Dialogic sharing of lived experience in different self-help/ mutual aid groups

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Abstract: This article is based on a recent re-visiting of published data related to the 'sharing' processes between members of two strikingly different types of self-help/ mutual aid groups run by and for peers who share the same situation. Data from taped meetings and observations with stress-coping Carers' groups is compared with observational data from an identity changing Alcoholics Anonymous group and discussed in relation to Bohm's (1987, 1996/2014) concept of dialogue as an alternative communication process that facilitates inquiry and the accumulation of knowledge. Groups were at extreme opposites in terms of their expected goals, strategies of help, and organisational characteristics yet unexpected similarities were found in relation to the authority of sharing lived experience which was in both cases respectful, supportive and non-judgemental. Group members did not openly disagree with each other, but expressed a difference in opinion by the juxtaposing of a personal story which suggested an alternative way of doing or viewing things. The paper contributes to our knowledge of how sharing lived experience can be a key similarity between strikingly different self-help/mutual aid groups. The paper also contributes to our understanding of the usefulness of dialogue as an explanatory framework for viewing self-help/mutual aid groups as collective learning enterprises.

Keywords: self-help/mutual aid groups; lived experience; dialogue; collective learning; sharing stories; groupwork; group work

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Introduction

The sharing of personal lived experience is a defining characteristic and the key communication process in self-help/mutual aid groups. Self-help/mutual aid groups are defined as: intentionally convened self-governing collectives of voluntarily participating peers with a purpose of resolving a common focal issue whose primary source of knowledge and authority is direct lived experience; predominantly occurring in the non-profit sector of civil society; formed to change their member's situation, they are neither social clubs nor some form of charity organised to give aid to others (Munn-Giddings et al, 2016). These groups are known to have developed in relation to every conceivable health and many stigmatised social situations (Borkman, 1999).

'Sharing' is a term often used in relation to material goods, but the term has also become widely used in relation to the distinctive conversation about their lived experience peers have with those who have the same or similar health or social issue (Wootton, 2005). Individuals can share two types of information about themselves: provide information about oneself that relate to past events which relate to the individual's problem or provide information about oneself that is analogous to that provided by a peer; the second form of information is helpful to the other as it validates that the problems are common and not idiosyncratic (Wootton, 2005, p. 334). Sharing similarities of lived experience is also critical for peers to identify with each other, a step beyond just being compassionate toward the other.

Bohm's Dialogue as specialised communication

Researching Alcoholics Anonymous in 1999, Zohar and Borkman considered Bohm's (1987, 1996) notion of dialogue as an underlying theoretical concept that described the characteristics of sharing that apply to 12 step mutual aid groups. The physicist David Bohm became dissatisfied with the competitive and argumentative-based process of scientific inquiry and developed the concept of dialogue as an alternative communication process that he thought facilitated inquiry and the accumulation of knowledge. Dialogue in Bohm's terms (1996/2014) and as it is used in this paper, is a specialised form of communication that is a sustained collective inquiry in a group setting into the assumptions,

certainties, and processes that structure everyday experience. The purpose of dialogue is to rise above any individual understanding, to build collective understandings and systems of meaning and to make the implicit explicit. He was concerned that the multiple troubles in the world—war, starvation, disease, etc., could not be solved without dialogue (Bohm, 1996/2014, p. 55). Dialogue is a collective learning process which focuses on sharing ideas for reflection and inquiry, hearing and understanding multiple and different perspectives, and discovering common meaning and shared visions. Dialogue, as defined here, is significantly different from conventional conversation which is often argumentative, persuasive, or involves debate.

Bohm's goal was the elimination of competition in discourse so that people could literally work together and develop something new together (i.e., collective knowledge). He contrasted dialogue with discussion or debate which focuses on pulling apart or winning. 'In dialogue nobody is trying to win. Everybody wins if anybody wins.' (Bohm 1996/2014, p. 7). Dialogue is both a distinctive *process* as a form of conversation and a set of *outcomes* of shared meanings and new collective learnings. He used the image of 'stream of shared meaning' building on the original Greek word dialogos to describe the process and the outcome. Dialogue is thus characterised as a form of conversation that suspends judgment; promotes active listening; surfaces and identifies tacit, core assumptions; and promotes active inquiry and reflection.

Certain preconditions are necessary for such a dialogic process to occur:

- Equal status of participants (Bohm, 1996/2014, p. 49)

  There is no place in the dialogue for the principle of authority and hierarchy. (Ibid., p. 49)

- Free space' (Bohm 1996/2014, p. 3)

  People are able freely to listen to each other, without prejudice, and without trying to influence each other. (Ibid.)

  Each has to be interested primarily in truth and coherence, so that he is ready to drop his old ideas and intentions and be ready to go on to something different, when this is called for.' (Ibid.)

Bohm was pessimistic that conditions for dialogue to occur would happen often; in effect he regarded dialogue as an ideal type of communication that could occur only rarely under special circumstances. More likely was 'limited dialogue' which involved the same communication processes except the group had a purpose or goal in mind; with limited dialogue 'It would be best to accept the principle of letting it be open; when you limit it you are accepting assumptions of the basis of which you limit it. If people aren't ready to be completely open in communication they should do what they can.' (Bohm, 1996/2014, p. 49) Limited dialogue thus is not open ended in considering all topics. Self-help/mutual aid groups that are organised around a single common issue they are interested in resolving potentially fit Bohm's situation of limited dialogue.

Objectives of this research

Borkman with colleagues (2000) researched sharing conversation in four open AA meetings; they found a stream of shared meanings and non-judgmental and active listening in all four meetings as well as other characteristics of Bohm's (1996/2014) dialogue. They hypothesised that the AA style of 'no cross-talk' was necessary to develop dialogue and would not be found in grassroots mutual aid groups that used ordinary discussion.

The authors, cross-national colleagues, who have separately and collaboratively researched self-help/mutual aid group processes over many years, in a recent re-visiting of their published data noticed some similarities in the sharing of two strikingly different kinds of mutual aid groups: stress-coping Carers' groups (Munn-Giddings, 2003; Munn-Giddings & McVicar, 2007) and identity changing Alcoholics Anonymous groups (Borkman et al, 2000). The results of that re-examination are presented here. The objectives of this paper are to:

1. Compare and describe the sharing in meetings of two self-help/mutual aid groups—Carers' groups and Alcoholics Anonymous groups in styles of conversations and characteristics associated with Bohm's (1996/2014) dialogic process; and
2. Assess how well Bohm's (1996/2014) concept of the dialogic process

applies in theory to self-help/mutual aid groups.

The paper is organised as follows. First, we review the research literature on sharing experience in self-help/mutual aid groups. Second, we introduce our separate researches and the methodology we used. Third, we present selected findings—a snapshot of findings of the multiple meetings with a portrait of a Carers' group and a portrait of an AA group. Fourth, we summarise our findings showing large differences in style of conversation in meetings but many similarities in the characteristics of sharing such as nonjudgmental quality and lack of direct advice giving. Finally, we summarise our findings in relation to Bohm's concept of dialogue (1996/2014) and suggest ideas for future research.

The paper will contribute to our knowledge of how 'sharing lived experience' can be a key similarity between strikingly different mutual aid groups. The paper will also contribute to our understanding of the usefulness of dialogue as an explanatory framework for viewing these groups as collective learning enterprises.

Literature review of research on sharing experience in self-help/mutual aid group meetings

Early academic research on self-help/mutual aid groups (Toch,1965; Traunstein & Steinman, 1973) identified sharing lived experience as important to the groups, but current researchers regard it as a defining characteristic of such groups (Munn-Giddings et al, 2016; Seebohm et al, 2013).

The empirical research literature on sharing experience in self-help/mutual aid group meetings can be generally classified into two approaches: first, the 'factor' approach originally developed by psychologists inspired by group therapy research; second, the 'narrative' or storytelling approach originally developed by linguists and sociologists studying 12 step addiction groups using specialised methodologies. Both the factor and the narrative approach have subcategories of research on (a) an individual or person level of analysis and (b) a group or collective level of analysis.

The factor approach identifies individual therapeutic factors that

measure tasks such as seeking information, or concomitants of sharing such as hope, that are likely to be statistically correlated with individual satisfaction or benefits of participating in the group. Yalom's (1970) list of curative factors derived from the study of professionally-led therapy groups is the theoretical basis of this early work. A wide variety of groups have been studied using the factor approach such as groups for those with mental health problems, parents grieving loss of a child, or breast cancer. Kurtz (1997, pp. 18-20) summarised the results showing that five factors are most frequently found to be helpful to participants: group cohesiveness, hope, knowing you are not alone with the problem, imparting information, and helping others.

Several specialised methodologies have been developed that went beyond Yalom's (1970) therapeutic factors that were based on researcher's knowledge of the distinctive features of self-help/mutual aid groups. Roberts and her colleagues (1991, 1999) developed collaborative projects (Rappaport et al, 1985) with the Grow organization in Illinois, a self-help/mutual aid group for people with mental health issues.

A mutual help observation system was created to record the flow of interaction in GROW meetings (see Roberts et al, 1991) in five categories of Behavioural Interaction Codes: Helping behavior, Questioning, Task orientation, Help-seeking and Disclosure, and Affective response. The observation system was used by 10 trained observers in 527 meetings of 13 GROW groups and psychometrically evaluated as adequate (see Roberts et al, 1991). A group level analysis of Grow's extensive data on the 13 groups was re-analysed within a different theoretical framework (Luke, Rappaport, & Seidman, 1991) ; four group phenotypes (behavioral patterns of groups that were related to varying individual outcomes) were found that are ordered here from best to least personal improvement for members: personal disclosure (N=3 groups; high self-disclosure); advising (N=4; high in guiding & 12 step contacts); small talk (N=3; high in small talk & 12 step contacts); and impersonal (N=3; high in information giving & also newest groups). This research confirmed what members say anecdotally that meetings of the same type of mutual aid group vary in their help giving characteristics.

An earlier group level of analysis was Rudolph Moos (1986) who, using a social ecological theory of the group's social climate that affect participants' reactions to the situation, developed standardised social climate scales. Kurtz (1997, pp. 41-43) reviewed studies using this

approach and found mutual aid groups to be high on cohesion and leader support; highly task oriented and orderly unlike psychotherapy groups; and typically low on anger and aggression.

More recently, other specialised factor approaches have been developed based on extensive knowledge of self-help/mutual aid using a social exchange theory in the US (see Brown et al, 2014) or in UK using a specialised national mental well-being checklist (see Seebohm et al, 2013).

The factor approach has ignored storytelling or narrative which is the major focus of the second approach. The narrative approach '… takes as its object of investigation the story itself' (Riessman, 1993, p. 1). Early narrative studies were mainly conducted on the 12 step/12 tradition group Alcoholics Anonymous using specialised methodologies such as narrative analysis (Riessman, 1993), linguistic analysis (Jensen, 2000) or discourse analysis or conversation analysis (O'Halloran, 2008; Wooffitt, 2005). Discourse and conversation analysis can be highly technical having developed elaborate notational systems such as the Jefferson system to transcribe verbatim and (in real time) lengths of pauses, all utterances, talk overs (where two people are talking at once), and the like (Wooffitt, 2005). The narrative analysis of sharing in AA meetings has a moderately large empirical literature --see Arminen (1998a, 1998b), Cain (1991), Jensen (2000), O'Halloran (2008), and Pollner & Stein (1996). The researchers analyse the structure of interaction (such as norms about turn taking), styles of interaction, characteristics of stories, and the role of humor. They cover topics such as how storytelling is integral to alcoholics' identification with each other; how storytelling is involved in the change of personal identity, and how it contributes to mutual aid.

In the narrative approach the individual and group levels of analysis are so interconnected that they need to be considered together (Noorani, Karlsson, and Borkman, 2018). On the group level of analysis is the 'meaning perspective' (Borkman, 1999) which is the group's collectively developed cognitive framework or belief system. The belief system includes how the group defines and deconstructs the focal issue and its causes; strategies that work and do not work to solve/resolve the issue; and the impact on and changes in identity. Other researchers use terms such as 'ideologies' (Antze, 1976), 'worldview' (Kennedy & Humphreys, 1994) or 'normative community narrative' (Rappaport,

1993, 2000) for similar ideas.

On the individual level of analysis a number of researchers (Cain, 1991; O'Halloran, 2008; Jensen, 2000; Pollner & Stein, 1996) have explored how telling one's story as an AA member contributes to the formation of a new identity within the arc of the general AA 'meaning perspective': As a newcomer becomes a committed member, stops drinking alcohol, and changes other behaviors and attitudes, his/her story and identity evolve to become an individualised version of AA's 'meaning perspective.'

Jensen's work (2000) is noteworthy because of his special interest in how the storytelling can be more transformative than writing personal essays or autobiographies for print, because of interaction with an audience. Jensen's (2000) analysis used the literary-rhetorical approach to narrative of the Russian M.M. Bakhtin. Bakhtin was interested in how the audience affects the speaker's story; Bakhtin (Jensen 2000, p.75) developed the concept of the 'sideward glance' which refers to a speaker's expectations of how the audience will interpret and criticise what they say, which in turns affects what and how honest and open the speaker is willing to be. Jensen (2000) argues that in AA speakers can move beyond the sideward glance to be more honest and open in telling his/her personal story, because it is told to listeners like themselves who only listen and are not judgmental.

The second approach of narrative analysis or storytelling in meetings was relevant to our research; we focused on the stories or fragments of stories based on the individual's lived experience that constituted the sharing in meetings.

Methods

As previously mentioned, the first author (Borkman et al, 2000; Zohar & Borkman, 1999) and a research associate observed four open meetings of four different groups of Alcoholics Anonymous in the US. The second author (Munn-Giddings, 2003; Munn-Giddings & McVicar, 2007) studied two Carers' groups in the UK through participant observation and taping two sessions in each group. Most members in both groups were spouse caretakers of dementia sufferers or family members with disabilities.

Both the Carers' groups and the AA groups fit the definition of self-help/mutual aid group and they were also similar in being mature groups that had operated for over five years. At least two major differences separated the AA & Carers' groups-- differences posited by analysts as significant in affecting the nature of the interaction within the groups and organisational stability and longevity. First, structurally and organisationally the two were significantly different. AA is more than 80 years old, has an international organisation, a well-established and time-tested program of personal change (the 12 steps) and structure of autonomous but interdependent local groups (the 12 traditions) (Denzin, 1993; Makela et al, 1996). In contrast, the Carers' groups were relatively young, local, and unaffiliated. Powell (1987) and others (Archibald, 2007) argue that local unaffiliated groups are less stable, with weaker leadership and support structures than the local groups of national self-help organisations. Second, comparing Carers' with members of Alcoholics Anonymous is contrasting people with very different kinds of problems. Carers are categorised by researchers (Levy, 1976; Wollert, Levy & Knight, 1982, p. 214) as being stress coping groups while AA is viewed as a behaviour control group, with large differences in goals and in help-giving strategies used by the two kinds of groups.

To summarise: the Carers' groups and the AA groups are significantly different structurally and organisationally; and the groups are at extreme opposites of self-help/mutual aid groups in terms of expected differences in goals, strategies of help, and accompanying organisational characteristics. Having groups that are extensively different such as the Carers' and AA to compare may be an advantage in order to test the hypothesis that it is the no cross-talk rule in AA meetings that specifically creates the conditions for dialogue. Further, extensively different groups illuminate the universal features present in different types of self-help/mutual aid groups. Similarities in sharing characteristics despite stylistic differences may show that similar relationships are developed by self-help/mutual aid groups within different organisational and group structures, goals and help-giving strategies. The similarities you find in sharing of experience may be generic to peer-directed self-help/mutual aid.

As described above, the authors independently had observed multiple self-help/mutual aid group meetings. In both cases the groups were

asked for permission to observe following the ethical requirements of the human subjects boards at the respective universities. The Carers' group meetings were tape recorded and transcribed (2 meetings of each group). The primary unit of analysis was topics of conversation. The data are fine-grained with a written record of each person's concrete and complete utterances of talk in sequence.

With the AA groups, two observers were used to add reliability to the observations since no recordings or notes could be taken in the meeting; one was the author, a sociologist researcher, the other a local AA member who was also a master's level psychiatric nurse. See Borkman et al. (2000) for further details of how permission to observe meetings was obtained and observations were recorded and finalised. While the resulting data of the AA meetings are not as fine grained nor detailed as those of the Carers' group meetings, given the kind of analysis being made we do not think the difference in detail will affect the results.

To compare the data sets the authors looked at the results of the observational data relating to AA meetings presented in Borkman et al, (2000) alongside data presented by Munn-Giddings, (2003, pp.193-223). The latter study contained extended excerpts from taped grassroots group meetings as well as observational data. Data analysis of the grassroots groups meeting followed the analytic process adopted by Borkman et al, (2000): firstly data was examined for content (theme and sub-theme of the conversation) and then by sequence (how was the topic introduced, who discussed what and when, how did (or didn't) the 'leader' or others attempt to influence inclusion. The two sets of data were then compared to identify similarities and differences in the group processes. The data re-analysed for the purpose of this article are already in the public domain (Borkman, 1999; Munn-Giddings, 2003 and Borkman and Munn-Giddings, 2008) and did not therefore require additional ethical approval.

A meeting of the Carers' groups and the AA groups will be briefly described to provide a context for the analysis; a composite portrait of a meeting has been constructed that covers the commonalities of each type of group. All of the names (both individuals and groups) are pseudonyms and no detailed particulars about the meetings are given in order to preserve their anonymity.

Portrait of a carers' group meeting in Southeast England

Group 1 met for two hours on an afternoon in the middle of the week. The 'typical' meeting was held in the lounge of a residential home. The eight people included six regular members (five women and one man) plus a new member – a man – and the researcher. Chairs were arranged in a circle around a coffee table in the large room.

There was a warm and informal exchange regarding people's circumstances, the health of the person they cared for and others that members knew in common. The meeting was opened by the Chair who started the meeting by displaying a picture that one member had painted and was donating to a local hospital ward. Several people joined in the discussion congratulating the painter. The new member Nigel was welcomed. The Chair then instigated a general discussion including the finances of the group and the group's plans for a stall in the summer fete.

Forty minutes after the meeting had started the Chair specifically asked: 'Does anybody have any particular problems or anything?' One woman recounted a story about her difficulty in clarifying her financial entitlement following her husband's assessment for residential care. Her situation was discussed; a suggestion was made to write, not telephone the organisations, to obtain the information she needed and the emotional impact of her situation was acknowledged. Other carers sympathised and gave their own examples of similar situations. After some time the Chair directed a question to a male carer: 'And how is your wife, Eric?' Eric described problems he was having with the equipment for his wife as follows:

Eric: So I have got a hoist but no one has come up with a way of telling me how I can put the hoist on. And get the clothes down, onto the toilet, wash her whilst she has the hoist on and get the clothes back on. It is impossible.
Dave: Is it manual or an electric one?
Eric: Electric—you can push it but it is really just for transfer
Dave: A ceiling one?
Eric: No, it is not a ceiling one
Dave: You have a chair that she can go into and then over the toilet?
Eric: Well, the slit in the dress that is all right in your own home but when you are out…that's the trouble.

Mary: How about an oval slit? Like a pinafore?

Eric: Velcro fastenings have been suggested.

Dave: I could tell you what we used to do. You get them on the hoist—get them out of the wheelchair on to the hoist—pull the wheelchair away while they are hanging there unfortunately and put the other chair in and just lift the skirt—it is better if you use one big flared skirt. And then there was a switch to bring them down. We could do it in about 24 minutes in the end. You get used to it.

Mary: How does Sarah feel about it—does she feel safe?

Eric: She doesn't seem to mind. At times there are problems.

At a certain point in this conversation the Chair specifically asked the new member Nigel how he was coping. Nigel answered in relation to his wife rather than himself, but moved it into an area where he expressed his concern about controlling his temper when he became frustrated about looking after her. All joined in by suggesting their own strategies for controlling temper. Much sympathy was expressed and stories swapped about the 'emotional exhaustion caused through long term caring'. The issue of respite care was raised and the guilt reactions some carers felt in using it. Two members offered their telephone numbers to the new member. The Chair drew the meeting to a close.

The meeting was generally informal with opportunities for everyone to contribute. However, the focus of the meeting revolved around the situation of just two members in particular. The Chair's role was not only to conduct the business of the group but she raised and explored issues while others responded to her direct questioning. Her direction ensured the exchange of experiences, information and suggestions among members.

Portrait of an open discussion meeting of Alcoholics Anonymous in a Maryland suburb

Twenty people including the two observers meet in a church basement on a Saturday night about 8: 20 pm for the weekly meeting of the 'Happy, Joyous, and Free' local group. Members, who obviously know each other, drink coffee and chat before the meeting begins at 8:30 pm. The hour long meeting follows a definite structure typical of most AA meetings with a voluntary and rotating Chairperson opening with a ritualised

beginning, a midpoint break for 'business' oriented announcements, taking monetary donations, and celebrating lengths of sobriety; and a ritualised closing (see Makela et al, 1996; Denzin, 1993).

Eight of the 20 attendees are female and six are African-Americans with the rest being white. The Chair Anna formally opens the meeting with the reading of the AA preamble and introduces the speaker for the evening who introduces herself as 'My name is Mora, I'm an alcoholic.' She gave an account of how she started drinking and her recent struggle with alcohol over the last 15 years, which was characterised by many attempts to stop drinking, attending AA meetings for short periods of time, and relapses or returns to drinking. When she would stop attending meetings, stop seeing her AA friends, she would relapse. Hopefully she can stay sober this time. After Mora spoke for 15 minutes she concluded by announcing that the topic was relapse.

Two women immediately responded by raising their hands. Mora called on Rene first and then Jan. Rene spoke for 7 minutes and began by saying 'My name is Rene; I am an alcoholic.' Rene told how she had started drinking, had started going to AA when she was 30 years old and how she relapsed when she had been sober for a year. She talked of subsequent relapses, DUI arrests, her divorce, and how she had had trouble identifying with AA members and thinking that she was an alcoholic. She thought she could control her drinking and stop when she wanted. But she kept relapsing. Now she has been sober for six months, goes to AA meetings every day, has a sponsor, a service position making coffee at another meeting and is following suggestions. She ended by saying 'thanks for listening'.

Jan spoke next beginning with the ritualistic 'My name is Jan and I am an alcoholic' which serves to establish her credentials as knowledgeable about alcohol. She gave a similar concrete factual story of her experience with relapse, of attending AA but not really participating in it or following suggestions and relapsing again. She concluded her 8 minute story by talking about how long she has been sober this time, what parts of the AA program she is using and how hopeful she feels that she will not have to relapse again.

After a break where cross-talk permitted during the business of the meeting is discussed, Anna turns the meeting back to Mora who asks for volunteers to speak.

Bob, a 45 year old white male, raised his hand to speak. Bob said he

had been sober since he got to AA five years ago and had not found it necessary to take a drink. Relapse is not inevitable or necessary he said. Bob briefly recounted the history of his drinking and its consequences over 15 years, his giving up the thinking that he could control his drinking when he got to AA and how he used his Higher Power (being an agnostic his Higher Power was the wisdom of the AA group), to help him stay sober as well as the 12 steps, his sponsor, friends and the other tools of AA especially service positions. He ends with a popular slogan: To keep it you have to give it away.

The speaker Mora resumes calling on volunteers each of whom share from one to eight minutes long about their experiences of relapsing or not. and how the meetings and various aspects of the AA program helps them with sobriety. The Chair calls the meeting to a close which ends with attendees standing in a circle, holding hands and repeating the Serenity Prayer. After the meeting small groups of people chat for 10 or 15 minutes while putting the chairs away and cleaning up the coffee service.

Findings

There were large differences in conversational style between groups (Carers or AA).

The Carers' groups used a conventional conversational style with questions asked and answered directly, and people talking to one another (and interrupting each other) in turn. Three members participate with Eric who is talking about his difficulties with equipment in helping his wife. They ask questions, give information, are emotionally supportive, and make suggestions but without giving directive advice, They share their own similar and different experiences with an issue or a suggested 'solution' to a problem. On the surface the sharing varied between men (practical exchanges) and the women (who add emotional factors) – however the observations revealed the men were crying whilst exchanging seemingly non-emotional sharing.

In contrast, the AA groups used the distinctive form of 12th step conversation that includes:

no cross-talk—no one responds directly to anyone else's comments; if

questions are asked, they are not directly answered (see Makela et al., 1996)--each person gives what appears to be a story or fragment of a story (Jensen, 2000). The person is framing his/her story in terms of the 'meaning perspective' of the AA program such as alcoholism being the loss of control over one's drinking, not a matter of will power, and that there are a variety of tools to help an individual stay abstinent from alcohol e.g. go to AA meetings, get a sponsor, be of service to other alcoholics, and avoid being around people or places where alcohol is used.

The sharing described in the above illustrations was characteristic of all the meetings observed of AA and of Carers'. Despite stylistic differences, the sharing in the Carers' group and in the AA group had many of the same characteristics. Table 1 summarises these similarities.

Table1
Commonalities in Sharing Experience in Carers' and in AA Meetings

1. *Experiential, not professional basis of knowledge & authority*

2. *Knowledge conveyed with narrative (storytelling)*

3. Personal relationships—on first name basis

4. Experiences with given issue can be similar & also differ

5. *Differences of opinion expressed as ' My experience is …..'*

6. *Non-judgmental exploration of various facets of issue and various views*

7. *No direct advice given; indirect suggestions by speaker referring to their experience handling the issue.*

8. Strengths-based, not pathology or psychiatric diagnosis

9. Constructive and positive reactions to each other

10. Black humor

Note: Italicized items are an implicit 'rule' of sharing in AA's 8 country study (Makela et al., 1996)

   Commonalities were: sharing was based on stories (or fragments of stories) of the individual's personally lived experience or that of the experience of their peers (the authority was personal experience,

not scientific or professional knowledge): the sharing was respectful, nonjudgmental and supportive of peers; attendees did not openly disagree or argue with each other , but expressed different opinions and points of view by referring to a story of their experience; members offered suggestions for alternative ways of thinking or doing something rather than directive advice as in 'You should do x or y'. The AA meetings all conformed to the ten implicit rules of speech that the eight country study of AA groups identified as the template of AA sharing in meetings (Makela et al, 1996). A number of these 'rules' also characterised the Carers' groups although they had no explicit list of rules: speak from your own personal experience; do not give direct advice to others; be as honest as you can; do not speak about other people's private affairs; do not present causal explanations or psychological interpretations of other members' behaviors (Makela et al, 1996, pp. 140-141).

In the case of AA, the observations of sharing in the meetings also corresponds to what is described in the research literature about AA (Arminen, 1998a, 1998b; Denzin, 1993; Jensen, 2000; Makela et al, 1996; O'Halloran, 2008,). There is no comparable body of research on sharing in Carers' meetings and the one study (Golden & Lund, 2005-2006) was framed in such different terms that comparisons are not possible.

Discussion

The only previous application of Bohm's (1996/2014) concepts of dialogue to self-help/mutual aid was made by Borkman and colleagues (2000), in relation to the observations of the AA meetings in suburban Maryland, which concluded that the characteristics of dialogue which were found in the AA sharing were due to the AA style of conversation--the norms of 'no cross-talk' in meetings. However, the findings in this paper has shown that the Carers' sharing and the AA sharing results in similar characteristics that fit Bohm's (1996/2014) concept of dialogue even though the style of conversation is significantly different. Borkman's (2000) hypothesis that the style of no cross-talk found in 12 step groups is needed to develop Bohm type dialogue is incorrect.

Both the AA groups and the Carers' groups met Bohm's (1996/2014) preconditions for dialogue—attendees were peers of equal status and

authority with 'free space.' In both kinds of groups findings revealed that attendees were able to listen freely to each other without judgement, criticism or being offered unsolicited advice: thus, the Bohm dialogic process was obtained in both groups. This research did not measure or demonstrate any specific outcomes such as the maintenance or change in a group's 'meaning perspective,' but demonstration of the groups' achievement of the Bohm(year?) dialogic process suggests that outcomes related to the 'meaning perspective' are likely.

The very definition of self-help mutual aid group indicates a group that is likely to meet the conditions for dialogue. Participants voluntarily come together who identify as having the same/similar focal issue, for the purpose of collectively dealing with the issue and improving their personal situation in a special setting without pressures of money, status, or prestige. As Jensen's (2000) observations of many AA meetings illuminated, limited dialogue is possible because the audience are alike in experiences; are in a voluntary problem solving situation; and in such a context, drawing on Bhaktin's 'sideward glance', the group environment is conducive for the individual to be honest and truthful. The concept of sharing used in the self-help/mutual aid group literature refers to open and honest self-disclosure within a meeting and is complementary to and encompassed by Bohms' (1996/2014) concept of the dialogic process. The fact that many self-help/mutual aid groups exist might have been an antidote to his pessimistic view that few collectives were likely that could engage in dialogue.

Bohm's (1996/2014) concept of dialogue is useful to self-help/ mutual aid groups research literature in its focus on the collective nature of the sharing, or the group's 'meaning perspective.' The dialogic analysis could be particularly fruitful in explaining how groups develop, maintain, and evolve their meaning perspectives. While researchers have recognised the significance of and described meaning perspectives, they have not explored how they are created, maintained, or altered to any extent (Borkman, 1999 as an exception). This research suggests that dialogue as a specific form of communication may be necessary for a group to develop and maintain a workable meaning perspective.

These findings are preliminary and limited as they are based on a small sample of face-to-face meetings of only two types of groups. Other examples exist that highlight that not all self-help/mutual aid groups reach the conditions for dialogue (see for example Lieberman, 1990 and

Kitchin, 2002). Empirical questions therefore are: (1) which specific kinds of self-help/mutual aid groups theoretically meet the conditions for dialogic process to occur; and/or (2) which mutual aid groups have the group setting, conditions, and a form of conversation that allows the dialogue as a process to develop?

The core finding that dialogic discourse in Bohm's (1996/2014) sense can be found in groups with varying styles of discourse needs explaining and highlighting to professionals concerned that 'lay' people in a self-help/mutual aid group lack the skills to handle difficult group dynamics (see Chesler, 1990). This research suggests that often groups have a structure and/or process that prevents conflict (such as the distinctive form of 12 step tradition groups conversation that precludes cross-talk and the subtle juxtaposing of stories of lived experience in the stress-coping groups) which implicitly if not explicitly impedes or limits arguing, quarrelling or verbal sparring. As such the self-help/mutual aid group formats offer an alternative or complement to groups with a facilitator trained in group dynamics.

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