide their atheism at church (a few still attended to please family members) or around certain family members. In previous studies, about a third of atheists reported that their families asked them to pretend that they still believers and to keep their atheism a secret (Hammer et al., 2012; Zylik, 2019).

**Subtheme: Supportive atheist friends.** I found that all the participants had supportive friends who were also atheists. This was consistent with research by Abbott (2017). Atheists do not tend to experience stigma and discrimination within their social circles.

## Theme: Meaning of Atheism

**Subtheme: Defined as the absence of belief in god.** The participants in this study all defined atheism as a lack of a belief in god or nonbelief in god, consistent with the operational definition that scholars have deemed most representative of the atheist construct (Bullivant, 2013). The secular population has self-identified using a variety of terms such as *agnostic*, *spiritual but not religious*, and *secular humanist*. Researchers have found that some people who identified with these categories may also profess a belief in god, an important distinction in this study as my goal was to investigate the lived experiences of atheists who, by definition, lacked a belief in god (Murray, Goggin, & Malcarne, 2006; Murray, Malcarne, & Goggin, 2003).

**Subtheme: Low centrality and salience.** Living with a concealed, stigmatized identity may result in psychological distress. Predictors of psychological distress in people with a concealed stigmatized identity are the *centrality* (how much the identity defines a person), *salience* (frequency of thinking about the status), and the *anticipation of stigma* (Quinn & Chaudoir, 2009).

My findings were consistent with research by Baggett (2019), who conducted a study of atheists using a sample from the general population, as opposed to atheist organizations, where researchers on atheism often recruit their sample. Baggett (2019) found that atheism was not important to his study participants and not considered by them to be a central part of their identity. Most participants in my study did not consider atheism a defining characteristic of themselves or status that they think of often. Most participants spoke about the impact of atheism in their everyday lives in the context of

making decisions and living in the present, as opposed to living in preparation for an afterlife.

There were three participants for whom being an atheist was distressing because of living in a highly religious area or having a highly religious family of origin, which, paradoxically, increased the centrality and salience of their atheist identity due to the fear of being "outed."

**Theme: Experienced Stigma and Discrimination**

My findings were consistent with research that showed atheists are stigmatized and discriminated against regularly in the United States (Abbott, 2017; Edgell et al., 2016; Scheitle et al., 2018). All except one of the participants received negative reactions from strangers and acquaintances in their communities, including school and work.

The comments made to participants in this study were consistent with research which found that Americans hold an assortment of negative stereotypes of atheists such as angry, self-indulgent, evil, and irresponsible (Gervais, Shariff, & Norenzayan, 2011; Meier, Fetterman, Robinson, & Lappas, 2015; Saroglou, Yzerbyt, & Kaschten, 2011). Scholars have surmised these stereotypes exist because, to theists; moral behavior is an expression of faith, and, as such, stems from a belief in god. Hence, atheists are without a god to prescribe and enforce morality and, undaunted by god's wrath, atheists lack the motivation to behave morally (Gervais, 2014).

A few participants in my study were stereotyped as lacking morals because they were without a belief in god. Those participants were offended by this logic and expressed negative attitudes toward religious people.

Steven's experience was not consistent with the research on stigma and discrimination of atheists in the United States. Steven did not experience any negativity from other people because of his atheism, so he would not have had any predilection to conceal in treatment out of anticipation of stigma or maltreatment. Steven disclosed his atheism in treatment and regretted it because staff pressured him to convert to Christianity (i.e., to "read the bible and join sermons")

## Theme: Experience in Treatment

**Subtheme: Choice of 12-step treatment.** To see if the participants in this study considered the potential conflict between the 12-step philosophy and their atheism as a factor in choosing their treatment program, I asked about their decision-making process in choosing 12-step treatment.

My study identified a forced-choice of 12-step SUD treatment and aftercare, consistent with Walters (2002), who found the Minnesota Model was often the only treatment program choice available. Only one participant, William, stated that he had misgivings about the higher power concept "being an issue, and it was."

The lack of availability of alternatives for atheists may indicate a lack of cultural awareness, competency, and mandated ethical, evidence-based practice within the field. Additionally, the participants in my study perceived that the only alternatives were expensive programs they could not afford. With few exceptions, the participants were unaware that medical insurance covers SUD treatment programs.

**Subtheme: Presentation of self/outness.** My findings related to self-disclosure and concealment are consistent with and extend atheist outness research to the context of

12-step treatment. Fewer participants concealed than disclosed their atheist identities in treatment (8 disclosed). Some of the participants *actively concealed* their atheism in treatment because they feared negative consequences. A few participants engaged in passive nondisclosures were not asked, did not volunteer, and did not actively conceal, such as pretending to believe or changing the subject.

Research has found that the decision to be "out" or disclose a stigmatized identity is related to the amount of anticipated stigma or fear of maltreatment (Camacho et al., 2020). The presence of either may be related to experiences in the past with disclosure and whether these experiences were affirming or unsupportive (Brewster, Velez, Geiger, & Sawyer, 2020; Camacho et al., 2020). The level of anticipated stigma had a significant, moderate, negative correlation with outness; the higher the anticipated stigmatization, the lower the outness (i.e., higher concealment).

There were small but significant associations between (a) anticipated stigma and psychological well-being, and (b) outness and well-being (Abbott & Mollen, 2018). However, the strength of the association between outness and well-being may depend on *how* the person revealed the stigmatized information. Camacho et al. (2020) found active concealment correlates with a higher level of depression and lower life satisfaction than passive nondisclosure. Active concealment was a better predictor of psychological distress than nondisclosure in people with a history of mental illness, chronic physical disease, and a minority sexual orientation (Camacho et al., 2020).

Most of the participants of my study disclosed their atheism in treatment and their lives before treatment. The few participants who actively concealed their atheism

reported fear of being "outed." One of these participants reported that she developed depression while in treatment. Misattunement of staff was also frustrating for atheists in treatment.

**Subtheme: Staff bias and lack of referral.** My findings were consistent with extant research on counselor bias toward 12-step programs. None of the participants was educated as to non-twelve-step mutual-aid groups (e.g., SMART Recovery), even when they expressed concerns about the religious tenor of the literature and program philosophy.

Statistically, most SUD treatment programs use the Minnesota Model, a hallmark of which is a staff that has successfully resolved their SUD with a 12-step program (Novotna et al., 2013). Researchers have found that these counselors held a bias towards their 12-step lived experience as more credible than empirical research. Bias towards the 12-step modality led to treatment staff unwittingly misinforming clients about the existence and effectiveness of secular alternatives to 12-step SUD treatment and support groups and resistance to the adoption of evidence-based modalities (Laudet & White, 2005; Novotna et al., 2013; SAMHSA, 2017; Weisner & Hay, 2015). Laudet and White (2005) surveyed SUD counselors as to their referral practices for "clients who did not want to attend AA." They found the counselors showed little awareness of options for clients who reject the 12-step philosophy; 47% stated non-12-step approaches were ineffective, 45% indicated AA was the only approach, and only 8% said there *were* helpful alternative approaches (Laudet & White, 2005). These assertions were not accurate, as research by Zemore et al. (2017) found no discernible difference between the

efficacy of 12-step programs and alternative programs such as SMART and Women for Sobriety.

The experiences of participants in my study were consistent with the research on staff bias. None of the participants was referred to or offered information about alternatives to the 12-step program. A few participants were pressured by counselors to embrace the 12-step philosophy, and one staff member explicitly told a participant that he would not achieve or sustain sobriety without religion.

**Subtheme: Universality and support of peers.** Some of the participants' experiences were consistent with extant research, which found that camaraderie and a sense of belonging reinforced participation with 12-step mutual-aid groups (Galanter, 2014). A surprising new finding in my study was that many of the participants became friends and socialized with peers from their treatment episodes and 12-step meetings, even after they had stopped going to 12-step meetings. These participants commented on the importance of these new friends as a support network. This finding adds to the research on atheists in 12-step SUD treatment and aftercare.

**Subtheme: Too much god-talk /paradox of isolation.** Exclusion is painful. Social exclusion correlates with anxiety, depression, and lowered self-esteem (Leary, Tambor, Terdal, & Downs, 1995). Rejection due to feelings of being a cultural misfit is associated with lower levels of self-esteem and general life satisfaction and higher levels of anxiety and depression (Bernard, Gebauer, & Maio, 2006). I found that the participants in my study felt excluded at times because they did not have a belief in god while their peers engaged in conversations about god frequently. This finding was unexpected and

new in this context, adding to the knowledge about the experience of atheists in 12-step SUD treatment programs. This added knowledge will inform practice and raise awareness of clinicians of feelings of exclusion of atheists.

The participants in my study did not like the religious language and the frequent god-talk in the 12-step program. This finding is consistent with research as to the religiosity of participants in 12-step groups and secular alternatives. Atkins Jr and Hawdon (2007) found that religiosity was one fundamental difference between participants of 12-step versus secular groups; the religious were significantly more likely to be involved in 12-step groups than the secular.

**Theme: Aftercare**

Most participants had an aftercare plan that called for continued attendance at 12-step meetings, getting a sponsor, and working the 12 steps. There has been very little research into the structured behaviors that comprise the therapeutic practices of AA or "working the program" (Irving, 2015; Sanders, 2006, 2019; Thompson & Thompson, 1993). These behaviors are working the steps, meeting attendance, and working with a sponsor, and sponsoring new members (Sanders, 2019).

**Subtheme: 12-step alternatives found or sought.** My findings were consistent with research by Borras et al. (2010), which indicated 12-step groups were problematic for non-religious individuals and recommended referring these clients to alternative mutual-aid groups that are more compatible with their worldview.

Some participants sought, found, and remained in alternatives to 12-step groups once discharged, and reported being satisfied with their choices. The participants'

experiences were consistent with extant research, which found higher levels of group cohesion and satisfaction reported by all non-12-step group attendees (Zemore et al., 2017). Higher satisfaction in alternative secular groups is a critical finding, as mutual-aid group attendance correlates with positive SUD outcomes (Horvath & Yeterian, 2012).

Two of the participants, Michael and William, had experiences with the 12-step program that were inconsistent with research (Borras et al,. 2010; Zemore et al., (2017). After discharge, these participants enjoyed AA enough to remain involved in their 12-step groups were still attending meetings at the time of the study. Interestingly, Michael was in Los Angeles at the time of his treatment and stated he had "lots of options" for SUD treatment and aftercare. Los Angeles County AA offers more than two thousand meetings every day. All of the meetings have a different culture and population. For example, the meetings could consist of only women; only men; LGBT focus; conducted in a certain language such as Armenian, Spanish, or Russian; catered to professionals or people with co-occurring disorders. Michael was able to find a group with people that he liked, and he felt comfortable enough to stay. Michael stated he knew that "giving myself to the group was the right thing to do." Meaning the group could be functioning as his higher power. Being unable to clarify this point is a limitation of this study, which I will discuss later in the chapter.

**Subtheme: Difficulty working the steps**. Research by Sanders (2019) on women in AA found that participants had the most difficulty with the third step, which reads: "Made a decision to turn our will and our lives over to the care of God as we understood him" (Alcoholics Anonymous, 2001, p. 37). For the participants in Sanders's study, the

idea of turning her will over to the care of god was difficult due to past religious experiences.

These findings were consistent with the participants' experiences in my study, as all reported having difficulty working the steps. Two participants completed a modified version of the steps using the group or themself as their higher power. Most participants failed to work the steps and cited an inability to perform the "mental gymnastics" needed to work the steps with integrity.

**Subtheme: 12-step meetings.** My results were consistent with research that found atheists were reluctant to participate in 12-step meetings (Tonigan et al., 2002). Nine of the participants stopped attending 12-step meetings after discharge. Of these, four became involved with non-12-step alternatives they found after returning home. Some participants were frustrated about the lack of mutual-aid programs that are suitable for people without any religious beliefs. The participants may have had an easier transition to mutual-aid groups after discharge if the staff had educated them about non-12-step alternatives or, optimally, introduced the participants to non-12-step groups while they were still in treatment. Only four of the participants continued to participate in 12-step meetings after leaving treatment. These participants had embedded themselves successfully while in treatment and had been able to reconcile the 12-step philosophy with their atheism.

The findings of Tonigan et al. (2002) provided quantitative evidence that atheists derived a benefit from AA regardless of a belief in god. In a meta-analysis of 25 years of AA research, Kelly (2017) found "AA's beneficial effects seem to be carried

predominantly by social, cognitive and affective mechanisms" (p. 1). My study findings were consistent with this research. Some participants experienced a sense of social acceptance from AA peers, which mediated the effect of the cognitive dissonance on the participants' ability to reconcile their atheism with the 12-step philosophy wherein a central tenet is a reliance on a higher power or god. I will analyze the role of cognitive dissonance in the next section of this chapter.

**Subtheme: Sponsorship.** About half of the participants formally obtained a 12-step sponsor. These relationships appear to be beneficial as support in aftercare. Despite leaving the 12-step programs, participants retained their sponsors who were able to mentor the participants' sobriety within the framework of atheism. These findings were consistent with research, which showed that there is a quasi- therapeutic-alliance among sponsors and their mentees, which correlated with better substance use outcomes (Kelly, Greene, & Bergman, 2016; Kelly & White, 2012; Young, 2013).

## Theoretical Framework

Extant research supports the use of several compatible theories to explain the experiences of atheists in 12-step SUD treatment and aftercare. My theoretical framework individually combined three theories with minority stress theory as the overarching theme (Meyer, 2003). The three theories were: the management of stigmatized identity theory (Goffman, 1963), cognitive dissonance theory (Festinger, 1957), and the rejection identification model of social identity theory (Branscombe et al., 1999; Tajfel & Turner, 1986). I will discuss minority stress theory in the next section and then the three aforesaid theories in subsequent sections.

## Minority Stress Theory

In his seminal research, Meyer (1995) found the chronic stressors inherent in being a member of a stigmatized population were correlated with poor psychological and physical outcomes. I used the minority stress model as the overarching theme to position atheists as a marginalized group. In the United States, atheists are not typically included in the civil rights dialogue except in academia. Because atheism is not a visible attribute, individuals who choose to stay in the closet are generally not perceived as being marginalized members of the community. Individuals who disclose their atheism routinely experience chronic stressors such as "discrimination, slander, social ostracism, denial of opportunities, and hate crimes" (Brewster, et al. 2020, p.2). Hence, atheists need to monitor their environment and manage the information others are privy to. Depending on the environment, having to decide whether to disclose or conceal atheism is a chronic stressor that could contribute to negative psychological and physical effects (see Meyer, 2003; Meyers, Brown, Grant, & Hasin, 2016).

I found that all except for one of the participants in my study had experienced discrimination and stigma in their everyday lives, such as disparaging remarks, discrimination, anger, abuse, and unwanted proselytizing. These negative experiences increased participants' fear and anticipation of stigma in the future.

Recent research by Brewster et al. (2020) found that a supportive community affiliation mediated the negative effects of marginalization. Community alliances are available to atheists in the form of support groups, activist groups, and social Meetups. However, access to these resources requires joining with other atheists.

My findings were consistent with the research on minority stress. In my study, I found that only two of the participants had joined atheist groups. Eleanor lived in the Deep South and was hiding her atheism because the consequences were dire if anyone in her community found out she was an atheist. She could be denied housing and employment, her son would be bullied, and she would be ostracized from the community. Eleanor was not comfortable in her community and did take refuge in a Meetup group of atheists. When she started a 12-step treatment everyone assumed she was a Christian and she did not correct this assumption. For Eleanor and Kathleen, the fear of being "outed" was always there.

In 12-step treatment, participants reported the salience of their atheist identity heightened. A few participants concealed their atheism from staff and peers, choosing to act "as if" they believed in god. For these participants, there was a constant fear of being "outed" to others and ejected from the program. Others disclosed their atheism in the hopes that there would be a way to succeed in treatment despite their atheist status.

The psychological discomfort of trying to reconcile nonbelief with conflicting tenets of the 12-step program is called cognitive dissonance, which I will discuss in the next section.

**Cognitive Dissonance Theory**

Cognitive dissonance is the psychological discomfort that arises from holding conflicting cognitions at the same time (Festinger, 1957). Cognitions may be attitudes, beliefs, or behaviors (Festinger, 1957). Cognitive dissonance theory refers to the drive to maintain internal equilibrium. People who experience inconsistency are motivated to try

to reduce this dissonance and avoid situations and information likely to increase it. Internal equilibrium is restored by modification of attitudes and beliefs to better align with behavior.

A common example of cognitive dissonance theory is the smoker who *knows* cigarettes cause cancer (belief) but smokes (behavior) nonetheless. Rather than quit smoking, it is easier to restore equilibrium by altering their attitude about smoking. The idea that smoking causes cancer is not threatening when distorted by a “magical” belief that they will never get cancer.

Research indicates that cognitive dissonance can be reduced by lessening the magnitude of the dissonant belief or by adding more consonant elements. This process is a sort of cost/benefit analysis for the successful resolution of inner conflict. In the context of 12-step programs, which are heavily laden with references to god and prayer, an atheist may be able to alleviate cognitive dissonance by altering their attitude toward such references (Cooper, 2007). For example, they may deem AA’s overtly religious practices, such as group recitation of the Lord’s prayer, as not prohibitively offensive. They will try to fit in by focusing on more desirable aspects, such as social support.

All of the participants in my study experienced cognitive dissonance while in treatment. Most participants cited the higher power concept as the most troublesome piece of the 12-step philosophy. The participants in my study cited feeling left out as if they were “being brainwashed,” and “depressed”, were cynically offered platitudes such as “there are many atheists in AA.” For some participants, the resolution of their cognitive dissonance was the active concealment of their atheism. To hide their atheism,

these participants made false claims and fabricated examples to indicate their progress with step work. They changed the topic when a discussion turned to the higher power construct. The participants relayed how difficult it was to conceive of a higher power that would be congruent for themselves. Most participants were not able to perform the "real mental gymnastics" or tolerate the dissonance.

Some participants managed to resolve their inner conflict by modifying the concept of a *higher power* to a more consonant object such as themself or the group to allow them to complete a modified version of the steps. If able, then they considered the sense of belonging, new friends, and social support network worth the cost of modifying their attitudes. In essence, the participants had assuaged their cognitive dissonance by modifying their attitude and adding the consonant element of social interaction and support to their dissonance equation.

In addition to cognitive dissonance arising from the religious aspects of the 12-step modality, some participants were troubled by a conflict between their highly-valued personal agency and the 12-step emphasis on *giving up one's will* to a higher power. These participants preferred personal responsibility, control, making decisions for themselves, and denounced the possibility of divine intervention.

Paradoxically, changing attitudes to facilitate 12-step involvement may eventually lead to feelings of hypocrisy (Yousaf & Gobet, 2013). Hypocrisy is disturbing for people whose identity centers around the forsaken value or belief, leading to negative emotional and attitudinal consequences such as guilt and shame. Guilt and shame could lead to depression and maladaptive coping skills, such as alcohol or drug use (Yousaf & Gobet,

2013). This process was evident in a couple of participants who actively concealed their atheism by “lying” or “fudging” conversations about step-work or their belief in god. These participants reported a very negative assessment of the 12-step program, in that the program is not inclusive and creates dependence, acceptance of weakness, is fraudulent, and forced religion on them.

Lastly, there is a narrative of critical free-thought within the atheist identity (Fitzgerald, 2003; Zimmerman et al., 2015). According to Hunsberger and Altemeyer (2006), atheists who deconverted perceive their atheism as a result of critical thinking and an independent assessment of religion. In my study, the atheists with a religious upbringing had already experienced the painful and unpopular process of deconversion and coming out. These participants validated the research that concluded that attempts to change an atheist’s belief system or ask them to keep an open mind about the existence of a god or a higher power are dismissive and invalidates the atheist worldview (Garneau, 2012; Her, 2017; Sue, 2010). In a few participants, the dismissal of beliefs led to resentment and hostility towards 12-step proponents. Likewise, I found participants in this study, who grew up in atheist families, bristled at being told they must be open to the possibility of the existence of a god or divine intervention and were offended by the suggestion (Simonson, 2011; Zimmerman et al., 2015).

**Rejection-Identification Model**

In addition to the intrapersonal effects of cognitive dissonance, the external effects of membership in a stigmatized group can be analyzed using social identity theory as regards intergroup behavior. Groups are a significant source of pride, self-esteem, and

provide a sense of belonging. An ingroup is a group an individual belongs to, and an outgroup is a group they do not. Prejudice and discrimination arise when members of a group are viewed with homogeneity and stereotypes by members of another group. For members of stigmatized or disadvantaged groups, sustained discrimination or prejudice tend to be internal, stable, uncontrollable, and convey widespread exclusion and devaluation of the group. In the United States, atheists are considered an outgroup as a stigmatized minority.

The rejection identification model of social identity theory describes the phenomenon of the strengthening of members' identity with an ingroup in reaction to negative interactions with members of an outgroup (Branscombe et al., 1999). This phenomenon occurs when the group members attribute the negative interactions to prejudice and functions to protect self-esteem (Branscombe et al., 2012). For example, atheists may join atheist activist groups as a reaction to a vitriolic speech by fundamentalist Christian groups. For the self-identified atheist in 12-step SUD treatment and aftercare, this theory would predict a trajectory wherein atheists reject the 12-step philosophy, bolster their identification with the atheist identity, and develop hostility to treatment staff and members of the 12-step community. This trajectory may lead to a negative psychological state such as depression, and possibly to maladaptive coping mechanisms.

According to the rejection-identification model of social identity theory (Branscombe et al., 1999, 2012; Tajfel & Turner, 1986), members of disadvantaged groups cope with the pain of rejection attributed to prejudice by increasing identification

with their disadvantaged group. The integration of the model with minority stress theory predicts that attributions to prejudice are considerably more harmful to the psychological well-being of members of disadvantaged groups than they are for members of privileged groups.

Most participants in my study eventually rejected the 12-step program and a few displayed hostility towards staff who proselytized Christianity during the treatment period. However, there is no evidence that the level of identification with atheism increased for the participants as a result of their undergoing 12-step SUD treatment and aftercare. All of the participants had experienced negative and discriminatory interactions with theists before going to SUD treatment. According to the rejection-identification model, these interactions may have resulted in the participants strengthening their identification with atheism at the time, but none reported high identification with atheism. Only a few participants expressed negative attitudes toward theists.

One reason for this may be that the participants did not experience the negative events as threats to their self-esteem or self-image. Researchers found that statistically, atheists tended to be members of privileged groups, such as male, white, and highly-educated. So, negative interactions may not sting as much as for those whose atheist identities intersect with other disadvantaged identities. In other words, members of historically privileged groups may not readily attribute negative interactions to prejudice, and their self-esteem would not need protecting or rehabilitating through strengthening their identity with atheist groups. As to hostility towards theists, the majority of

participants in my study expressed tolerance and understanding towards theists as people but denounced religion.

Another reason given for low identification with atheism was the reluctance to be associated with so-called *new atheists* (e.g., Richard Dawkins or Christopher Hitchens). The term “new atheists” was coined by a journalist, Gary Wolf, to denote intellectuals who rejected the existence of god and sought to illuminate damage wrought by religion through books and public debate. In the United States, new atheists have a negative stereotype of angry, militant, anti-religion activists (Bullivant & Ruse, 2013). A few participants were against joining an atheist group or publically identifying as an atheist because they did not want to appear to embody these stereotypes.

**Management of a Stigmatized Identity**

A consequence of negative stereotypes for atheists is their current status as one of the least trusted and most stigmatized groups in the United States (Edgell et al., 2016). As such, atheists experience discrimination, invalidation, and prejudice (Cragun et al., 2012). Research on the management of concealable stigmatized identities showed the anticipation of stigma and discrimination correlated with concealment and attendant distress (Chaudoir & Quinn, 2016; Elliott & Doane, 2015; Goffman, 1963; Quinn et al., 2014)

The management of spoiled identity theory hinges on whether the atheist experiences anticipated stigma and fear as to whether disclosure would be supported and accepted, or met with a negative reaction, mistreatment, or alienation from the group. Anticipated stigma for atheists in SUD treatment can be intense because the basis of the

12-step philosophy is the belief in, and submission to, a higher power or god, an abhorrent proposal for atheists even if there is not high centrality and high salience to their atheist identity. Atheists prefer not to practice blind faith and value critical thinking, further rejecting the idea of divine intervention.

There was evidence of the management of stigmatized identity in the narratives of the participants in my study. Some participants concealed their atheism from all or selected members of their families, and, and after negative interactions, were reluctant to disclose it in public. As regards disclosure in treatment, there were varying degrees of anticipated stigma and fear of rejection among the participants. Some participants actively concealed or passively nondisclosed their atheist identities because they feared expulsion or mistreatment. Some participants did disclose their atheism out of fear of treatment failure; others did not want their atheism to be a distraction.

## Limitations

### Transferability

The explorative nature of qualitative research necessitates the use of small samples. The goal of qualitative researchers is to render a narrative about participants' experiences with a particular phenomenon. The results of qualitative studies are not intended to be transferable to all atheists that experience 12-step SUD treatment and aftercare.

Instead, the findings may resonate with readers on a case-by-case basis. However, I would ask the reader to note that to protect the privacy of the participants I did not include basic demographic information such as age, race, ethnicity, location of domicile, or marital status. This is important because the geographical scope was the United States where the prevalence of atheism and attendant stigma varies widely by region.

### Data Collection

The use of asynchronous email to transmit the questionnaires precluded me from asking questions in real-time. I was not able to immediately probe or ask for clarification of a response. Hence, my ability to ascertain participants' emotional experience was limited to information provided in response to my open-ended questions or spontaneously added by the participant.

### Personal Bias

As discussed in Chapter 3 I was aware of a personal bias I held against the use of 12-step SUD treatment *for atheists*. I used bracketing to address this bias so that it did not affect my interpretation of the results of the study. Bracketing is a form of

compartmentalization, wherein the researcher strives to take a fresh perspective by setting aside their experiences throughout the research process (Creswell, 2016; Hamill & Sinclair, 2010; Husserl, 1931). I used journaling to bracket the research experience and my personal bias (Hamill & Sinclair, 2010; Husserl, 1931). I journaled throughout the process of collecting and analyzing my data, as well as when I wrote up the results and conclusion.

As an additional precaution, before I gathered data, I submitted interview questions to SUD treatment experts and my doctoral research committee who confirmed the neutrality of wording and screened for "leading" questions. I also used member checking. The transcripts were sent to the participants to review so that they could confirm that I captured the meaning of their interview responses.

## Recommendations for Future Research

Future researchers can build on this study to expand the knowledge of atheists' experiences in 12-step SUD treatment and aftercare. For example, a quantitative study with a large sample could provide statistically significant data to support practice and policy in the design of more responsive SUD treatment and aftercare for atheists.

Researchers could conduct quantitative studies to measure the effect of independent variables on the experience of atheists in SUD treatment. In the United States, age, the region of domicile, religiosity in the family of origin, the strength of atheist identity, race, and ethnicity may intersect to moderate or mediate the experienced stigma of being an atheist in society, and, in turn, an atheist in SUD treatment. For example, the construct, "strength of atheist identity" can be measured using an instrument

developed by Robele (2015). A comparison could be made between participants from organized atheist groups, whose strength of atheist identity is presumably of high centrality and salience, and non-members for whom an atheist identity may not be as central and salient.

Another independent variable is the region of domicile. The experiences of stigma may also be different as the religiosity of regions varies. Also, the prevalence of non-12-step mutual-aid alternatives varies by region. For example, SMART Recovery and Refuge Recovery were each founded by Southern California residents and are more numerous there than in other parts of the country affording atheists there a larger variety of meetings.

## Positive Social Change

There are social change implications of understanding the atheist experience in 12-step SUD treatment and aftercare. Currently, about 80-90% of SUD treatment and aftercare are based on the 12-step model. It is hoped that these findings will inform clinicians who seek to gain an understanding of the needs of atheists in SUD treatment. Such heightened awareness would contribute to clinicians' provision of culturally competent, evidence-based practice.

Ideally, the clinician would facilitate their client's involvement in 12-step alternatives while in treatment. Facilitation could include exposure to, and factual education about, alternatives to the 12-step programs. In turn, atheist clients may experience less distress during treatment and longer periods of engagement with aftercare.

As a result, atheists may learn to successfully manage their SUD and achieve long term sobriety, lessening the burden of SUD on families, businesses, and society-at-large. Another positive outcome would be more stable families with less domestic abuse, less interpersonal violence, and crimes associated with SUD; impaired driving, interpersonal violence, and property crimes. Eventually, the societal change could manifest in the aforementioned ways as well as increased economic productivity and lower healthcare costs.

## Clinical Implications

My findings will add to the body of literature available to clinicians who work with atheist clients and their families. Results apply to many areas including education and training, as well as individual therapy, group therapy, family therapy, and primary-care medicine.

### Training and Education

The findings of this study can help to inform clinical educators as to the inclusion of atheists as a special population in cultural diversity curricula. Extant literature indicates the clinical training of psychologists as regards religious and spiritual issues is insufficient (Schafer et al., 2002). Psychologists and other mental health clinicians need to be educated on religious diversity including the social cost of identifying as an atheist, a stigmatized minority in the United States (Elliott & Doane, 2015). Stigma and discrimination are positively correlated with psychological distress such as depression and anxiety, also known as minority stress (Meyer, 1995). I will discuss the implications for the practice of individual therapy in a later section.

As regards training specific to the treatment of SUD, it is hoped the findings of this study will encourage authors of curricula to include sections on secular alternatives to 12-step programs. It is reasonable to expect an increase in clients who are atheists and the findings of this study will help to inform clinicians who strive to respond effectively to their needs.

**Professional Ethics**

Psychologists have an ethical duty to provide evidence-based practice (EBPP), which is the "integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preference" (American Psychological Association, 2017, p. 276). A goal of EBPP is to provide clients with a full range of effective alternative interventions to choose from (American Psychological Association, 2006). In the context of 12-step SUD treatment and aftercare, the findings of this study may inform clinicians in the provision of ethical and culturally competent treatment for their atheist clients.

**Individual Therapy**

The findings of this and other studies can help clinicians conceptualize the psychological profile of the atheist client. As previously discussed, atheists are highly stigmatized in the United States (Edgell et al., 2016). Consequently, atheists may go through a coming out experience that is somewhat akin to the experiences of coming out for members of the LGBT populations (Zylik, 2019). Disclosure is often met with distrust, exclusion, discrimination, and emotional abuse that negatively impact psychological health (Meyer, 2003).

As a stigmatized minority, atheists need therapists who are self-aware as to personal biases and can affirm and validate clients whose beliefs and values are different from their own. The findings of the current and a previous study by D'Andrea and Sprenger (2007) can inform therapists of the atheist client's worldview and what their life meaning. .For example, one recommendation was for the therapist to be flexible with self-disclosure by answering the client's questions as to their religious stance (D'Andrea & Sprenger, 2007). Atheists may be suspicious of religious people due to negative encounters in the past, and therapists need to make sure they do not pathologize such suspicion (D'Andrea & Sprenger, 2007). Lastly, atheists may decide they comfortable working with a therapist who is not religious.

One narrative of the atheist identity is the embrace of science and reason and atheists do not appear to the concept of divine intervention  Therapists should be careful about the language used when interacting with atheist clients. For instance, atheists may bristle at phrases akin to “everything happens for a reason”. Atheists who do not believe in the god or a grand design will be offended when the therapist intended to offer comfort.

In the 12-step SUD treatment setting, these feelings may be compounded by the frequent god-talk and cognitive dissonance of reconciling atheism with the 12-step philosophy. In particular, the findings of this study can help clinicians understand the importance of referring atheist clients to non-12-step alternatives. Kelch (2014) recommended that referrals be considered at all stages of the treatment process, beginning with initial screening, informed consent, biopsychosocial assessment,

treatment planning and goals, and discharge. The findings of this study indicate clients should be asked about their stance on god and religion. During the treatment episode, therapists need to check in with atheist clients as to their ability to cope with the frequent god-talk vis-à-vis feelings of exclusion.

**Group Therapy**

Group therapy is a hallmark of SUD treatment programs. The findings of this study will help clinicians to be aware of the social stigma atheists experience. Theist group members may not understand the atheist worldview or may be misinformed as to the characteristics of atheism. Group facilitators can model affirmative discourse, acceptance, nonjudgement, and respect for the atheist clients' worldview. It might be helpful to provide psychoeducation to clarify the atheist worldview to avoid misunderstandings.

**Family Therapy**

Clinicians may find the results of this study useful as a resource to learn about the experience of coming out as well as the stress of staying in the closet in both religious and non-religious families. As with other stigmatized minorities, atheists fear ostracism from their families and experience guilt for leaving the family religion. Family members may invalidate the client by insisting atheism is only a rebellious phase rather than the result of curiosity and critical thinking. This may be more likely to happen during adolescence when children individuation from their parents. Zylik (2019) found that a rupture in the family may repair in time, and therapists can offer hope to the families as regards future reconciliation.

### Primary Care Physicians

Primary care physicians are often the first to screen patients for SUD and provide referrals to 12-step programs. The findings in this study could inform physicians as to the need for referrals to secular mutual-aid group options for patients who present with SUD. Atheist patients may not feel comfortable disclosing their nonbelief so all of the options should be presented to the patient If only 12-step options are provided the patient may go once and decide the religious overtones are an insurmountable barrier. In this case, the patient may never go back to meetings or receive treatment. Atheists would have a more positive experience if their cultural preferences and beliefs were accommodated. All patients would benefit from education about and referral to secular options such as Women for Sobriety, SMART, and Refuge Recovery.

### Policymakers and Other Stakeholders

The findings of this study contribute to the knowledge about atheists to inform the work of psychologists, physicians, academia, law enforcement, and corrections personnel, policymakers, researchers, and consumers of SUD treatment and aftercare. There is a need for more accessible and effective SUD treatment and aftercare for atheists and a need for increased awareness of the needs of and options for atheists.

## Conclusion

The prevalence of self-identified atheists is increasing in the United States, especially among young people (aged 18-34), who are the largest group admitted to SUD treatment each year. The 12-step SUD treatment model presents a serious internal conflict for atheists because the philosophy revolves around fostering a relationship with

a god or a higher power. My study explored the experiences of the participants in 12-step SUD treatment and aftercare to provide greater insight into the phenomenon.

About half the participants feared maltreatment or rejection and concealed their atheism. Paradoxically, participants felt supported by their peers but excluded due to the frequent god-talk. Participants could not successfully do the "mental gymnastics" needed to mitigate their cognitive dissonance and do the steps. After discharge, participants dropped out of the 12-step program and found secular alternatives. The SUD treatment staff seemed to lack the cultural and technical competency to adequately respond to the needs of atheists.

I hope that the knowledge provided by the participants will contribute to the body of literature regarding how atheists experience 12-step SUD treatment and aftercare, inform practitioners in the field and help to advance the understanding of the lived experiences of atheists in this context from a theoretical standpoint.

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# Appendix A: Invitation Letter

You are invited to take part in a study about the experience of atheists in 12-step substance use disorder treatment and aftercare. This study is being conducted by Elizabeth Bayley, a doctoral candidate in clinical psychology at Walden University. Ms. Bayley is working with her advisors, Dr. Tracy Marsh and Dr. Matthew Hertenstein, on her doctoral dissertation. This study is a good opportunity to have your voice heard and contribute to the knowledge of substance use disorders professionals and others in the field to provide atheists with the highest standard of ethical, culturally competent, and evidence-based treatment.

There are two phases to this study, the qualifying phase, and the interview phase. The qualifying phase consists of two short surveys, which are designed to screen for certain study criteria. The first survey will ask you demographic questions. The second survey will ask you about substance use disorder treatment. Compensation for the first survey will be $1, deposited to your MTurk account. Compensation for the second survey will be $3, deposited to your MTurk account. If you do not meet the study criteria, you will be disqualified and compensated for your participation up to that point.

If you meet the study criteria, you will participate in a one-hour interview, via your choice of Skype or synchronous email, to be scheduled at a time convenient to you. If you choose a Skype interview, the audio will be recorded and transcribed to construct an interview transcript. If you choose an asynchronous email, the conversation thread will create an interview transcript.

When the interview transcript is completed, I will send it to you via email. At that time, you may review the transcript and make corrections and clarifications you deem necessary for the transcript to reflect your experiences and attitudes accurately. I will incorporate all changes in the final transcript that will be analyzed for study results. You will receive a thank you gift of $25 deposited to your Mechanical Turk account.

All participation is on a volunteer basis. After you have taken the two surveys, you will send me an email address where I can contact you to arrange an interview day and time. Please specify in your email whether you would prefer your interview via Skype or synchronous email. The email you provide can be a randomized address or have identifying information. Your identity will remain confidential in study records, as will the contents of your interview.

If you would like to participate in the study, please answer “yes” below to go to the informed consent page. If you do not wish to participate, please answer “no,” which will exit you from this study.

Would you like to participate in this study? Yes ___ No___

# Appendix B: Demographic Information Survey

1. Age: _____
2. Gender:
    - a. Male_____
    - b. Female _____
    - c. Other _____
3. State residing in: _____
4. Marital Status:
    - (1) Single _____
    - (2) Partnered _____
    - (3) Married _____
    - (4) Other _____
5. Number of children: _____
6. With which of the following do you most identify (please check one or more)
    - a. Protestant _____
    - b. Hindu _____
    - c. Catholic _____
    - d. Muslim _____
    - e. Agnostic _____
    - f. Baptist _____
    - g. Atheist _____
    - h. Methodist _____

i. Episcopal _____

j. Nonreligious _____

k. Jewish _____

l. Other (please specify) ___________

7. Ethnicity (please check all that apply)

   a. Decline to State ____

   b. Black/African American ____

   c. Hispanic/Latino ____

   d. East Asian _____

   e. South Asian____

   f. Pacific Islander ____

   g. Native/Indigenous Americans ____

   h. White/Caucasian _____

   i. Other ____

8. Highest level of education completed: _______________

9. Occupation: ______________________

10. Which of the following best describes the area you live in? (please check one)

    a. (1) In open country, but not on a farm ____

    b. (2) On a farm ____

c. (3) In a small city or town (less than 50,000)

____

d. (4) In a medium-size city (50,000-250,000)

____

e. (5) In a large city (over 250,000)

____

11. Have you ever met the researcher, Elizabeth Bayley? Yes __ No ___

# Appendix C: Substance Use Disorder Information Survey

Please answer the following questions.:

Have you ever been to substance use disorder (SUD) treatment? Yes __ No ___

How many times have you been to (SUD) treatment in the last three years? ___

Were any of these SUD treatment episodes involuntary? Yes ___ No _

Were any of these SUD treatment episodes voluntary? Yes___ No__

<u>For the ***voluntary*** SUD treatment episode</u>**:**

Was the SUD treatment facility located in the United States? Yes___No___

Was the SUD treatment facility oriented to the twelve-step philosophy? Yes___No___

Did you attend any 12-step meetings in the last three years? Yes___ No___

If so, how many?

Less than five ___

Five or more ___

Did you have an aftercare program in place when you left SUD treatment? Yes___No___

Which of the following were components of the aftercare <u>*plan*</u> (whether you participated or not)?

Sober/transitional living ___

12-step meetings ___

Therapy ___

Sponsor ___

Work the Steps ___

Group counseling ___

Psychiatrist ____

Medication ____

Non-12-step support groups ____

## Appendix D: Interview Questions

Childhood and Family of Origin Beliefs:

Please describe your religious beliefs, if any, while growing up?

Please describe your religious practices, if any, while growing up?

What was your attitude towards atheism while growing up?

How did your primary caregiver(s) feel about religion?

How did your primary caregiver(s) feel towards atheism?

Was there a time when you changed your religious beliefs? If so, please explain.

How, if at all, did your family and friends react when you began to identify as an atheist?

Have you ever chosen to conceal your atheism?

If so, what was (were) the circumstances?

Why do you think you chose to conceal your atheism at that time?

Present Day Atheism:

How do you define atheism?

How do you feel about religion?

Do the people in your life know that you identify as an atheist?

Have you ever received positive or negative experiences because of your atheist identity? Please explain.

How important is being an atheist to you? Please describe how and why atheism is important to you?

Do you belong to any atheist groups or organizations?

If so, please explain what the group is and why you belong?

Is there anything else you would like to say regarding your atheist identity?

Is there anything you would like others to know about what atheism is or is not?

Substance Use Disorder Treatment:

What did you know about the 12-step philosophy before you entered treatment?

How did you choose the 12-step substance use disorder treatment you attended?

Were you asked about your religious beliefs during your admission assessment?

Did you tell your therapist/program staff that you were an atheist?

How did your therapist/program staff respond to your atheist identity, if at all?

Were there any non-12-step options for treatment in your area? If so, what were these?

How long were you in treatment?

What was your experience like in treatment?

What were the positive aspects of 12-step treatment?

What were the negative aspects of 12-step treatment?

How often did you attend 12-step meetings during treatment?

How did you experience these meetings?

What were the positive or negative aspects of the meetings?

Did you complete any steps in treatment? Please explain which steps and how these were integrated into the treatment program?

Did you get a 12-step sponsor during treatment?

Aftercare:

What was your discharge plan?

Did you move into sober living after treatment?

Did you attend 12-step meetings after treatment? If so, which meetings were they? How often and how long did you attend? If not, please explain why?

Are you attending 12-step meetings now?

Overall, what impact, if any, did your identity as an atheist have on your treatment and aftercare experience? What impact, if any, did your identity as an atheist have on your attendance at 12-step meetings?

**Thank you for taking part in this interview. Do you have anything to add that was not captured in the questions I asked?**