To what extent is the spirit of motivational interviewing present in the experience of Alcoholics Anonymous members?

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To What Extent is the Spirit of Motivational Interviewing Present in the Experience of Alcoholics Anonymous Members?

Mark Williams

A report submitted in Partial Fulfilment of the Requirements for the Award of Bachelor of Arts (Psychology) Honours

Faculty of Computing, Health and Science,

Edith Cowan University

Submitted October, 2010

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To What Extent is the Spirit of Motivational Interviewing Present in the Experience of Alcoholics Anonymous Members?

Abstract

More people turn to Alcoholics Anonymous (AA) in an attempt to recover from alcohol dependence than any other intervention. AA has historical links with confrontational approaches to alcohol treatment, and motivational interviewing (MI) was conceived by Miller in the 1980's as an alternative to these confrontational approaches. There are divided opinions on whether AA is confrontational; therefore, the primary aim of this qualitative study was to gain an insight into how the spirit of AA is experienced by its members. Ten members of AA were interviewed using a semi-structured interview schedule. Thematic analysis from a constructionist perspective was utilised in order to interpret the participants' experiences. Six themes were identified: 'direct positive confrontation'; 'negative confrontation'; 'authority'; 'collaboration'; 'evocation'; and 'autonomy'. Overall, AA was experienced by its members as supportive, mentor-based, and collaborative and the themes identified here largely supported Miller's (2009) theory that AA and MI are compatible in terms of their 'ways of being' with people. Some elements of a confrontational approach were found, but confrontation in AA was chiefly experienced as accurate, helpful, and supportive. Implications and recommendations for future research are highlighted.

Keywords: Alcoholics Anonymous, spirit, motivational interviewing, alcohol dependence

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Submitted: October, 2010
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Acknowledgements

There are a number of people who I would like to thank who helped make this research project possible. First and foremost, I would like to thank my supervisor Dr. David Ryder and co-supervisor Dr. Julie-Ann Pooley for their support and guidance throughout the year. I would also like to thank the participants from this study for sharing their stories with me. Lastly, I would thank my mother Kate, my sister Ebbie, and my fellow Honours students for their support and encouragement whilst undertaking this project.
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SPIRIT OF MOTIVATIONAL INTERVIEWING IN AA

To What Extent is the Spirit of Motivational Interviewing Present in the Experience of Alcoholics Anonymous Members?

More people turn to Alcoholics Anonymous (AA) in an attempt to recover from alcohol dependence than any other intervention (Groh, Jason, & Keys, 2008; McCrady & Miller, 1993; Moos & Timko, 2008). Although not conceptualized as a treatment method due to its non-professionalized nature (Borkman, 2008), the AA 12-step model has been influential in the field of alcohol and other drug (AOD) treatment (Galanter, 2007). Confrontational approaches have historically abounded in the AOD treatment field, but recently a more scientifically-grounded approach has been favoured, based on the concept of the therapeutic alliance (Miller, 2009). Miller’s motivational interviewing (MI) has become popular in the AOD treatment field as a collaborative, client-centred intervention (Beckham, 2007; Miller & Rollnick, 2002). Researchers disagree on whether confrontation is used in AA (e.g., Miller & White, 2007; Fraser & Solovey, 2007), and no research to date has attempted to identify if confrontation is inherent in the experiences of AA members.

This thesis adopts a phenomenological design to gain an insight into how the spirit of AA is experienced by its members. It is hoped that the results will shed light on whether AA’s ethos is consistent with the current evidence-based therapeutic recommendations for treating people with alcohol problems. This research study is significant because clinicians in Australia are advised that both MI and AA are to be recommended as suitable interventions for alcohol misuse (Shand, Gates, Fawcett, & Mattick, 2003), but previous research has not investigated whether the approach of AA is compatible with the collaborative MI approach.

The purpose of this literature review is to provide a contextual background for an investigation into the spirit of AA. The review begins with a discussion of the
definitions and theoretical rationales in the AOD treatment field, followed by a
description of the AA model and a review of AA-based research. A discussion on the
Minnesota model follows where 12-step based treatment centres integrated
confrontational approaches to counselling in the 1960’s and 1970’s. Recent
developments concerning definitions of confrontation in treatment are then considered
and following that, MI is discussed in relation to the shift in focus from confrontational
methods to a collaborative therapeutic relationship. The research on MI is briefly
discussed, and then the question of whether the approach of AA is compatible with the
collaborative MI approach is considered. The review concludes by stating the purpose
of this research: To investigate the spirit of AA by interviewing AA members and
finding out their experiences of ‘ways of being’ with people in the AA fellowship. To
what extent are these experiences consistent with the spirit if MI (collaboration,
evocation, autonomy)? Furthermore, to what extent are these experiences consistent
with confrontational counselling approaches?

Literature Review

Prevalence

Over 80% of the Australian population aged 14 years and over uses alcohol,
making it the most widely used drug in Australia (Australian Institute of Health and
Welfare, 2008). Although drinking alcohol is accepted and enjoyed as an Australian
national pastime (Pettigrew, 2002; Room, 1997) it is also a leading cause of preventable
death in Australia, causing approximately 4000 deaths each year (Ryder, Walker, &
Salmon, 2006).

Research shows that 22% of Australians have experienced an alcohol use
disorder at some time in their life according to the Diagnostic and Statistical Manual of
Mental Disorders (Revised 4th ed. [DSM-IV]; American Psychiatric Association, 2000)
diagnostic criteria, with 4% of those meeting the criteria for alcohol dependence at some time in their lives (Teesson et al., 2010). Alcohol dependence has been associated with a wide range of problems including family dysfunction, mood disorders, health problems, high arrest and imprisonment rates, homelessness, and economic cost (Teesson et al., 2010). While people with alcohol problems can benefit from a number of different treatment approaches (Babor, Miller, DiClemente, & Longabaugh, 1999) and communities derive the benefits of decreased expenditure on healthcare and criminal justice as a result of alcohol treatment interventions (Polcin, 1997; Teesson et al., 2010), many individuals with alcohol problems remain undiagnosed and receive no treatment or inadequate levels of care (Teesson et al., 2010; Teesson & Proudfoot, 2003). Teeson et al. believe that many clinicians fail to identify alcohol problems and maintain a limited clinical perspective that fails to adapt treatment approaches to the needs of alcohol dependent clients.

Definitions and Models of Addiction and Recovery

The term alcohol dependence will be used in this review to encompass other related terms such as alcoholism and alcohol addiction. To begin, it is appropriate to consider the clinical definitions of substance abuse that are found in the contemporary medical model. The DSM-IV (American Psychiatric Association, 2000) states that alcohol abuse is considered to be part of the disorder referred to as alcohol dependence. Substance abuse is defined by the DSM-IV as a pattern of substance use leading to significant impairment in functioning. One of the following must be present within a 12 month period: (1) recurrent use resulting in a failure to fulfill major obligations at work, school, or home; (2) recurrent use in situations which are physically hazardous (e.g., driving while intoxicated); (3) legal problems resulting from recurrent use; or (4) continued use despite significant social or interpersonal problems caused by the
substance use. Substance dependence is defined by the *DSM-IV* as a substance use history which includes the following: (1) substance abuse (see above); (2) continuation of use despite related problems; (3) increase in tolerance (more of the drug is needed to achieve the same effect); and (4) withdrawal symptoms (American Psychiatric Association, 2000).

The AA literature describes alcoholism as “an illness, a progressive illness, which can never be cured but which, like some other diseases, can be arrested” (Alcoholics Anonymous World Services, 1952, p. 7). Alcoholism is defined here as “a spiritual, mental, and physical illness and recovery requires healing all aspects of the illness” (Alcoholics Anonymous World Services, 1952, p. 7).

Historically, there has been an ongoing lack of consensus concerning the aetiology and manifestation of alcohol dependence and its treatment (Nathan, 1997; Tevyaw & Monti, 2004), but it appears a period of confluence between the scientific and experiential paradigms may be emerging (Galanter, 2008; White, 2010). In a clinical context, the *DSM-IV* (American Psychiatric Association, 2000) diagnoses substance use disorders according to the presence of certain diagnostic criteria, and recovery can take place with the resolution of specific behavioural and physiological symptoms (Fraser & Solovey, 2007; Galanter, 2007). Perspectives such as the medical model categorize disease entities diagnosed based on explicit and discrete symptoms. Behavioural psychology is also highly regarded because it allows stimulus-response experiences regarding substance use to be observed directly by a clinician or researcher, allowing recovery to be framed in behavioural terms (Galanter, 2007).

A spiritually grounded definition of recovery is appropriate to the study of the AA 12-step recovery programme (Miller, 2003). Pioneered by William James, Carl Jung, and Bill Wilson (Cheever, 2004; Sandoz, 2005), spiritually grounded recovery is
based principally on self-reports of subjective experience rather than on directly measurable, observable behaviours. However, researchers are beginning to examine the spiritual element of recovery with increasing rigour (Galanter, 2007, 2008; Miller, 2003). Spirituality has been defined as “that which gives people meaning and purpose in life” (Galanter, 2007, p. 266). Recovery is a term used in AA and other 12-step groups to connote “the process by which alcohol dependent people become abstinent and undergo the self-help journey to heal the self, relations with others, one’s Higher Power, and the larger world” (Borkman, 2008, p. 13).

**AA and Recovery from Alcohol Dependence**

Successful treatment for alcohol dependence usually requires ongoing and extended assistance due to its nature as a relapsing condition. Australia’s National Drug and Alcohol Research Centre (NDARC) recommend AA as a suitable aftercare strategy option (Shand, et al., 2003). In addition, Shand et al. acknowledge that AA attendance may also be beneficial for people prior to or during professional treatment sessions.

AA is a 12-step recovery programme within a voluntary self-help organization of self-defined alcoholics (Borkman, 2008). AA as an intervention for alcohol misuse is not conceptualised as a form of treatment per se, because change is not facilitated or mediated by professionals (Borkman, 2008; Shand, et al., 2003). The organization was created in 1935 by co-founders Bill Wilson and Dr. Bob Smith (Alcoholics Anonymous World Services, 2010; Kurtz, 1982). AA as an organization is chiefly concerned with the personal recovery and continued sobriety of individual alcohol dependent people who turn to the fellowship for help (Alcoholics Anonymous World Services, 2010). The explicit primary purpose of the AA member is “to stay sober and help other alcoholics to achieve sobriety” (Alcoholics Anonymous World Services, 2010, p. 6).
More people turn to AA in an attempt to recover from alcohol dependence than any other method of intervention (Groh, et al., 2008; McCrady & Miller, 1993; Moos & Timko, 2008). AA lists its 2010 worldwide membership at over 2 million in 150 countries (Alcoholics Anonymous World Services, 2010), but because no formal lists are kept, it is acknowledged that difficulty exists in obtaining accurate membership figures. In Australia, the AA web site estimates a membership of 20,000 who attend approximately 2000 local groups with some regularity (Alcoholics Anonymous Australia, 2010). The 25 millionth copy of AA’s basic text Alcoholics Anonymous (the "Big Book"; Alcoholics Anonymous World Services, 1976), was printed in 2005, reflecting its considerable contribution to the field of substance abuse treatment (Galanter, 2007). The AA 12-step model has been applied to many other domains (Miller, 2003) and has spread across many different cultures holding diverse beliefs and values (Tonigan, Connors, & Miller, 2003). For example, Chenhall’s (2007) ethnographic study tracks how Indigenous Australians have adapted the AA model in a residential treatment setting in NSW. The AA model was used here as the base for a community intervention in order to facilitate recovery from alcohol dependence among Aboriginal people. According to Chenhall, the use of this adapted 12-step model has helped Aboriginal people reclaim their cultural heritage and Aboriginal spirituality.

AA’s Big Book suggests a 12-step programme of recovery (Appendix E) where personal powerlessness over alcohol is emphasized and members progress through the 12 steps at their own pace (Groh, et al., 2008). Recovery from alcohol dependence is achieved by abstaining from alcohol one day at a time, recognising that the first drink is the one to be avoided (Alcoholics Anonymous World Services, 1976). A spiritual change brought about by following the 12 steps (Borkman, 2006) is
augmented by regular attendance at AA meetings, service in AA, and members are encouraged to find a sponsor (Crape, Latkin, Laris, & Knowlton, 2002).

The sponsor should preferably have experience of the steps, some length of sobriety, and be the same gender as the sponsored person (Alcoholics Anonymous World Services, 2005). A sponsor, an experienced member having maintained abstinence and worked the steps, acts as a guide to someone less experienced in staying sober and working the AA programme (Borkman, 2008). The guide’s knowledge rests on an experiential understanding of how to apply the programme to drinking and living problems. Learning is primarily based on role-modelling and experience rather than didactic instruction, adding to the variability in how the AA programme is experienced (Borkman, 2008). AA members talk to their sponsors about private material that would be inappropriate to discuss at meetings (Kurtz, 2002).

**AA-Based Research**

The positivistic approach presuming there is a single knowable reality is limited for the study and understanding of AA in its very diverse social, cultural, and economic situations (Borkman, 2008; Kurtz, 2002; Miller & Kurtz, 1994). The anonymity of the fellowship, the emphasis on spirituality in it programme and its organic, egalitarian structure mean that generalisations about AA are problematic (Kurtz, 2002; Shand, et al., 2003). Larkin and Griffiths (2002) argue that issues of subjective experience must be addressed when accounting for substance dependency issues and that the importance of self and identity are essential when considering these experiences.

However, experimental studies of the past 15 years like those of Project MATCH (Babor, et al., 1999; Project MATCH Research Group, 1998) have established that high-quality AA trials are possible, and that such studies usually reinforce rather
than undermine the good reputation that AA enjoys around the world (Groh, et al., 2008; Humphreys, 2006). Many randomized controlled trials have found AA participation to be related to better alcohol use outcomes (Humphreys, Moos, & Cohen, 1997; Montgomery, Miller, & Tonigan, 1995; Moos & Timko, 2008). Participation in AA has been shown to predict higher abstinence rates post-treatment (Connors, Tonigan, & Miller, 2001). Other studies have found AA to be no better than alternative treatments (Kownacki & Shadish, 1999), and a Cochrane Review found that no experimental studies unequivocally demonstrated the effectiveness of AA or twelve step facilitation (TSF) approaches in treating alcoholism (Ferri, Amato, & Davoli, 2006). Although results to date provide limited evidence of the value of AA (Shand, et al., 2003), they do suggest that AA assists in the reduction of alcohol-related problems for people who attend meetings and become involved in AA (Owen et al., 2003; Shand, et al., 2003).

A limitation of this body of research is that nearly all of the data come from studies conducted in the USA. A lack of longitudinal research has also been criticized (Groh, et al., 2008), and the use of subjective self-reports of drinking behaviour rather than objective measures such as urine analysis hinder the validity of the findings, as individuals may not accurately report their actual consumption (Galanter, 2008; Tonigan, Toscova, & Miller, 1995).

Researchers have also begun to examine the mechanisms in AA that help promote behaviour change (Groh, et al., 2008; Owen, et al., 2003). Some mechanisms that have been studied include: spirituality (Forcehimes, 2004; Galanter, 2007; Miller, 2004; Sandoz, 2005), storytelling (Arminen, 1998, 2004), self-efficacy (Connors, et al., 2001; Morgenstern, Labouvie, McCrady, Kahler, & Frey, 1997), and social support (Crape, et al., 2002; Gröh, et al., 2008). The mechanisms of spirituality and storytelling
will now be discussed briefly considering the relative importance of each to this study of the spirit of AA.

Spirituality in AA as a mechanism of change was described by Forcehimes (2004) as resembling the phenomenon of quantum change. AA acknowledges that “such transformation can occur gradually” (Alcoholics Anonymous World Services, 1976, p. 183), however Forcehimes notes that nearly all of the stories in the Big Book involve discrete and sudden experiences. Miller (2004) defines the phenomenon of quantum change as a fairly major psychological shift that happens over a relatively short period of time. Miller interviewed 55 people and found that half of the participants were in some kind of crisis leading up to the change, similar to AA co-founder Bill Wilson. A third of the people were praying at the moment it happened, often for the first time in a very long time, which also maps onto Bill W.’s experience (Miller, 2004). About half the people described being in the presence of a profoundly accepting, loving entity. For a brief moment they reported experiencing a radical sense of being accepted as they are, in a way that was transforming, which left them with a permanent sense of safety (Miller, 2004, 2009). Miller (2009) describes how this type of transformational change is often present in the stories of AA members at AA meetings. He states “I sense that in some ways it is related to MI, that what is happening in a motivational interview is like the same-thing on a small scale, around a particular behaviour.” (Miller, 2009, p. 891)

Storytelling is an extremely important activity in AA, and AA meetings are organized around a series of personal monologues (Arminen, 2004; Humphreys, 2000). Arminen explored the therapeutic relevance of storytelling in AA. By aligning their own story with the previous speakers, members display identification and engage in a
recontextualization and reinterpretation process. This process helps to provide resolutions and serves as a resource for empowerment (Arminen, 2004).

Following this review of the AA literature, the next section will describe the historical underpinnings of AA's links to the confrontational approach in professional AOD treatment. This is discussed with particular reference to the exponential growth of the professionalized AOD treatment centre industry in the US, at a time when the confrontational approach was at its zenith.

The History of Confrontation and Professional Treatment Centres

Therapeutic confrontation has been defined as "the process by which a therapist provides direct, reality-oriented feedback to a client regarding the client's own thoughts, feelings or behaviour" (Miller & White, 2007, p. 40). The psychoanalyst Dr. Harry Tiebout set the stage for confrontational therapies in the treatment of alcohol dependence (Miller & White, 2007). Dr. Tiebout was Bill Wilson's psychiatrist for many years, and believed that alcohol dependence was rooted in character malformation consisting of ego inflation, self-encapsulation, inner tension, and a preoccupation with power and control (Tiebout, 1944, 1947). Tiebout believed the alcohol dependent individual was not able to perceive themselves accurately due to entrenched defence mechanisms such as denial and projection of blame. Only by hitting bottom and surrendering completely could they experience deflation of the ego, self-acceptance, inner peace and humility (Miller & White, 2007; Tiebout, 1949). Dr. William Silkworth, another very influential figure at the time and author of the Big Book preface "The Doctor's Opinion" (Alcoholics Anonymous World Services, 1976, pp. xxi-xxviii) echoed the theme. His advice to Wilson was to "give them the medical business, and give it to them hard" (Alcoholics Anonymous World Services, 1957, p.
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67). The ‘medical business’ meant to convince the alcohol dependent person that they were suffering from an incurable fatal illness.

Dr. Tiebout asserted that the task of the professional helper was to break down the superficial compliance and behavioural defiance of the alcohol dependent person to a point of surrender, before facilitating a process of personality reconstruction and the development of a disciplined way of life (Tiebout, 1947, 1949). Tiebout’s influence on Bill Wilson and the alcohol treatment field was significant; he served on the AA Board of Trustees from 1957-1966; was widely published in AOD academic literature; and spoke at many professional AOD conferences, at times inviting Bill Wilson to speak about AA (Kurtz, 2002; Miller & White, 2007).

By 1950, fledgling alcohol treatment programmes in the US such as the Minnesota model at Hazelden were heavily influenced by AA, but these programmes were not subject to research validation before they were put into practice (Galanter, 2007; Miller, 2003). Although confrontation was not a technique originally used (Miller & White, 2007), by the late 1960’s confrontation had become ingrained into the Minnesota model (Fraser & Solovey, 2007; Miller & White, 2007). This shift towards confrontation coincided with the growth in professionalized AOD treatment programmes. In 1966, there were less than 200 treatment programmes in the US; in 1977 there were 2400; by 1987, there would be almost 7000 (Kurtz, 2002). In 2010, there are over 14,000 AOD treatment programmes in the US (US Drug Rehab Centers, 2010). It has been reported that AA now receives 31% of its membership from treatment centre referrals (Kurtz, 2002).

The family intervention approach of Johnson (1973) used professionally facilitated confrontation. Family members, employers, and significant others of a problem drinker would present feedback on the person’s drinking and the specific
effects it was having on them, and request the individual take certain specific action to address their drinking problem (Miller & White, 2007). Former US First Lady Betty Ford entered AOD treatment in 1978 following a family intervention organised by her daughter (Miller & White, 2007). In 1982 she founded the Betty Ford Center for Drug and Alcohol Rehabilitation in California.

During the 1980’s and 1990’s, research was conducted on the effectiveness of confrontational approaches in AOD treatment. Miller and White (2007) reviewed this research and found no scientific evidence suggesting that confrontational counselling had a therapeutic effect, or that substance dependent people have abnormal defence mechanisms. Instead, substance dependent people react in a similar way that most other people do when confronted and consensual validation is threatened - with denial, rationalization, and resistance (Miller, 2003; Miller & White, 2007). Confrontational approaches were associated with relatively poor outcomes and high dropout rates (Fraser & Solovey, 2007). In a study comparing the impact of counsellor style, a single counsellor behaviour was predictive of drinking outcomes at 1 year: the more the counsellor confronted, the more the client drank (Miller, Benefield, & Tonigan, 1993).

This type of imposition and confrontation on the part of the therapist is now seen as harmful rather than helpful (Miller, 2009; Miller & White, 2007; Mueser, Noordsy, Drake, Fox, & Barlow, 2003). In the mid 1980’s due to emerging scientific evidence and poor results, Hazelden decided to recant its aggressive confrontational approach, expressing regret that such approaches had become identified with the Minnesota model (Miller, 2003). Fraser and Solovey (2007) argue that despite these admissions, movement away from the confrontational approach has been slow, and that many substance abuse counsellors use aggressive confrontational approaches to this day.

Confrontation – A Different View
Polcin (2006) argues that the AOD treatment literature has usually used the term confrontation to represent authoritarian attempts by treatment professionals to convince clients that they have an AOD problem and need to change (e.g., Miller & White, 2007). Authoritarian confrontation was originally thought to be a way to break down denial (e.g., Tiebout, 1947), but studies have shown that this type of confrontation may result in arguments between clinician and client that increase resistance and are counterproductive (Miller, et al., 1993). Confrontation of this sort may be especially counterproductive for clients with high levels of anger (Karno & Longabaugh, 2007).

A different view of confrontation as defined by Polcin (2003) is “a client being challenged to take responsibility to change some aspect of their behaviour or thinking that is detrimental to their recovery” (p. 166). The effects of confrontation may be dependent on a number of factors, such as the context within which it occurs, the person doing the confronting, and the perceived motive of the confrontation (Polcin, 2003). For example, some AOD treatment programmes educate clients when they enter treatment about the purpose of confrontation and how it can support recovery. Programmes that use confrontation typically emphasize confrontation from peers more than staff (Polcin, 2003). In another study based in residential recovery houses, confrontation from peers in the form of warnings about the potential harm associated with continuing substance use was generally experienced as accurate, helpful, and supportive (Polcin & Greenfield, 2006).

The issue of confrontation is discussed in the Betty Ford Center Professionals in Residence (PIR) training manual (Betty Ford Center, 2009). In this context, confrontation is described as a courageous and honest communication on the part of one member to another in the same small group therapy setting. Confrontation is
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defined here as "presenting a person with himself/herself by describing how I see him/her" (Betty Ford Center, 2009, para. 3). The Betty Ford Center (2009) summarizes confrontation in treatment as follows:

We are most useful as confronters when we are not so much trying to change another person as we are trying to help them see themselves more accurately. Change, if it comes, comes later, when a person chooses it, and enlists the spiritual help that the steps of the AA program describe. Because of our egocentric blindness and self-delusion, we are all dependant on others for that completed picture. Confrontation provides it. (para. 4)

Polcin (2010) identifies the level of skill with which confrontation is delivered as another factor which may influence its impact on people with AOD problems. In a study of MI, which is commonly viewed as a non-confrontational intervention (Miller & Rollnick, 2002), confrontation from clinicians with high levels of therapeutic skill was found to improve the therapeutic alliance (Moyers, Miller, & Hendrickson, 2005). Moyers et al. found that rather than engaging in counterproductive argumentation, these clinicians used a type of confrontation that consisted of honest feedback about the potential harm that may result from substance use and gave suggestions to the client about what might be helpful to them. The authors suggested that these types of interactions may promote increased transparency in the therapeutic alliance and thus enhanced collaboration (Moyers, et al., 2005). Clinicians provided honest advice to clients in a supportive manner that appeared to improve the therapeutic relationship (Polcin, et al., 2010).

Now that the issue of confrontation in AOD treatment has been discussed, the next section will describe the collaborative MI technique. MI is described as an
alternative to the confrontational approach (Miller, 2009; Miller & White, 2007) where empathic listening skills and client autonomy are paramount (Miller & Rollnick, 2002).

**Motivational Interviewing**

Miller began developing MI in the early 1980’s as a clinical strategy designed to enhance motivation for change in problem drinkers. MI was conceived as an alternative to confrontational approaches that were widely used in AOD treatment at the time (Miller, 2009). Miller argues that there has never been a scientific basis for believing that people with a dependency on alcohol possess a unique character disorder requiring authoritarian confrontation in order to break down walls of denial (Miller & White, 2007). Miller and Rollnick define MI as a “client-centred, directive method for enhancing intrinsic motivation to change by exploring and resolving ambivalence” (2002, p. 25). The technique has its roots in the work of Carl Rogers’ client-centred therapy (Rogers, 1951), but departs from this tradition in that MI has a directional approach. Clinicians attempt to influence clients to consider making changes in the MI process, rather than the therapy being purely an exploration of the self (Miller & Rollnick, 2002). MI seeks to explore ambivalence and promote self-efficacy throughout the initial stages of AOD treatment rather than confront denial or highlight one's powerlessness over alcohol or other drugs (Horay, 2006; Miller & White, 2007).

The spirit of MI is guided by the principles of collaboration, evocation and autonomy (Miller & Rollnick, 2002). A collaborative therapeutic relationship is vital, where the clinician avoids an authoritarian stance and provides a supportive, understanding presence that is conductive rather than coercive to change (Miller & Rollnick, 2002). Evocation refers to the process whereby the clinician draws out or calls forth the intrinsic motivation to change from the client, rather than instilling it in them (Arkowitz & Miller, 2008). Finally, Miller and Rollnick (2002) assert that in MI,
responsibility for change is left with the client. Respect is shown for the individual’s autonomy, with the overall goal being a change that arises from within the client (Miller & Rollnick, 2002). MI can be used a prelude to treatment and as a stand-alone treatment, or can be combined with other interventions (Shand, et al., 2003). Miller and Rollnick (2002) contrast the three elements of the spirit of MI (collaboration, evocation and autonomy) with the supposed mirror-images of the confrontation approach to counselling (confrontation, education and authority).

**MI-Based Research**

Studies have consistently found MI interventions to be superior to no-treatment control groups (Beckham, 2007; Lundahl & Burke, 2009). A review of four meta-analyses found that MI was significantly better than no treatment and similar in effectiveness to comparison groups such as skills-based counselling (Lundahl & Burke, 2009). MI has become extremely popular around the world as a key therapeutic intervention within the AOD treatment field and beyond, and its popularity is beginning to be reflected in strong scientific literature attesting to its specific efficacy (Beckham, 2007). Project MATCH adapted a time-limited, four-session MI format in a large clinical trial comparing different alcohol treatments. It was found that MI yielded identical outcomes to longer outpatient methods which consisted of 12 sessions, and MI was more effective with angry clients (Babor, et al., 1999).

Miller and Rollnick (2002) identified counsellor effects as a crucial aspect in AOD treatment and recovery, where the Rogerian conditions of accurate empathy, non-possessive warmth and genuineness help to explain differential outcomes. They argue that the therapeutic relationship stabilizes quickly in early sessions and that the nature of the clinician-client relationship in early sessions predicts retention and outcome (Fraser & Solovey, 2007; Miller, Moyers, Arciniega, Ernst, & Forcehimes, 2005).
Skilfulness in accurate empathy is recommended as a central qualification in hiring addiction counsellors (Miller, et al., 2005).

Is the Spirit of AA Compatible with the Spirit of MI?

Miller (2003, 2009) suggests that clinicians must move away from a confrontational stance to an empathic, collaborative one when treating substance dependent clients. While AA is separate and distinct from professional treatment approaches (Borkman, 2008), it is important that the underlying spirit of AA be investigated due to its prominence in the alcohol intervention milieu. Researchers have different opinions on whether confrontation is used in AA. Miller believes that AA is distinctly non-confrontational, and that the spirit of AA is compatible with the spirit of MI:

As for AA and the 12-step approach, when I read Bill W, I hear a lot that’s familiar in terms of how you work other people – a patient, compassionate approach that is not blaming or judging. It’s nothing like what the treatment industry created with “12-step disease model treatment”. Original AA is entirely different, and I think that motivational interviewing is quite compatible with the original 12-step way. (Miller, 2009, p. 890)

Miller and White (2007) also argue that traditional AA is non-confrontational because it discourages cross-talk at its meetings. They report that personal experience is shared in response to any disclosure in meetings, rather than any direct feedback or advice. Again, no specific evidence is presented for the idea that AA is distinctly non-confrontational, aside from references to textual and historic AA meeting practices (Miller, 2009; Miller & White, 2007). In fact, electronic AA meetings lists do show groups such as the Redondo Beach young person’s closed cross-talk group in Los Angeles (Alcoholics Anonymous in Staten Island, 2010), calling into question the idea
that cross-talk is discouraged in AA meetings as a general rule. Fraser and Solovey (2007) argue that confrontation is used in AA, and that it may be considered more palatable because the confronting person is a fellow individual in recovery (e.g. Polcin, 2006). However, Fraser and Solovey do not provide any evidence to back up their statement, nor do they elaborate on what type of confrontation may be used, and in what context.

Although both MI and AA are recommended in Australia as viable interventions in the treatment of alcohol dependence (Shand, et al., 2003), existing research does not demonstrate whether the spirit of AA is aligned with the MI collaborative approach or contrary to it. As Miller notes, the Big Book of AA (Alcoholics Anonymous World Services, 1976) appears to contain a largely collaborative approach (Miller, 2003, 2009), which is ironic considering that Dr. Harry Tiebout, the personal psychiatrist of AA co-founder and primary Big Book author Bill Wilson, largely set the stage for confrontational approaches in AOD treatment (Miller & White, 2007). Therefore, the purpose of this research is to investigate the spirit of AA by interviewing AA members and finding out their experiences of ‘ways of being’ with people in the AA fellowship.

The research objective set out here seeks to explore the issue of the relational spirit experienced by AA members in AA. Miller and Rollnick (2002) stress the vital importance of a specific ‘way of being’ within the therapeutic relationship when carrying out MI techniques. If specific ‘ways of being’ with people are to be explored, then in AA, sponsorship is an important consideration. If in MI the significant relationship is clinician-client; the comparable relationship in AA is sponsor-sponsee, and a large part of the data set in this study is located in this relationship domain. The other relational aspects of AA considered here would include general member-to-
member interpersonal contact, the specific experiences members may have had at the meetings, and the mutual help society that is the fellowship of AA in an organizational sense.

Summary

The purpose of this literature review was to provide a contextual background for the exploration of AA members’ lived experiences of the spirit of AA. The review began with a discussion of the definitions and theoretical rationales in the AOD treatment field. This was followed by a description of the AA model and a review of AA-based research. A discussion on the Minnesota model followed where 12-step based treatment centres integrated confrontational approaches to counselling in the 1960’s and 1970’s. Recent developments concerning definitions of confrontation in AOD treatment were then considered, and then MI was discussed in relation to the shift in focus from confrontational methods to a collaborative relationship approach when treating alcohol dependent individuals. The research on MI was briefly discussed, and then the question of whether the AA approach is compatible with the collaborative MI approach was considered.

Research Purpose

Until now, no studies to the best of the author’s knowledge have explored how the relational spirit is experienced in the members of a 12-step mutual help group such as AA. In addressing this gap in the research literature, the aim of the present study was to identify themes in the participants’ experiences of relational spirit in the fellowship of AA, and to investigate the extent to which these experiences were consistent with the spirit of MI (collaboration, evocation, autonomy). Conversely, to what extent were these experiences consistent with confrontational counselling approaches? Scientific, quantitative enquiry into a spiritual recovery movement such as AA is difficult, as
recovery is defined on reports of individuals’ own subjective experience (Galanter, 2007, 2008). The phenomenological approach adopted in this study is consistent with the aim of understanding the subjective experiences of AA members. By researching the subjective experiences of AA members, more understanding can be gained about how the spirit of AA is experienced by its members.

In Australia, clinicians often suggest participation in AA to clients as an aftercare strategy because there is some evidence of its suitability for this purpose (Shand, et al., 2003). Clients will sometimes choose to attend AA before or during professional treatment, as well as using the self-help group to support their recovery process post-treatment. If more is known about the experiences of AA members and the process of recovery as it takes place in AA, clinicians can better coordinate treatment for the client who attends AA (Sommer, 1997). Due to the fact that AA is so widely employed in the alcohol treatment community, is vitally important for researchers and clinicians to have a better understanding of AA and the spirit that underlies it (Galanter, 2007).

Research Questions

What are AA members’ lived experiences of the spirit of Alcoholics Anonymous?

To what extent are these experiences consistent with the spirit of MI (collaboration, evocation, autonomy)?

To what extent are these experiences consistent with confrontational counselling approaches?

Method

Research Paradigm and Methodological Design
This research was concerned with describing the individual, subjective experiences of AA members; therefore phenomenology was adopted as the theoretical perspective. Phenomenology is embedded within a constructionist epistemology, and in this paradigm there is no objective truth waiting for us to discover it, but truth, or meaning, "comes into existence in and out of our engagement with the realities in our world" (Crotty, 1999, p. 8). The positivist approach, which presumes there is a single, objective reality, was not considered to be well suited to the study and understanding of AA due to the extremely diverse social, cultural, and economic situations that exist in voluntary mutual help organisations (Borkman, 2008). Phenomenology as a theoretical framework stems from the works of Husserl (as cited in Liamputtong, 2009), who was particularly interested in the way an individual thinks about his or her experience (Hesse-Biber & Leavy, 2005; Liamputtong). The researcher transcends existing knowledge to understand a phenomenon at a deeper level. Hesse-Biber and Leavy explain that phenomenology is not only a philosophical stance (as in the work of Husserl, Schutz, Heidegger, Merleau-Ponty), but also a research methodology that can be used as a framework for understanding the lived experience of individuals (Moustakas 1994; van Manen 1997; Giorgi 2004).

Phenomenology as a research methodology seeks to understand the nature of phenomena through the lived experiences of people (Becker, 1992). A phenomenological methodology was employed in this study in order to draw out an understanding of participants’ lived experiences of the spirit of AA. Specifically, this study examined to what extent these experiences were consistent with the spirit of MI (Miller & Rollnick, 2002) and conversely, it explored to what extent these experiences were consistent with authoritarian confrontational approaches.
The method of data collection involved an informal, interactive process and utilised open-ended interview questions in order for the researcher to develop a rich description of the essence of the experience (Moustakas, 1994). Data can be seen here as being contained within the perspectives of the people that are involved with AA (Groenewald, 2004), and because of this the researcher engaged with the participants in collecting the data for this research.

**Participants**

Phenomenological studies do not require a large number of participants, but those participants must have experienced the phenomenon under investigation and be willing to speak about it (Liamputtong, 2009). A purposive sample of 10 people (six males and four females) who have had a dependency on alcohol participated in this phenomenological study. No diagnostic materials were used to verify their claims; if the participant believed they were dependent on alcohol at some point in their lives and attended AA, then they were eligible to be included in the study (e.g., Zakrzewski & Hector, 2004). Over one-third of AA members are women (Alcoholics Anonymous World Services, 2010; Kaskutas et al., 2005), so the sample in this study may be viewed as a reasonable representation of gender proportion in AA. The participants ranged in age from 28-71 years ($M = 42.60$, $SD = 11.81$), had achieved an extended period of abstinence, and self-identified as members of AA. Length of continuous abstinence ranged from approximately six months to 30 years ($M = 11.42$ years, $SD = 9.96$ years).

The researcher's base network of personal contacts was used as a starting point for recruitment of this sample from what could be described as a hidden, vulnerable population (Liamputtong, 2009). Subsequent recruitment was achieved through snowballing (e.g., Guilfoyle & Hill, 2002; Liamputtong, 2009). Liamputtong describes
the snowball method as initially selecting a single or a small number of research participants and asking them to introduce other people who meet the criteria of the research and may be interested in participating. Atkinson and Flint (2001) advocate the use of snowball sampling to locate hard-to-reach populations due to the difficulty in accessing these hidden populations through more formal methods such as the use of existing lists or screening. Only those recruited through snowballing participated in the study, and none of the participants were personal contacts of the researcher. Recruitment of participants was ongoing until data saturation (Corbin & Strauss, 2008). Liamputtong & Ezzy (2005) explain that data saturation occurs when additional information does not generate any new understanding, and Patton (2002) suggests that approximately 10 participants are considered adequate in order to reach saturation point. In this case, saturation was considered to be reached by the researcher when three consecutive interviews provided no new patterns in the data items upon initial code generation and thematic searching (Braun & Clarke, 2006).

Instrument

Due to the interpretative approach adopted, a semi-structured interview schedule of nine open-ended questions (Appendix A) was used to guide the interview. The researcher was particularly interested in exploring participants’ experiences of the relational spirit of AA and to what extent these were consistent with the spirit of MI (Miller & Rollnick, 2002) and/or authoritarian confrontation approaches. The phenomenon of how the spirit of AA is experienced from the point of view of the AA members themselves was a focus of these questions.

The interview commenced with a general question, “how did you come to be in AA?” in order to gain an insight into the background of each participants’ experiences of their initial exposure to AA. The questions then became increasingly
focussed on the participants’ relational experiences with other people in AA, such as “have you ever had an AA sponsor?” and “how would you describe their style?” and “to what extent do you feel free to make your own choices in AA?” Several general probing questions were utilized throughout the interviews in order to draw out further information, such as “can you tell me more about that?” Reflective listening to participants’ responses guided the path of the interview.

In order to determine the flow and clarity of the interview questions (Breakwell, 2006), they were trialled with a single member of AA. The initial contact person recruited at the AA meeting agreed to participate in a trial capacity only, and was verbally informed that their interview data would not be used in the study. The trial process assisted in generating potential probes and eliminating double-barrelled and leading questions.

Procedure

After gaining approval from the Edith Cowan University Human Ethics Committee, the researcher employed the ‘hanging out’ strategy (Liamputtong, 2009; Rosenthal, 1991) at an AA meeting in order to recruit an initial contact who was given an information letter (Appendix B) and asked to introduce others who may be interested in participating in the study. Volunteers recruited via snowballing contacted the researcher directly by telephone, or were contacted by the researcher by telephone after a number was provided by a link in the referral chain. The nature of the study and their potential involvement was discussed, and potential participants were sent an information letter (Appendix B) by email or post prior to their participation. The information letter provided the potential participant with information on the details of the research being undertaken. Those that were interested in participating contacted the researcher to arrange a suitable time and place for the interview.
Interviews were conducted at a mutually convenient location such as a quiet coffee shop or public library. Prior to the commencement of the interview, participants read and signed the consent form (Appendix C) and were verbally assured of their confidentiality and anonymity. The questions were kept from the participant's view to encourage a natural, conversational response. The semi-structured interview was recorded on an audio-recording machine after permission was sought from the participants to audio-record the interview. Each research participant was interviewed for approximately 25 minutes using the semi-structured interview questions (Appendix A) as a guide.

Participants were debriefed following the interview, and no concerns were raised by any participant that needed to be addressed and clarified by the interviewer at that time. In the hour following the interview, the interviewer used a research journal to record reflections and comments about the interview in order to assist in achieving scientific rigour. The journal notes were used to assist in analysis. Collected data will be securely stored at Edith Cowan University for perpetuity, allowing time for them to be scrutinized or referenced by other researchers and interested parties if and when required.

Transparency and Integrity

The primary researcher's status as a person in recovery from alcohol dependency who self-identifies as a member of AA is openly acknowledged. Reflexive self-awareness and ownership of this perspective (Liamputtong & Ezzy, 2005; Patton, 2002) reduces the likelihood that the analysis and interpretation of findings were affected. Rigorous attempts were made to set aside prejudgements, assumptions and potential biases from the information disclosed by participants through the process of bracketing (Fischer, 2009; Giorgi, 2004; Zakrzewski & Hector, 2004). Husserl referred
to bracketing in terms of the freedom from suppositions as *epoche* - meaning to stay away from (Fischer, 2009; Groenewald, 2004).

An audit trail was recorded in the form of a reflective journal, and was used in this research study as a bracketing technique (Fischer, 2009). An audit trail provides “detailed clarification of the researcher’s reasons for making particular theoretical, methodological, and analytic choices” (Liamputtong, 2009, p. 30). It enables the research process to be critically scrutinized by others and hence increases the trustworthiness of the findings and analysis (Liamputtong, 2009).

When carrying out phenomenological research, it is impossible to control for all researcher bias (Fischer, 2009; Zakrzewski & Hector, 2004). Even when attention is paid to reflexivity and common bracketing techniques such as an audit trail are employed, total objectivity is not possible due to the researcher being an active human participant in the process (Groenewald, 2004; Moustakas, 1994). In striving for transparency and reflexivity, the researcher has attempted to make his presuppositions explicit; therefore the integrity of the research process is enhanced.

Rigour is vitally important in demonstrating integrity and competence, and the legitimacy of the research process (Tobin & Begley, 2004). Member checking was conducted by presenting a summary version of the transcript to three of the participants in order to verify the themes and sub-themes, and to ensure an accurate interpretation of the findings by the researcher (Silverman, 1993). Peer review was also used as a way of reducing researcher bias (Cresswell, 2007). A colleague of the researcher checked the themes and sub-themes that were identified in order to assist in verifying their sufficiency (Liamputtong, 2009).

*Ethical Considerations*
The researcher acknowledges that ethical issues are a particularly pertinent consideration when conducting qualitative research, due to the close interaction between the researcher and the participants, and the less structured nature of qualitative research methods (Liamputtong, 2009). Participants were informed during the initial contact phase in the information letter (Appendix B) that participation in the research was voluntary and they were free to withdraw at any time during the study without penalty. It was explained that any data that they had contributed before withdrawing would not be included in the analysis. A signed informed consent (Appendix C) was obtained. Confidentiality and anonymity were regarded as a particularly important ethical consideration in this study, given the name of the participants’ fellowship is Alcoholics Anonymous and the principle is so highly valued in that context as well as in conducting ethical research. Assurance was given verbally and in writing that the anonymity and confidentiality of the participant would be upheld, that all recorded data would be erased after transcription, and all transcripts would be de-identified. Pseudonyms were used rather than real names as a way of protecting the identity of the participants (Liamputtong & Ezzy, 2005).

Participants were provided with a list of counselling/AOD services (Appendix D) in the event that they should experience any anxiety or trauma arising from the process of sharing their story during the interviews. One participant did become visibly emotional during an interview when sharing about how people in AA had been there for him in hard times, but the emotional state was interpreted by the researcher during the interview as one of extreme gratitude and the participant was not considered to be at risk of being harmed.

Data Analysis

The interviews were transcribed verbatim to ensure accuracy of descriptions for analysis. Thematic analysis was utilised in order to interpret the participants’
experiences. Thematic analysis involves the inductive identification of themes within the data (Liamputtong & Ezzy, 2005). The thematic analysis was informed by the constructionist perspective (Crotty, 1999) because it seeks to examine the multiple realities constructed by individuals and the implications of those constructions for their lives and interactions with others (Patton, 2002). A thematic analysis of the data was carried out using guidelines set out by Braun and Clarke (2006) in order to explore participants’ experiences of the relational spirit of AA.

The transcriptions were read and re-read several times in order for the researcher to become familiar with the data, make initial notes, and check for data saturation (Braun & Clarke, 2006). The data set was then extracted from the full interview transcripts (data corpus) by identifying any relevant instances in the transcripts that the participants spoke about their experiences of the relational spirit of AA in terms of their interactions with other members, the meetings, and the fellowship in general. The data set was then analysed by generating initial codes from the data. This involved comparing events, actions and interactions, and the subsequent grouping of emerging themes into categories (Liamputtong & Ezzy, 2005). Attention was paid in the initial coding stage to thoroughness, giving full and equal systematic attention to all the data, and identifying interesting aspects in the data that may form the basis of themes across the data set (Braun & Clarke, 2006). Potential themes were identified and all data relevant to the potential theme were gathered together. Themes and sub-themes were reviewed and a thematic map (Braun & Clarke, 2006) was generated. Memo writing in a reflective journal was used to assist with interpretation of the data as this is recognised as an important step between coding and writing (Liamputtong, 2009). Themes and sub-themes were then defined and named, and increased rigour was obtained by member checking (Silverman, 1993) and peer review (Cresswell, 2007).
Finally, the most vivid and appropriate extracts were selected as examples of the sub-themes and the findings and interpretations were written up and analysed in relation to the research question and the relevant literature (Braun & Clarke, 2006).

Findings and Interpretations

The aim of the research study was to find out about AA members' lived experiences of the spirit of Alcoholics Anonymous. To what extent were these experiences consistent with the spirit of MI (collaboration, evocation, autonomy) (Miller & Rollnick, 2002)? Furthermore, was the spirit of authoritarian confrontation experienced by AA members, and if so, how? Six major themes were identified from participants’ responses during analysis (see Table 1) that reflected their lived experiences of the spirit of AA: direct positive confrontation; negative confrontation; authority; collaboration; evocation; and autonomy. Also listed are 15 sub-themes which were identified as prominent within each of the main themes.

**Direct Positive Confrontation**

Being challenged to take responsibility for changing some aspect of their behaviour or thinking that was detrimental to their recovery (Polcin, 2003) was a common experience for AA members who participated in this study. This direct form of honest communication was generally experienced as positive and helpful (Polcin & Greenfield, 2006).

‘Life or Death’ Confrontation

“If a person’s on the verge of death, sometimes I’ll be a bit straight with them, very straight with them - well, you know, you’re fucking killing yourself so...you know, if you wanna do that that’s your choice, but don’t expect me to not challenge that when I’m hearing what you’re saying, cause you’re actively quite mad...but that’s very rare that I would say that to anyone, I’d have to be very close to that person to even take the risk of doing that.” (Patrick, 21 years abstinence)
Table 1

Themes and sub-themes related to AA members' lived experiences of the spirit of AA

<table>
<thead>
<tr>
<th>Theme</th>
<th>Sub-theme</th>
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<tbody>
<tr>
<td>Direct Positive Confrontation</td>
<td>‘Life or Death’ Confrontation</td>
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<tr>
<td></td>
<td>Honest Supportive Feedback</td>
</tr>
<tr>
<td>Negative Confrontation</td>
<td>Unsolicited Authoritarian Confrontation</td>
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<tr>
<td></td>
<td>Cross-Talk</td>
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<tr>
<td>Authority</td>
<td>Authoritarian Sponsors</td>
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<tr>
<td>Collaboration</td>
<td>Empathy, Honesty and Acceptance</td>
</tr>
<tr>
<td></td>
<td>Mentor/Substitute Parent</td>
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<tr>
<td></td>
<td>Sharing Experience, Strength and Hope</td>
</tr>
<tr>
<td>Evocation</td>
<td>Healing Energy of the Rooms</td>
</tr>
<tr>
<td></td>
<td>Identification</td>
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<td></td>
<td>Evoking Self-Efficacy</td>
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<td></td>
<td>Questions that Develop Discrepancy</td>
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<tr>
<td>Autonomy</td>
<td>Welcoming Autonomous Atmosphere</td>
</tr>
<tr>
<td></td>
<td>Encouragement and Suggestions</td>
</tr>
<tr>
<td></td>
<td>Freedom of Choice</td>
</tr>
</tbody>
</table>

In the first extract, the participant discusses an occasion where he directly confronted a less experienced AA member, who had recently relapsed, about his drinking. The confrontation can be viewed as a carefully considered action designed to convince the alcohol dependent person that they are suffering from an incurable fatal illness (Alcoholics Anonymous World Services, 1957). The important thing to consider here is the spirit in which the confrontation is carried out. The participant notes that the
SPIRIT OF MOTIVATIONAL INTERVIEWING IN AA

confrontation is a carefully considered risk, used sparingly, and carried out as an act of
closeness and kindness in an extreme situation.

The theme of alcohol dependence as a life or death matter ran consistently
through the data set. As a long-time abstinent member of AA, the confrontational
nature of the first extract is framed in reference to the participant’s past experiences of
seeing seriously alcohol dependent people die from their continued use:

"Ten of the people who I was in rehab with are dead, all of them through active
drinking or suicide. This isn’t about drinking and not drinking, it’s a life and
death struggle, and until people can begin to frame it in them terms, they won’t
see it for what it is.” (Patrick, 21 years abstinence)

In the extract below, when confronted by his sponsor about a lack of
commitment to staying abstinent in AA, the member was initially angry and defensive -
a normal human response to being confronted, according to Miller and White (2007).
The sponsor’s confrontational approach was later experienced as accurate, helpful and
supportive (Polcin et al., 2007). Furthermore, the participant described this
confrontational event as the defining moment in his journey of recovery so far:

"He’s not afraid to tell me the truth. Probably the defining moment was when I
was a few months sober again, and I’d been in and out of AA, and he said to me
“Doug, you’re not committed to your sobriety”, and that sort of pissed me off,
and then I thought about it later on, and decided that he was right, and I needed
to start going to more meetings, and treating it more seriously, and no matter
what happens, just don’t drink or do any drugs. So yeah, he helped me by...he
wasn’t afraid to tell me the truth. One day he got in my face and just said
“Doug, we’re powerless, we’re powerless”, and he just kept repeating the
word” powerless”, and it sort of finally sunk in that, you know, I needed to get
help from another power to stay stopped and to [pauses] stay sober, really.
Yeah, so he’s been a wonderful help for me.” (Doug, 2 years abstinence)

Honest, Supportive Feedback

In the extracts below, the vital spoken perspective of being told the truth about
one’s situation within the context of a trusting sponsor relationship was an extremely
common theme. This theme aligns with what is written in the AA-based Betty Ford PIR
manual (Betty Ford Center, 2009) about confrontation. The focus is not so much on
trying to change another person as it is on trying to help that person see themselves more accurately.

"Having a sponsor, for me, is...it's a must, because I don't see what I need to see a lot of the time, you know, and my sponsor does, and he'll tell me. He loves me enough to say "You've been a shit, go and have a look at yourself", you know." (Tom, 15 years abstinence)

"She'll say “Oh you're being a bitch” or...but to me, that's just being honest, you know, and I just like to have people around me that are honest...I might not always like what somebody's saying, but usually if it makes me angry I know that there's some sort of truth to it [laughs] I might not like it, and I'll go away and I'll think “oh you bitch” and you know, whatever, but then, when I sit back and look at it, then I look at my part in things and, OK, well what should I have done there, or, what could I have done better, and do I owe an amends.” (Jenny, 12 years abstinence)

Again, the confrontational nature of the honest feedback was usually met with initial resistance. This is considered normative for human beings rather than being considered as an abnormal defence mechanism particular to substance dependent individuals (Miller & White, 2007). In this sense, confrontation was based on being told the truth about specific patterns of thought or behaviour and usually not related specifically to drinking behaviour.

This type of honest, no-nonsense feedback in AA is provided by a more experienced peer in recovery rather than a clinician, so may be considered as more palatable by the receiver (Fraser & Solovey, 2007; Polcin, 2003). Nonetheless, honest confrontational feedback is experienced here as helpful, accurate and supportive in the context of a person being challenged to take responsibility to change some aspect of their behaviour or thinking that is detrimental to their recovery (Polcin, 2003; Polcin & Greenfield, 2006). The value placed by the receiver on this type of supportive, honest confrontation in recovery appears to support the notion that clinicians with high levels of therapeutic skill should be encouraged to use this type of communication. These types of interactions may promote increased transparency in the therapeutic alliance.
and thus enhanced collaboration (Moyers, et al., 2005). More research is needed in this area in order to determine the appropriate circumstances in which supportive confrontation could be used by highly-skilled clinicians as a method of effective communication.

**Negative Confrontation**

This theme follows a more traditional definition of authoritarian confrontation, and is defined by an over-riding of the newer AA member’s impaired perspectives by imposing awareness and acceptance of ‘reality’ that the person cannot see or will not admit (Miller & Rollnick, 2002).

**Uninvited Authoritarian Confrontation**

“There was one guy who said to me that I shouldn’t speak about my drug use in an AA meeting, and I should go to NA, and I told him I didn’t really think that was right, and that got a little bit heated, I really felt like drinking after that...yeah, so there are people in AA who do have opinions about your situation, but sometimes you’ve just gotta try and work through those resentments if they come up”. (Doug, 2 years abstinence)

As illustrated in the above extract, some participants experienced confrontation that occurred outside the trusting relationships they had formed with a sponsor in the form of unsolicited authoritarian comments and feedback from other AA members before, during, or after AA meetings. This type of approach was experienced as completely negative (Miller & White 2007), and threatened to taint the individual’s experience of AA. A common reaction to this type of approach was that the person did not want to come back to AA meetings, and may even relapse or consider relapsing on alcohol, as seen in the extract above.

Confrontational approaches that contain the spirit of non-acceptance such as the one described above can be seen to align with the relatively poor outcomes and high dropout rates of the traditional confrontational approach to addiction treatment (Fraser & Solovey, 2007). The normal human response which is evoked by this type of
confrontational style is to be defensive, to want to flee, to feel angry, hopeless or discouraged (Miller, 2009). Human beings may do or say anything to get out of a situation where they are being judged, criticized, put down, or threatened (Miller, 2009). Although not as common as some of the other sub-themes, this type of uninvited authoritarian confrontation was found in the experiences of AA members.

**Cross-Talk**

"I remember sitting at a meeting, and I was being as honest as I was able, which I was finding this coming to terms with my blindness very distressing, and **three different people** told me in their sharing, that I couldn’t accept what was happening, and I can still remember coming home, **absolutely** devastated...and ringing someone and them saying, Gloria, don’t believe that, you’re going through another stage of grieving" (Gloria, 30 years abstinence)

In the extract above, the participant became extremely despondent after cross-talk occurred at a meeting, then sought to discuss the incident with a trusted friend in AA (Borkman, 2008). The extract illustrates why personal experience is usually shared in response to any disclosure in meetings, rather than any direct feedback or advice (Miller & White, 2007). A lack of empathy here demonstrates that even in mutual support groups, there are still times when people are not supportive.

**Authority**

This theme is defined by the AA sponsor or fellow AA member telling the person what he or she must do. It described as the mirror-image of the fundamental MI spirit of autonomy (Miller & Rollnick, 2002).

**Authoritarian Sponsors**

Most participants spoke about their experiences of sponsorship as egalitarian relationships which featured collaboration rather than domination (Borkman, 2006). Borkman describes this egalitarian approach to relationships as the essential method of AA. However, some participants experienced a model of sponsorship that involved a strict and authoritarian relationship. Here, the sponsor lays down the rules and the
sponsee reacts with unquestioning obedience. In the extract below, the participant saw her role as a sponsor as first and foremost authoritarian. This style is consistent with Miller and White's (2007) description of the confrontational counselling approach that evolved in US addiction treatment circles in the latter half of the 20th century. The fundamental message of "I have what you need" (p. 52) is echoed here:

"If you want what I have, and you've asked me to be your sponsor, then you need to do what I've done, basically." (Jenny, 12 years abstinence)

In the following extract, the participant describes how he has modified his sponsorship approach, moving away from the strict authoritarian relationship model. However, he clearly expresses his willingness to sponsor someone only if the person remains abstinent:

"I've tried the thing where you have to ring me here and here, and you have to do this, this and this, and it's like, no - when someone's ready, they'll be willing to do it. I don't have to force anybody to do anything. There is one thing that I have found to be true - that if I'm sponsoring someone, once they pick up, then they have to find another sponsor." (Clint, 18 years abstinence)

There is certainly extreme variability in how sponsorship is experienced and practiced in AA (Borkman, 2008), and it is clear from the experiences of the participants here that an authoritarian approach does exist in certain AA sponsor relationships. Many different models seemed to exist upon analysis of the data set in this study. It may be the case that the sponsorship models are often dynamic ones. The relationship may begin in a rigid, authoritarian fashion but gradually work to strengthen the autonomy of the sponsored person as they remain abstinent and their capacity to trust themselves increases.

Collaboration

This theme is defined as involving a partnership that honours the AA member's expertise and perspectives. The experienced AA member/group provides an atmosphere that is conductive rather than coercive to change (Miller & Rollnick, 2002).
Empathy, Honesty and Acceptance

"He encouraged me to stay sober and attend as many meetings as possible, and sometimes I'd meet him at the meetings and go and have coffee with him afterwards... he listened actually... he was a very stable presence in my life, and he listened to me a lot." (Patrick, 21 years abstinence)

Although authoritarian confrontation was found in some sponsorship experiences, a much more common experience of the participants in this study was one of collaboration and alliance in the sponsor relationship. In the extract above, the participant expressed how his sponsor was a stable presence in his life and was there to listen to him without judgement. The thread of provision of support within a positive interpersonal atmosphere was woven right through the data set. This is consistent with Miller and Rollnick's (2002) spirit of MI, where a core belief is that a person will grow in a positive direction given the proper conditions. This approach can be traced further to the client-centred approach of Carl Rogers, who defined three conditions that he believed a counsellor should provide to foster positive change: empathy, honesty, and acceptance (Rogers, 1957). Many participants indirectly acknowledged the existence of these conditions in the people in the AA fellowship, as illustrated in the extract below:

"So without AA and the people in it, you know, genuine people [pauses] genuine people who care about you [has tears] like they say in AA, you get loved back to life, don't ya?" (Oliver, 3 years abstinence)

Mentor/Substitute Parent

As in the extract below, many participants described their AA sponsor as a mentor who guided them through the programme and their recovery from alcohol dependence:

"I got my sponsor when I was six months sober, and then he showed me a lot of the tools that we use in sobriety, and we've done a few retreats together. He's been an excellent mentor... we did the same meetings together, so he was always watching me, or... he could see that I was on the right path, so he just, you know, let me go and do my thing." (Andrew, 14 years abstinence)
AA members talk to their sponsors about private material that would be inappropriate to discuss at meetings (Kurtz, 2002), and therefore these relationships often develop into ones that are very trusting and close. A number of the participants declared that “He/She knows me” (e.g., Debbie, 6 months abstinence) when speaking about their sponsors, and the idea of being known, understood, and valued is consistent with the MI spirit where individual perspectives are honoured (Miller & Rollnick, 2002).

“He’s got a lot of sobriety and he’s much older, he’s really been like a mentor, for me and [visibly softens]...in some ways was a bit like the substitute father who I never had.” (Patrick, 21 years abstinence)

There were a number of instances where participants extended the mentor concept and spoke about their sponsor as a substitute parent, as in the above extract. This may relate to Smith and Tonigan’s (2009) finding that AA participation was associated with increased self-reported secure attachments and a significant reduction in avoidant and anxious attachment styles. In the context of AA’s focus on the development of relationships in order to achieve abstinence and recovery, sponsors provided a stable, parental-like presence for some of the participants in this study who had not experienced this type of attachment pre-AA.

Sharing Experience, Strength, and Hope

The theme of fostering supporting, collaborative relationships that help to promote recovery in AA is again evident in this sub-theme: sharing experience, strength, and hope.

“I guess I’d just share my experience, strength and hope with them that if they wanna get better, they can ring me anytime and...I’ll be there to help them. So there’s a lot of support in AA, and we get well by helping each other. We can’t do it alone, we need each other.” (Doug, 2 years abstinence)

Before every AA meeting the AA preamble is read, and states “AA is a fellowship of men and women who share their experience, strength and hope with each other that they may solve their common problem and help others to recover from alcoholism.”
SPIRIT OF MOTIVATIONAL INTERVIEWING IN AA

(Aliquotics Anonymous World Services, 2010, p. 6). AA meetings are organized
around a series of personal monologues (Arminen, 2004; Humphreys, 2000) and
Arminen notes the therapeutic relevance of sharing stories in AA. The process of
sharing and co-constructing experiences helps to provide resolutions and a serves as a
as the essential method of AA, egalitarian peers share their lived experiences, and
convey hope and strength to one another in a spirit of collaboration.

**Evocation**

Evocation as defined in this theme is where the resources and motivation for
change are presumed to reside within the individual (Miller & Rollnick, 2002). Intrinsic
motivation for change is enhanced by drawing on the individual AA member’s own
perceptions, goals, and values.

**Healing Energy of the Rooms**

“I don’t really understand how it works, but when you sit in the meeting and
you listen to the people sharing, and whether you share or you don’t share,
there’s an energy in the room, and...it works. It has a healing effect on the soul,
if that makes any sense.” (Andrew, 14 years abstinence)

A number of the participants spoke about experiencing a healing energy in
meetings of AA. The literature on spiritual transformation in AA as a mechanism of
change (Forcehimes, 2004) and the phenomenon of quantum change (Miller, 2004) is
useful in interpreting the common experiences of a number of the participants here. In
Miller’s study on quantum change, many people who reported experiencing the
phenomenon of quantum change described being in the presence of a profoundly
accepting, loving entity. In the extract below, the spiritual energy of the group is
understood as the basis for healing and evoking change:

“There’s a group conscience which has basically expressed itself in a spiritual
energy, and I understand that as the healing principle. The healing principle of
AA, with one AA member to another AA member – that’s love. That’s what it’s
called. Love is the healing principle, but people do not awaken to that until they've been around AA for a fair time in a very committed fashion or, as we say in AA, our primary purpose is to stay sober and to help other alcoholics to achieve sobriety.” (Patrick, 21 years abstinence)

AA members experienced a sense of being accepted as they are in the rooms of AA in a way that was transforming, which left them with a sense of safety. This resembles the description of the phenomenon of quantum change as described by Miller (2004, 2009). Here, the AA group acts as an accepting presence and transformational change can occur as a gradual process. Healing, growth, and change are evoked from the AA member as they become present and attempt to follow the AA programme.

Identification

Many people who are alcohol dependent can become alienated and isolated (Flores, 1988), and a common initial experience of AA for many participants was a difficulty or unwillingness to connect with the people in the meetings, as in the extract below:

“I...vaguely knew the people there, but to be honest I thought they were a bit odd, and a bit weird, when it was really me that was a bit odd and a bit weird...and I didn’t wanna get too involved with them.” (Oliver, 3 years abstinence)

A majority of the participants in the study had initially rejected AA, and then returned at a later time when the consequences of continued use of alcohol had become extremely difficult to bear. Change arose from within as the person became ready and willing to remain abstinent. A gradual surrender to the AA programme over time was a common experience among participants in their recounting of what brought them to AA. Powerlessness over alcohol was eventually admitted and accepted, and people progressed through the 12 steps at their own pace (Groh, et al., 2008). Many also spoke about feeling a sense of identification with another member or members upon re-exposure to AA, and this is illustrated in the following extract:
“She was my age, she was well dressed, she seemed a bit like me, and I related...and she was wearing a hat, which I think hats are pretty glamorous, so...she had come up to me afterwards and said that there was a really good meeting this Sunday, and she said, “I was thinking of going to that meeting, but if you come, I’ll definitely be there.” So that I had somebody I knew, a little bit, and that really did influence me to go to my second meeting, because I’d met this nice lady and she would be there at my next meeting, and, someone to just give me a friendly smile, or sit next to me.” (Kelly, 6 months abstinence)

**Evoking Self-Efficacy**

“AA influenced me against deciding to drink again, because I had planned to drink again. I was 20 when I came in and I thought, on my 21st, I would drink again. But once I stopped drinking and started getting involved in AA and feeling the benefits of sobriety, I decided that I wouldn’t drink again, that I would stick this...you know, this was pretty good, and I would stay with it, and...so AA gave me a sobriety that was enjoyable, like I’d stopped drinking before, and it was a nightmare, but what AA had given me was a programme to put into my life that allowed me to enjoy life without the need for drugs or alcohol.” (Andrew, 14 years abstinence)

In the extract above, the participant describes how the AA programme drew out from him an intrinsic motivation to change by giving him a way to live abstinent from alcohol that was enjoyable. Despite actively planning to drink again, being part of the fellowship and programme elicited the motivation for change from within.

**Questions that Develop Discrepancy**

In the extract below, the sponsor asks questions in order to develop a discrepancy between the participant’s present or planned behaviour (i.e., thinking about relapsing on alcohol) and their broader goals or values (i.e., wanting to live a much more satisfying life by remaining abstinent).

“And since my sponsor knows me so well, she might point out what would happen if I went out, or “why do you feel like you wanna go out? What’s the reason? What’s the real reason?” It’s obviously not just because you wanna have a nice little cocktail, there’s always a reason behind it. So they’re always like “OK well, play it out, what does it look like if you drink?” , and then we’ll talk about that.” (Debbie, 6 months abstinence)

Motivation to change or look at certain behaviour differently is drawn out of the participant rather than being instilled into the person by the sponsor (Miller & Rollnick,
This is certainly very similar in spirit to one of the four general principles of MI, develop discrepancy. In the process of talking through difficult issues with a sponsor or trusted friend in AA, the AA member presents their own arguments for change. According to Miller & Rollnick, people may be more likely to be persuaded by what they hear themselves say than what other people tell them.

**Autonomy**

The sponsor, AA member, or group affirms the person’s right and capacity for self-direction and facilitates informed choice. Autonomy is defined as the freedom to act independently (Miller & Rollnick, 2002).

**Welcoming Autonomous Atmosphere**

"The people were all very welcoming, and friendly, and no-one tried to tell me what to do. They didn't tell me ‘You gotta stop drinking’, they really left it up to me... and that it was really my decision, which is a very loving action when you think about it, there was certainly no pressure... to do anything. I just knew I needed to keep going to meetings." (Doug, 2 years abstinence)

Most participants expressed the view that they had never felt any sort of pressure to change as members of AA. The participant in the extract above describes how he was received at AA meetings after he relapsed on alcohol and spent a period of time away from the meetings. He experienced a welcoming atmosphere of unconditional acceptance upon returning to the rooms of AA. Once back again in a safe environment, the process of recovery from alcohol dependence could begin again. The relational spirit of MI has been described as a collaborative partnership style, one that respects people’s autonomy to choose their own life course (Miller, 2009). What is being expressed in this extract is consistent with the experiences of most of the participants, and is certainly compatible with the spirit of autonomy.

**Encouragement and Suggestions**

"It's not like they put pressure on you to not drink, they just say, what to do, when you feel like a drink, and I honestly feel like everything that's done in AA
is suggested - this is what we recommend, this is what I would do...you're not told to do anything, you take it on board and do it your way...it's like a dangling carrot...you know, it's like a promise that you're gonna change, not pressure that you have to.” (Kelly, 6 months abstinence)

Central to the AA experience for most participants was the relational spirit of autonomy (Miller & Rollnick, 2002), where a person was not demanded to take a particular course of action but instead certain actions were “suggested” or “encouraged”. In this way, responsibility for change is left with the AA member. The spirit of the authoritarian approach, where a person is “made” or “allowed” to do certain things, was not evident in the participants’ general experience of the spirit of the AA fellowship. The main exception to this finding was in the case of the authoritarian sponsor, and this sub-theme was discussed in an earlier section.

Freedom of Choice

“I think AA has given me the freedom to make my own choices. Before I came to AA, my choices were from drugs and alcohol, you know...that was what gave me the choice of what I wanted to do, whether I wanted to go this way or that way. In AA, I’ve just got my AA way of life, like I’ve found my AA way of life.” (Jenny, 12 years abstinence)

Many of the participants stated that being in AA had given them the freedom to make their own choices, instead of their choices being controlled by a dependence upon alcohol or other drugs. In the extract above, Jenny explains how she found her AA way of life after the alcohol and drugs were no longer controlling the choices she made. By being able to remain abstinent in AA and take on other elements of the AA programme such as the 12 steps, freedom from alcohol was gained and other choices in life were now possible. In being relieved of the need to drink or take drugs by the process of attending AA, freedom to act independently was gained by the recovering individual.
Conclusions

The purpose of this research study was to investigate members’ experiences of the spirit of AA. To what extent were these experiences consistent with the spirit of MI (collaboration, evocation, autonomy)? Furthermore, to what extent were these experiences consistent in spirit with authoritarian confrontational counselling approaches? Utilizing a social constructionist framework (Crotty, 1999; Patton, 2002), participants’ experiences of ‘ways of being’ with other people in AA were constructed based on their own individual perspectives of this phenomenon.

Overall, AA was experienced by its members as supportive, mentor-based, and collaborative. The themes identified here largely supported Miller’s (2009) theory that AA and MI are compatible in terms of their relational spirit, or ‘ways of being’, with people. A patient, compassionate approach that was not blaming or judging was found to be a common experience of AA members. The knowledge gained from this study suggests that AA’s ethos is consistent with the current evidence-based therapeutic recommendations for treating people with alcohol problems in a clinical setting.

However, some elements of a confrontational approach were found. In line with a recent study by Polcin and Greenfield (2006), confrontation in the form of warnings about the potential harm associated with continuing substance use was generally experienced as accurate, helpful, and supportive in AA. The perceived severity of the person’s condition and the closeness of the AA relationship appear to be crucial factors in determining when more experienced and long-term abstinent members used confrontation in AA. Confrontation is interpreted in this light as a courageous and honest action on the part of the confronter rather than an authoritarian demand for change. The definition that frames confrontation as an authoritarian attempt to convince
people that they have an alcohol problem and need to change was not found to be a common theme in the experiences of AA members.

It is clear from the experiences of the participants here that an authoritarian approach does exist in certain AA sponsor relationships. There appears to be extreme variability in the ways in which sponsorship is experienced and practiced in AA (Borkman, 2008). An interpretation of the participants experiences suggest that both AA sponsors and sponsees will end sponsor relationships if they discover over time that they are not viable (Borkman, 2008).

Implications and Recommendations

The knowledge gained from this study may have practical implications for clinicians and other health professionals in supporting individuals who have problems with their alcohol use. The findings showed that by and large, the spirit of AA is compatible with the collaborative approach to treating individuals who are having problems with their drinking. Therefore, treatment providers can encourage sampling of the programme and meetings of AA with an increased confidence that the ethos of AA is consistent with current evidence-based therapeutic recommendations. NDARC recommends AA as a suitable aftercare strategy option and notes its usefulness as an adjunct to professional treatment (Shand, et al., 2003). The present study may also help to elucidate the ways in which AA members interact with each other in order to bring about change and facilitate recovery from alcohol dependence.

Limitations and Directions for Future Research

The main limitation of this study was that the participants were recruited through snowballing. Homogenous samples can result from methods such as snowball sampling (Liamputtong & Ezzy, 2005) where the structure of the sample is shaped by the qualities and characteristics of the original respondent. In order to gain a more
representative sample, it is suggested that future research studies recruit participants from advertisements to the general AA population. This could be achieved by contacting the AA area service office and organizing an advertisement in the AA monthly magazine that is delivered to all local groups.

Another limitation of this study may be that the sample contained AA members from a relatively small area in Perth, Western Australia. In order to further explore the spirit of AA in its very diverse social, cultural, and economic situations (Borkman, 2008; Kurtz, 2002; Miller & Kurtz, 1994), the experiences of AA members in different areas of Australia and around the world should be investigated.

In conclusion, qualitative methodologies such as phenomenology, ethnography and in-depth field research are recommended as an important avenue for future research on AA, in order to begin to gain a greater understanding the nuances and diversity of the AA programme (Borkman, 2008; Chenhall, 2007). By drawing on individual’s subjective accounts and gathering empirical data on AA via field research, the nature of alcohol dependence and recovery in AA can be examined in greater depth than is possible with purely quantitative studies. These methodologies are recommended as appropriate for future studies investigating the relational spirit of AA.
References


http://www.simeetings.com/LA/RedondoBeachMtgs.html


SPIRIT OF MOTIVATIONAL INTERVIEWING IN AA

Addiction. Advance online publication. Retrieved from
http://dx.doi.org/10.1111/j.1360-0443.2010.03096.x


Appendix A

Interview Schedule

Before we start, I want to thank you for your participation in this research. I have nine things that I would like to ask you about, and am very interested in your thoughts about these issues. I first was hoping you could give me a brief account of what brought you to AA.

How did you come to be in AA?

1. Did AA influence your decision to stop drinking?
   Can you tell me a bit more about that?
   You mentioned that ________ (another AA member) influenced your decision to stop drinking. Can you tell me some more about how ________ (another AA member) helped you?

2. Have you ever had an AA sponsor?
   If yes – how would you describe their style? (If needed, the following prompts will be used. For example: were they strict, laid-back, or in between?)
   Can you give me examples of how they tried to help you?
   If no – can I ask why you have not had a sponsor?

3. Do you sponsor anyone in AA?
   If yes – how would you describe your style?
   If no - can you tell me a bit more about that?

4. Were there any occasions that you relapsed since you came into AA?
   If no – have you ever left AA and then returned after some time?
   If no – move on.
   If yes - can you tell me a bit about how other members of AA treated you when you came back to the meetings?
   If yes - did you stop going to meetings when you relapsed?
   If no – how did other members of AA deal with that?
   If yes - can you tell me a bit about how other members of AA treated you when you came back to the meetings?

5. Have there been other times when you felt tempted to go back to drinking?
   If no – can you tell me a bit more about that?
   If yes - did you tell others in AA? How did they deal with that?

6. Have you found that people in AA put pressure on you to change?
   Can you tell me a bit more about that?

7. To what extent do you feel free to make your own choices in AA?
   Can you tell me a bit more about that?

8. What would you tell a newcomer about what to expect in AA?

9. Is there anything else you would like to say about AA?
Appendix B

Information Letter to Participants

Is the Spirit of Motivational Interviewing Present in the Experience of Alcoholics Anonymous Members?

Dear Potential Participant,

Thank you for your interest in this study. My name is Mark Williams and I am currently completing my Psychology (Honours) degree in the School of Psychology and Social Science at Edith Cowan University, Joondalup Campus.

This study is designed to investigate the experiences of members of the AA fellowship in relation to their experience in AA during their time as a part of the fellowship. The study will examine members’ experience of AA and whether their experience was one of confrontation or one of collaboration. The research may be valuable in providing clinicians with a more realistic picture of how the AA programme and fellowship might fit into any collaboration-based treatment plan being developed between the clinician and client, without fear of a perceived confrontational spirit possibly contaminating the clinician’s work. In a broader sense, this research may help to challenge stereotypical images of AA at the level of the community and the individual. This project is not funded.

The rationale and design of this study has been approved by the Edith Cowan University Ethics Committee. Please be assured that any information you provide will be held in strict confidence by the researcher. Your involvement in this study will be to participate in one (1) interview at a quiet location convenient to you and answer general questions in relation to your experience as a member of the AA fellowship. The interview will be of approximately 30 to 60 minutes duration, and it will be audio-taped for transcription. Any information that may identify you personally will be removed from the transcript. The audio-tape will be erased immediately after transcription. The reason for recording the interview is to ensure that an accurate record of what was discussed during the interview can be analysed. Full copies of interview transcripts will be provided for your perusal. You are able to make comments or request information be altered. At the conclusion of this study, a report of the findings will be available upon request.

Please understand that your participation in this research is totally voluntary and that you are free to withdraw at any time during this study without penalty. Any data that you have contributed before withdrawing will be able to be removed at that time.

Although it is envisaged that this research will not be stressful, if at any time you become distressed with any aspect of this study, assistance is available to you through a number of counselling services attached. Any questions concerning this project can be directed to me via my contact details below, or to my Supervisor Dr David Ryder on 6304 5452 or Julie-Ann Pooley (Associate Supervisor) on 6304 5591.

If you have any concerns or complaints about the research project and wish to talk to an independent person, you may contact:
Name: Ms Kim Gifkins
Title: University Research Ethics Officer
Address: Edith Cowan University, 270 Joondalup Dr, Joondalup WA 6027
Phone: 08 6304 2170
Email: research.ethics@ecu.edu.au

If you are interested in participating or would like further information, I can be contacted as follows:
Name: Mr Mark Williams (Primary Researcher)
Phone: [Redacted]
Email: markw@our.ecu.edu.au

Yours sincerely,
Mark Williams – Researcher

Researcher’s Signature Date
Appendix C

Informed Consent Document

Is the Spirit of Motivational Interviewing Present in the Experience of Alcoholics Anonymous Members?

Statement indicating consent to participate

I, ____________________________, have read the information letter provided and freely agree to participate in the research study conducted by Mark Williams of Edith Cowan University.

I understand the purpose and nature of the study, and am participating voluntarily. Any questions I have asked have been answered to my satisfaction. I understand that my name, and other demographic information which might identify me, will not be used. I agree to participate in this activity, realising that I may withdraw at any time, with no penalty, should I decide to cease my participation. I understand that no risks are anticipated with my involvement in this research, but acknowledge that I have been provided with a list of counselling/alcohol and other drug services in the unlikely event that I should experience any trauma.

I understand that my participation in the research project will involve one (1) interview at a quiet location convenient to me and that I will be asked to answer questions in relation to my experiences as a member of the AA fellowship. I understand that the interview will be of approximately 30 to 60 minutes duration. I grant permission for the interview to be audio-recorded, and understand that the recording will be erased once the interview is transcribed and any information that may identify me personally will be removed from the transcript. I agree that research data gathered for the study may be published, provided that I am not identifiable.

Research Participant's Signature ____________________________ Date ____________

Contact Phone Number ____________________________

Primary Researcher’s Signature ____________________________ Date ____________
List of Counselling/Alcohol and Other Drug Services

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<th>Service</th>
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<td>Alcohol &amp; Drug Information Service</td>
<td>9442 5000</td>
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<td></td>
<td>1800 198 024</td>
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<td>Alcoholics Anonymous Perth Central Service Office</td>
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<td>Holyoake</td>
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<td>Samaritan Care Line (24 hrs)</td>
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</tr>
</tbody>
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Appendix E

The 12 Steps of Alcoholics Anonymous (AAWS, 1976, p. 59)

1. We admitted we were powerless over alcohol - that our lives had become unmanageable.
2. Came to believe that a Power greater than ourselves could restore us to sanity.
3. Made a decision to turn our will and our lives over to the care of God as we understood Him.
4. Made a searching and fearless moral inventory of ourselves.
5. Admitted to God, to ourselves and to another human being the exact nature of our wrongs.
6. Were entirely ready to have God remove all these defects of character.
7. Humbly asked Him to remove our shortcomings.
8. Made a list of all persons we had harmed, and became willing to make amends to them all.
9. Made direct amends to such people wherever possible, except when to do so would injure them or others.
10. Continued to take personal inventory and when 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 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 to practice these principles in all our affairs.