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TREATMENT

The Role of AA Sponsors: A Pilot Study

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Abstract — Aims: The aim of this study was to explore the roles of Alcoholics Anonymous (AA) sponsors and to describe the characteristics of a sample of sponsors. **Methods:** Twenty-eight AA sponsors, recruited using a purposive sampling method, were administered an unstructured qualitative interview and standardized questionnaires. The measurements included: a content analysis of sponsors' responses; Severity of Alcohol Dependence Questionnaire—Community version (SADQ-C) and Alcoholics Anonymous Affiliation Scale (AAAS). **Results:** Sample characteristics were as follows: the median length of AA attendance was 9.5 years (range 5–28); the median length of sobriety was 11 years (range 4.5–28); the median number of sponsees per sponsor was 1 but there was a wide range (0–17, interquartile range 3.75); and the sponsors were highly affiliated to AA (median AAAS score 8.75, range 5.5–8.75, maximum possible score 9). Past alcohol dependence scores were surprisingly low: 5 (18%) sponsors had mild, 14 (50%) moderate and 9 (32%) severe dependence according to the SADQ-C (median 26.5, range 11–56). Sponsorship roles were as follows: 16 roles were identified through the initial content analysis. These were distilled into three super-ordinate roles through a thematic analysis: (1) encouraging sponsees to work the programme of AA (doing the 12 steps and engaging in AA activity); (2) support (regular contact, emotional support and practical support); and (3) carrying the message of AA (sharing sponsor's personal experience of recovery with sponsees). **Conclusions:** The roles identified broadly corresponded with the AA literature delineating the duties of a sponsor. This non-random sample of sponsors was highly engaged in AA activity but only had a past history of moderate alcohol dependence.

INTRODUCTION

Alcoholics Anonymous (AA), as a whole, has been well researched. Although it is not a 'treatment' *per se*, a number of studies have shown that participation in AA activity is associated with a reduction in drinking, increased sobriety and an improved quality of life (Tonigan *et al*., 1996; Timko *et al*., 2006). The principles of AA are disseminated in an iterative fashion during meetings and via AA literature. However, sponsors play an important role as well. Sponsors are established members of the fellowship, who have been sober for a substantial period and have applied the principles of the AA programme to their own lives. They mentor other members, give advice and support, and assist them in completing the 12 steps (Chappel, 1994). Sponsors help both new and other established members of AA, but the support provided to 'newcomers' is given special importance in the fellowship. Little is known about sponsors, as few studies have focused on them, and none on their roles.

At the inception of AA, there were no official sponsors. In fact, sponsorship is not mentioned in the fellowship's original text, the *Big Book* (Alcoholics Anonymous, 1935). However, the support and help that AA's founder, Bill Wilson—himself only a few months sober at the time—gave to Dr Bob Smith, the fellowship's co-founder, is described as the first act of sponsoring in the AA pamphlet *Questions and Answers on Sponsorship* (Alcoholics Anonymous, 2005). In this booklet, a sponsor is defined as 'an alcoholic who has made some progress in the recovery program and shares that experience on a continuous, individual basis with another alcoholic who is attempting to attain or maintain sobriety through AA'. The roles of a sponsor, as delineated in this pamphlet, are summarized below:

- A sponsor does everything possible, within the limits of personal experience and knowledge, to help the newcomer get sober and stay sober through the AA programme.
- They field any questions the new member may have about AA.
- Sponsorship gives the newcomer an understanding, sympathetic friend when one is needed most—it assures them that at least one person cares.

Sponsorship is considered to be a mutually beneficial affair: the sponsee benefits from the practical and emotional support of a more senior member of AA, but the sponsor also maintains their sobriety through helping others (Chappel, 1994). This latter factor is supported by findings from the Project MATCH trial that showed that recovering alcoholics who help other alcoholics maintain sobriety were significantly less likely to relapse themselves (Pagano *et al*., 2004). There is an evolving literature about helping behaviour in recovering alcoholics and various helping scales have been developed (Zemore and Kaskutas, 2004; Kaskutas *et al*., 2007). Although there are areas of overlap, this literature does not focus specifically on sponsorship—helping behaviour is arguably only one of the roles of a sponsor, and many AA members who are not sponsors engage in helping behaviour.

The aim of this study was to explore how sponsors view their roles in helping sponsees. In the absence of scientific data relating to this aspect of sponsoring behaviour, the study reported here represents a preliminary primarily qualitative exploration of the opinions of a specifically recruited sample of sponsors about their roles with a view to developing more complex research questions for a subsequent study of this important

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AA activity. In addition, the characteristics of the sample of sponsors are described in terms of their affiliation to AA, past drinking and severity of dependence on alcohol.

METHODS

Inclusion criteria

To be included in the study, participants needed to be a sponsor or to have previously been a sponsor, to have 'worked' the programme of AA (have completed the 12 steps and regularly attend meetings) and to be sober.

Sampling method

A purposive sampling (Tronchim, 2006) method was used in keeping with the primarily qualitative approach adopted by the study. Purposive sampling targets a particular group of people (in this case AA sponsors) and is a useful method when the desired population for the study is rare or very difficult to locate and recruit for a study. According to the 2007 North American AA membership survey, 80% of attendees have a sponsor (Alcoholics Anonymous, 2008). However, there are no data available about the proportion of sponsors in AA (personal communication, Alcoholics Anonymous).

Recruitment

Sponsors were recruited from five 'open' AA meetings (i.e. meetings that are open to all attendees and not just those seeking recovery from alcoholism) in central London. Anticipating a 15–20% drop-out rate, we initially recruited 36 AA sponsors with the aim of achieving a sample of 30 sponsors. This number was decided upon following discussion with qualitative researchers in the addiction field who advised that sufficient data would be gathered from this number of participants to guide the research questions for the second phase of this study.

Data collection

In order to facilitate participation, the sponsors were offered flexibility in completing the research questionnaire: completing it by hand and returning it by post; completing by email; or by telephone interview. The questionnaire comprised two existing validated scales, as well as a number of questions specifically designed to elicit data pertinent to the aims of this study. The Alcoholics Anonymous Affiliation Scale (AAAS) was used to measure the degree of involvement in AA. Its utility in a sample of 927 alcohol treatment seekers and 674 untreated problem drinkers has previously been demonstrated (Humphreys *et al.*, 1998). The scale is short (nine items), covers a range of AA experiences and is internally consistent across diverse demographic groups, multiple health services settings, and treated and untreated populations. The AAAS has been widely used both as an interviewer-administered instrument and self-report questionnaire.

The Severity of Alcohol Dependence Questionnaire—Community version (SADQ-C) was administered as a retrospective measure of impaired control over drinking (Stockwell *et al.*, 1994). The SADQ-C was designed for community samples and it correlates almost perfectly ($r = 0.98$) with the SADQ. A score of <16 indicates mild dependence, 16–30 moderate and >30 severe dependence. The SADQ-C was slightly adapted for the purpose of this study to measure severity of alcohol dependence retrospectively by requesting the sponsors to answer the questions in relation to the heaviest period of their drinking career.

In another section of the questionnaire, the respondents were asked about what they see as their sponsorship roles. The question was kept simple and left open without probes; this approach that was used as the aim of the study was to gather preliminary data regarding sponsorship roles to help formulate more complex research questions for the next phase of the study (involving face-to-face interviews/focus groups with a sample of sponsors).

Data analysis

No specific hypothesis was tested in the study, as few data exist in the scientific literature regarding sponsorship. As such, a grounded theory approach (Glaser and Strauss, 1976) was used for collecting and handling data relating to sponsors' views of their role, i.e. a theory generating rather than hypothesis testing method was used.

As data were gathered by different means (i.e. self-completion of the questionnaire or telephone interview), they were initially collated into a standardized format. Responses were separated into statements and coded line-by-line so that emerging themes could be identified. All roles identified through this analysis were listed. Thereafter, overlapping themes were linked by identifying common nodes (points of connection) and were reported as super-ordinate roles. A triangulation method was applied to the thematic analysis: a colleague of the first author conducted an independent content analysis of the responses, and any points of disagreement were discussed. When disagreement persisted with regard to individual sponsors' responses, they were contacted again to clarify what they meant in the given response. Finally, a member validation method was used—the research report was sent to two selected sponsors and amendments were made based on their comments.

RESULTS

Sample characteristics

Thirty-eight sponsors were approached. Two did not meet the eligibility criteria (one was currently drinking and another was not regularly attending AA). Thirty-six sponsors who initially agreed to consider participation were sent the study's introduction pack. Eight sponsors failed to respond following two attempts to contact them via an invitation letter, email or telephone call. Thus, a total of 28 sponsors completed the questionnaire or interview (21 by email, 6 by post and 1 via telephone interview).

As this was primarily a qualitative study, random sampling was not used. We were cautious when interpreting descriptive and analytical statistics, as the sponsors included may not be a representative group. Twenty-four (86%) male and four (14%) female sponsors participated. The median age was 43 [interquartile range (IQR) 17, range 33–73]. Nineteen respondents were white British (68%), two (25%) were non-white British and seven white non-British (four Americans, two Irish and one South African). With regard to employment status, six

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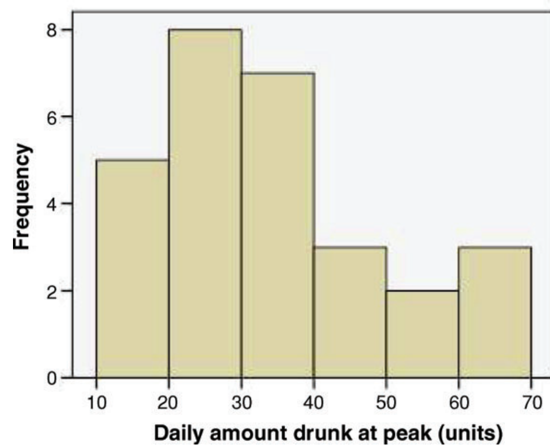

Fig. 1. The average daily consumption of alcohol (UK units) by sponsors at the peak of their drinking.

(21%) sponsors worked in a managerial capacity, nine (33%) were professionals, seven (25%) were self-employed and two (7%) worked in sales. Three sponsors (10%) were retired and only one was unemployed.

AA activity and sponsoring behaviour

The median length of AA attendance was 9.5 years (range 5–28). There was a wide range (0–17, IQR 3.75) in terms of the number of current sponsees but the median was 1. Eleven sponsors (39%) had no current sponsees whereas one sponsor had 17, more than twice as many as the next highest number.

The sponsors scored highly on the AAAS (median 8.75, range 5.5–8.75, maximum possible score is 9) indicating strong AA affiliation and activity. To put this in context, a previous study reported a mean AAAS score of 2.96 (SD 2.49) in a sample of treatment receiving problem drinkers and a score of only 0.43 (SD 1.4) in a community dwelling sample of problem drinkers (Humphreys *et al.*, 1998).

Past drinking behaviour

The median length of sobriety of the sample was 11 years (IQR 8.6, range 4.5–28) and the mean was 13.3 years (SD 6.6). The length of sobriety was highly correlated with the sponsor's length of AA attendance ($r = 0.81$, $P = 0.01$).

Alcohol consumption

Seven sponsors (25%) reported that they had been binge drinkers at the peak of their drinking, 10 (36%) had been daily drinkers and a further 10 (36%) reported both patterns at different times at the peak of their drinking. One sponsor did not answer this question. Figure 1 shows the average consumption of alcohol (UK units) per day at the peak of the sponsors' drinking (median 12, IQR 20, range 10–70; mean 31.6, SD 16.3). The median duration of heavy drinking was 12 years (IQR 14, range 3–27).

Severity of dependence

The median past severity of alcohol dependence score as measured by the SADQ-C was 26.5 (IQR 14, range 11–56) and the mean score was 27.4 (SD 1.7). Five sponsors (18%) had mild dependence, 14 (50%) had moderate and 9 (32%) had severe dependence. The sponsors' median scores for the SADQ-C subscales, which have a maximum possible score of 12, were as follows: physical withdrawal symptoms (4, IQR 4); relief drinking (4, IQR 3); alcohol consumption (5, IQR 3.75) and rapidity of reinstatement subscales (5, IQR 4), indicating mild to moderate severity in those domains. However, scores for affective withdrawal symptoms were higher (median 9, IQR 5).

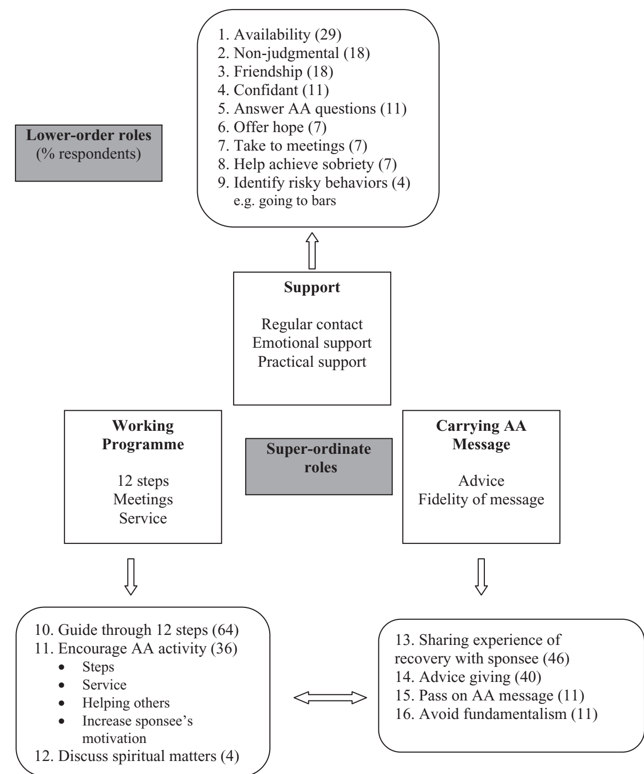

Fig. 2. Sponsoring roles identified by thematic analysis of sponsors' responses.

Sponsorship roles

Sixteen sponsorship roles were identified through the initial content analysis. These are listed in Figure 2, ranked by frequency of response. Data saturation occurred after sponsor 25, i.e. no new roles were identified during the analysis of the last three questionnaires. The degree of agreement between the two coders was good (kappa = 0.8). Three super-ordinate roles were created by categorizing the roles identified during the initial analysis into themes by linking nodes in common. These roles, working the programme of AA, support, and carrying the message of AA, will be discussed in turn.

Working the programme of AA

The most important role of a sponsor is to encourage their sponsee(s) to work the programme of AA, which comprises the following core activities.

Completing the 12 steps. The sponsors were of the view that the steps should be completed in the order they are written and should be applied to all aspects of life (not just alcohol-related ones) or, as it says in AA literature, 'in all our affairs'.

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> The most important thing is taking [sponsees] through the steps, not telling them how to do them but what the meaning behind them is. This involves reading [AA literature], discussing and understanding. (sponsor 12, male, 73 years old)

Regular attendance at AA meetings. The sponsors regarded encouraging their sponsees to attend meetings as one of their main roles. However, none commented specifically on how often they thought that their sponsees should attend meetings. The mean number of meetings the sponsors themselves had attended in the previous year was 121 (SD 66, range 20–300), an average of just over 2 per week.

Doing AA service. Doing service is voluntary but it is embedded in AA culture and is considered helpful both to the recovery of the individual member and to AA as a whole. Service positions include being involved in the running of a meeting (e.g. being a greeter, making tea or being the secretary) and/or being involved in the functioning of AA as an organization (e.g. manning the telephone at an AA call centre).

Support

The second most common super-ordinate role was support giving. The two main mechanisms for providing support were speaking regularly with the sponsee by telephone and in person, usually in the sponsor's home or in a café. The face-to-face meetings often occur in the sponsor's home if formal 'step work' is being undertaken or in a café/at an AA meeting if the sponsor and sponsee are meeting about other matters. The support offered by sponsors can be broken down into two broad types. The first is of an emotional nature, which is especially important in the sponsee's early days of recovery and during periods of difficult life events, such as a divorce.

> To offer empathy and support through difficult times, helping the person to know that they are not alone. (sponsor 16, male, 34 years old)

Secondly, practical support is provided around AA-related issues. This ties in with the previous super-ordinate role of working the programme of AA. A number of sponsors recognized that sponsees may have issues that were not directly related to AA, such as co-morbid mental health problems, and indicated that they would encourage their sponsee to seek help from other appropriate sources outside of AA, such as a doctor or a counsellor, if they had done so themselves.

> I think it is important to note that a skilful sponsor will also know when to recognize that a sponsee has problems outside their own sphere of experience and encourage the sponsee to get help from another source if required. This may be another AA member or help outside of AA if required. (sponsor 21, male, 39 years old)

Another theme to emerge from the data was that AA meetings were not an appropriate environment to share problems of a particularly personal nature, for example sexual problems. A benefit of sponsorship is that such issues can be discussed in a more confidential way. This is in keeping with the AA literature, which suggests that sharing in a meeting should be kept general and should relate to alcoholism and/or recovery.

The need to develop their sponsee's trust was an important role identified by the sponsors. This connected with the lower-order theme of being non-judgmental. The fact that the sponsor is not a professional person and is a recovering alcoholic increases identification, and a sense that the sponsor has 'been there' too.

> Be accepting—tell the guy he's not alone, try to reassure him that he is not more than an averagely 'bad' person, i.e. share my experience. Tell him I've done that too. (sponsor 20, male, 42 years old)

Finally, a number of participants recognized that the role of sponsorship changed over time as the sponsee developed a longer period of sobriety, often growing into a genuine friendship. Five sponsors identified friendship as a primary role.

Carrying the message of AA

Arguably one of the most interesting, if contentious, themes to emerge from the analysis related to the 'passing on' of the message of AA from the sponsor to the sponsee. According to the AA literature, this involves sponsors sharing their experience of alcoholism and recovery with their sponsees, but doing so within the framework of AA principles rather than adopting a personal viewpoint. The concept of propagating AA for the benefit of other alcoholics is embedded in the final step of the programme, step 12, i.e. having completed and benefited from doing the 12 steps themselves, an AA member should carry the message of the fellowship to other alcoholics and AA newcomers through service. Although not a requisite of the final step, the AA member may, in turn, become a sponsor.

Carrying the message included the lower-order role of advice giving. As might be expected, a sponsor relating their own experience of recovery and doing the programme of AA will often venture into the territory of giving advice to a sponsee, or a sponsee will seek their sponsor's opinion on an issue. The role of advice giving was the only theme for which differing, and sometimes contradictory, responses were provided by sponsors. The various viewpoints taken by sponsors in the domain of advice giving are described in Table 1.

A number of sponsors were of the view that the message of AA should be delivered gently to sponsees. It seems that within the various subcultures that exist in AA, some members can be quite harsh with newcomers and some sponsors are perceived as 'controlling' by their sponsees. One member admitted to having been a controlling sponsor initially but now recognized that this was the wrong approach.

> When I came in [to AA], I was very much a 'step Nazi'. I told everyone exactly what to do and fired them [i.e. stopped sponsoring them] if they didn't do what I said. (sponsor 14, male, 70 years old)

DISCUSSION

Representativeness of the sample

Despite the use of a non-random sampling method, the sponsors were representative of AA members in general in terms of age and ethnicity. However, there were fewer women in this study than in AA as a whole (14% versus 35%) and the sponsors were from higher socio-economic backgrounds (as determined by occupation) than those in the 2007 AA membership survey. Whether the sample is representative of AA sponsors as a whole is unknown as there are no previous studies describing the characteristics of sponsors. Caution is needed in interpreting these comparative data as the AA membership survey covers

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members in North America only and our sample comprised UK sponsors.

The number of sponsees per sponsor

The number of sponsors who had active sponsees was lower than we expected. The average number was one per sponsor but there was a wide range (0–17). Despite the fact that all the respondents had been a sponsor in the past, 11 had no current sponsee (this was, in fact, the modal number). No data exist about the number of sponsors in AA (personal communication, Alcoholics Anonymous), but the AA membership survey of 2007 indicated that 80% of members had a sponsor. It is probable though that there are fewer sponsors than sponsees. In addition, it is likely that sponsees change sponsors over time, which may account for the low number of currently active sponsors in this sample.

Severity of alcohol dependence

The average severity of past alcohol dependence of the sample was less than we expected. Only 32% of the sponsors had been severely alcohol dependent. This is arguably lower than National Health Service alcohol treatment samples in the UK. For example, in a study by Harris *et al*. (2003), 63% of patients undergoing an inpatient alcohol detoxification, who had also attended at least one AA meeting previously, were severely alcohol dependent according to their SADQ scores. There are a number of potential explanations for this discrepancy. First, we did not ask whether the sponsors had ever received treatment for alcoholism and it is unfair to compare a treatment sample, especially an inpatient detoxification one, with a community sample. In addition to this, there was heterogeneity within the sample with some sponsors scoring highly on the SADQ-C (three scored >50, indicating very severe dependence). Second, it might be that individuals with more social capital (the sponsors were from high socio-economic backgrounds) have shorter drinking careers (they seek treatment earlier than their counterparts from lower socio-economic backgrounds) and are, thus, less severely alcohol dependent and have a greater likelihood of becoming sponsors if they join AA.

High affective withdrawal symptoms scores

Another interesting finding relates to the sponsors' subscale scores. The sponsors obtained high scores on the SADQ-C affective withdrawal symptoms' subscale but relatively low scores on the other domains. The reason for this is unclear. However, it was the first researcher's impression from attending meetings that AA members' affective responses to difficulties, be they day-to-day hassles (e.g. commuting to work) or interpersonal problems, were often intense. It is possible that AA members have unusually strong affective responses to life events, and this may be one explanation for the need for ongoing support through meetings. King *et al*. (2003) found this to be the case for female, but not male, non-AA-attending alcoholics.

Sponsorship roles

The lower-order sponsorship roles identified comprised a combination of functions that are unique to 12-step fellowships, such as encouraging sponsees to do the steps, and others that are common to professional interventions. For example, concepts such as being non-judgmental and the instillation of hope are well established in the general psychotherapy literature, and increasing motivation to achieve/maintain sobriety and identifying behaviours that put sobriety at risk are ubiquitous in the addiction field.

Table 1. Various viewpoints of sponsors regarding advice giving to sponsees

Viewpoint	Respondents (%)	Comment
Guidance rather than advice[a]	37	Gently guide sponsee within the framework of AA principles rather than telling them what to do
Experience rather than opinions[a]	25	Restricting discussions to sponsor's own experience of alcoholism/recovery means that they relate facts rather than opinions to their sponsees. This prevents sponsors from giving potentially harmful advice to their sponsees
Limited advice	11	Advice only given when sponsee asks for it
Advice on life issues[b]	22	Giving advice to sponsees about life issues rather than just sharing their experience of recovery/AA-related matters

[a]In keeping with AA principles; [b]Not keeping with AA principles.

There was considerable overlap between the various themes identified from the sponsors' responses. However, it was possible to categorize the roles into three superordinate roles—working the programme of AA, support giving, and carrying the message of AA. These broadly matched the meta-themes described in the AA pamphlet, Questions and Answers on Sponsorship, viz. achieving sobriety through working the programme, answering AA-related questions outside of meetings and friendship. Our sponsors placed less emphasis on the role of helping sponsees achieve sobriety with only one sponsor identifying this as a specific role. It could be that attempting to achieve sobriety is 'given' in AA and the sponsors did not feel the need to mention this as a specific role. The sponsors who did highlight sobriety as a role focused on maintenance (e.g. advising sponsees to avoid 'wet places') rather than achieving sobriety. Only one sponsor directly mentioned Questions and Answers on Sponsorship, which is interesting as this is the main AA document dealing with the issue of sponsorship.

Fidelity of the AA message and the role of advice giving

The sponsors broadly agreed on the first two super-ordinate roles, i.e. working the programme and support giving. The theme of carrying the message of AA was the only one for which differing responses were given by the sponsors. However, most sponsors agreed that carrying the message of recovery should be in keeping with AA principles.

The issue of fidelity of AA principles is directly connected to the role of advice giving (Table 1). The sponsors in this study can be divided into three groups based on their attitude to advice giving: those who do not give advice at all; those who advise in certain circumstances; and those who give advice freely. Sponsors who do not give advice directly use the mechanism

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of describing or sharing their personal experience of recovery as a way of guiding sponsees rather than telling them what to do. This approach is most in keeping with AA principles.

AA guidance may be applied in a straightforward fashion when it relates to sobriety. The message for sponsees is clear: do not drink, go to meetings and work the programme of AA. However, a number of sponsors recognized that their sponsees often needed help in areas of their lives other than in maintaining sobriety. In these circumstances, some sponsors were prepared to advise as long as the advice was either sought by their sponsee or it was given within the principles of AA. This seems to be a reasonable approach and not contradictory to AA guidance.

A small subset of sponsors admitted to freely giving advice to sponsees. This is not in keeping with the principles of AA and is not without risk. AA states clearly in its 12 traditions that it is not a professional organization and does not have views 'on outside matters' (i.e. issues not directly related to alcoholism/recovery) (Alcoholics Anonymous, 1976). In addition to its protective properties, not giving direct advice potentially increases the motivation of sponsees to remain sober and engage in the programme of AA. A comparison may be made with motivational interviewing, in which the professional delivering the therapy develops discrepancy between the drinker's life intentions and their use of alcohol, rather than by directly telling them what to do.

Controlling behaviour by sponsors

The matter of advice giving may relate to the extent to which some sponsors wish to impose their will on their sponsees. A number of sponsors referred to what could be loosely described as their controlling behaviour, often recognizing that it is unhelpful. Sponsor 14 even referred to himself as a 'step Nazi'. The term 'controlling behaviour' is not well described in the psychiatric literature and is, perhaps, a lay term. However, AA literature refers to this type of behaviour as 'self-will run riot', which it believes to be at the core of 'the disease' of alcoholism.

AA has devised an elegant antidote to issues relating to self-will—the steps. It is interesting that only step 1 mentions alcohol. All the others are about dealing with life, as well as managing the non-drinking aspects of 'alcoholism' and psycho-emotional problems ('character defects'). The concept of spirituality or a 'higher power' is embedded within the steps. The related idea of 'letting go' may be one of AA's greatest techniques in dealing with control issues. Recent developments in psychology have mirrored this. Kabat-Zinn and colleagues have successfully married cognitive-behavioural therapy (CBT) and mindfulness meditation (a type of Buddhist meditation) in treating depression, anxiety and other psychiatric disorders (Kabat-Zinn *et al*., 1992; Teasdale *et al*., 2000). Unlike traditional cognitive therapy, mindfulness-based CBT uses techniques, learned through meditation, to avoid engaging (i.e. 'letting go') in negative thoughts and other cognitive errors rather than trying to challenge them, the process of which can actually cause more distress to some clients.

Implications for services

Given that the majority of AA members have a sponsor, it is important that professionals working in the addiction field have an appreciation of the function of sponsors. The 'buddy system' has been used in the treatment of alcoholics for over 40 years (Androes and Whitehead, 1966), and its efficacy has been shown in the treatment of smokers (West *et al*., 1998). However, it is important to distinguish a 'buddy' from a sponsor. The former involves a professional, linking one of their clients with an AA member for support during a period of introduction to the fellowship, whereas to obtain a sponsor an AA member needs to approach another member directly at a meeting and ask them to be their sponsor. There may be subtle differences (e.g. in terms of motivation) between the two. In addition, a sponsor is arguably more likely to be strongly affiliated to AA than a buddy, who may not necessarily be a sponsor.

Limitations

The study has two main limitations. First, the non-random sampling strategy may have resulted in unrepresentative sample of sponsors. Exacerbating this potential problem with generalizability, the lead author's gender (male) and social class (professional) may have accounted, in part, for the under-representation of women and the over-representation of sponsors from a professional background.

Second, the SADQ-C was used as a retrospective measure. The median length of sobriety of the sponsors was 11 years giving rise to the possibility that recall bias may have influenced the SADQ-C scores—this may account for the relative difference in the subscale scores, with affective withdrawal symptoms being remembered more than physical symptoms. In addition, the first limitation may have led to the recruitment of sponsors who were less severely alcohol dependent.

Future directions

This study represents a pilot study used to formulate further research questions about sponsorship roles. In depth face-to-face interviews and focus groups will be conducted during the second phase of the study, which will use this sample of sponsors (plus additional sponsors recruited through a snowballing technique). The data generated by this study will be used to develop the probes that will be used during the interviews and focus groups so that a more complex understanding of sponsorship roles and behaviour can be achieved.

There are a number of issues that will be addressed in the subsequent study. First, we plan to explore how members learn how to sponsor. Second, the issue of so-called 'controlling behaviour' within AA merits further examination. Such behaviour may be linked to sponsorship style—some sponsors adopt a more authoritarian approach ('step Nazi') whilst others have a more relaxed style. Sponsees may respond in a differential fashion to sponsorship style. It is also possible that the same sponsee benefits from a different sponsorship style at different points in recovery, for example early versus later sobriety. To what extent and for what reasons do AA members change their sponsors over time, and does such change reflect a perceived need to tailor sponsorship style will be addressed in the subsequent study.

Finally, each of the sponsorship roles will be examined in greater detail with a particular exploration of the divergent views regarding advice giving that were reported in this study, as well as looking at other roles that were not emphasized (e.g. the need for members to have a 'home group' meeting).

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We were fortunate to be able to develop trustful relations with the sponsors recruited in this study. However, AA can sometimes be wary of professional involvement so we would advise others to consider conducting similar research to proceed carefully. We found attending 'open' meetings useful in this regard. Details of local 'open' meetings can be determined by telephoning the AA National Helpline (0845-769-7555 in the UK).

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