

ALCOHOLISM

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RESEARCH ON ALCOHOLICS
ANONYMOUS AND SPIRITUALITY
IN ADDICTION RECOVERY**

**The Twelve-Step Program Model
Spiritually Oriented Recovery
Twelve-Step Membership
Effectiveness and Outcome Research**

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Kickbacks from Helping Others: Health and Recovery

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Abstract: AA is often viewed as a spiritual organization, but it is less commonly recognized that helping others is a fundamental part of AA's conception of spirituality. Helping others by bringing AA's program to other alcoholics (articulated in Step 12) is understood as the culmination of AA's program and the behavioral manifestation of a spiritual awakening (Step 11). Also, members are encouraged to help in all stages of their involvement in AA's, and it is this helping that is thought to keep them sober. Accordingly, the current chapter addresses the question of whether helping benefits the helper from an empirical standpoint—and specifically, whether helping might contribute to recovery in the context of AA involvement. In addition to describing AA's approach to helping, we review research on associations between helping and (a) health outcomes in the general population, (b) recovery in diverse mutual help groups, and (c) recovery from chemical dependency within and outside of AA. We find evidence supporting benefits for helpers in each of these domains and tentatively conclude in favor of helper therapy principles. However, the work is limited by the lack of experimental studies and by problems in defining helping. Other concerns are that "over-helping" can be worse than not helping at all and that helping may sometimes harm the intended recipients. Recommendations for further research are to address these limitations. Particularly useful would be research designing and testing interventions aiming to increase helping, perhaps informed by social model programs and principles.

Key words: helping; altruism; mutual help; AA; spirituality; alcohol

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1. Introduction

Traditionally, Alcoholics Anonymous (AA) has been known as a "self-help" group, emphasizing reliance on "one's self" for help in opposition to professionals. Yet such phrasing can be misleading. The American Psychological Association (APA) defines a "self-help group" as "a group composed of individuals who meet on a regular basis to *help one another* cope with a common life problem (*italics added*)" (VandenBos, 2007). Furthermore, among the "many benefits [of self-help groups] that professionals cannot provide," the APA includes "friendship, emotional support, experiential knowledge, identity, meaningful roles, and a sense of belonging." This definition paradoxically highlights the important role that the *other* members play, both as helpers and as recipients of help, in self-help groups. Accordingly, many researchers now prefer (as we do) the term "mutual help" or "mutual support" as a substitute for "self-help," since these terms draw attention to the mutual, interdependent nature of self-help group processes.

Although researchers have come late to recognizing the importance of mutual aid in mutual help groups, helping others has long been emphasized in AA. In fact, helping, spirituality, and recovery form inextricably intertwined strands in AA lore and practice. AA frames helping other alcoholics as a direct manifestation and ongoing source of spiritual growth and recovery. Helping others by carrying the message to other alcoholics (articulated in Step 12) is understood as the culmination of AA's program and the expression of members' spiritual awakening (Step 11). Helping other alcoholics is, thus, the explicit endpoint of the program. Yet helping others is viewed as a cause as well as an effect of personal recovery and spiritual transformation (which are considered almost equivalents; see Connors et al., Chapter 12); in order to keep their sobriety, helpers must "give it away." Hence, helping is a focus throughout the program, and service work (i.e., any actions benefiting fellow alcoholics) is considered fundamental to success.

What work does the encouragement of helping actually do in AA? That is the question this chapter poses. Clearly, service work and sponsoring contribute to the ongoing functionality of the organization. AA has proliferated expansively across the globe (Mäkelä et al., 1996) and generally continues to operate as a self-sustaining entity, without outside contributions, largely because many of its members and elected officials *volunteer* to help set up and run meetings, organize annual conferences, participate in decisions that affect the group as a whole, and donate to support salaried administrative positions. Receiving help from other alcoholics may also help the recipients of aid: Research suggests that the social bonds that individuals form in AA contribute to their ability to abstain from alcohol and drugs (Bond, Kaskutas, & Weisner, 2003; Kaskutas, Bond, & Humphreys, 2002; Longabaugh, Wirtz, Zweben, & Stout, 1998). Yet there may be even more reason to recommend peer helping as a therapeutic agent. This chapter suggests that helping may serve a third function in mutual help groups,

and in AA specifically: That is, we argue (as does AA) that helping directly contributes to the helper's recovery. Thus, the encouragement of helping may contribute to AA's continued proliferation not only by sustaining its functionality but by keeping both recipients and helpers sober. Just as an evolutionarily adaptive gene may promote the replication and survival of a particular species (Dawkins, 1989), AA's emphasis on helping may have promoted the group's survival as a network and institution over the long passage of time since its inception.

Toward better understanding the role of helping in AA and in recovery, the current chapter examines AA's philosophy and practice surrounding helping and reviews evidence for linkages between helping and better health and recovery outcomes. We aim at a balanced view of helping's benefits and potential drawbacks (such as overcommitment) and, in view of the state of evidence in this emerging field, urge that our conclusions be viewed with some caution.

We believe our chapter is appropriate for inclusion in the current volume, which addresses the role of spirituality in AA, because spirituality and helping are so tightly interwoven in AA. We hope that our examination will be useful not only in terms of understanding AA but also for formulating and evaluating substance abuse interventions conducted in treatment facilities and other community settings. Because of the paucity of research on the benefits of helping in any twelve-step program, let alone AA specifically, we draw on research involving a range of mutual help groups along with work on AA. Much of what we say should, in fact, be applicable to twelve-step groups generally, since such groups have typically adapted AA's steps, traditions, and literature to suit the problems they address.

2. AA's Approach to Helping

Helping has been defined in a variety of ways, depending on the scientific discipline. Within the context of twelve-step programs, helping others in recovery is most commonly referred to as "service." For our purposes here, synonyms for helping include service, pro-social behaviors, other-oriented behaviors, unselfish caring for others, good will, and altruism. Behaviors that are service-oriented or altruistic in nature are those that reflect kindness toward, and consideration of, others (Burnstein, Crandall, & Kitayama, 1994). A review of altruism definitions across interdisciplinary research has found five common elements: (1) the activity the individual is taking part in must benefit another person; (2) the act must be performed voluntarily; (3) the individual must perform the activity intentionally; (4) the benefit to another is the primary goal; and (5) the individual must not expect any external rewards or any type of reciprocation for service rendered. These elements are exemplified in moral psychology as "good will" (Kant, 1993).

Alcoholics Anonymous has put this idea of service into action: AA's primary aims are to keep members sober and to help alcoholics who still suffer

(AA World Services, 2001). Originating in Akron, Ohio, AA traces its roots to the Oxford Group, a Christian fellowship movement started in 1921. At the core of the Oxford program were the "four Absolutes": absolute honesty, absolute purity, absolute unselfishness, and absolute love (AA World Services, 1957). Unselfishness was highlighted as the spiritual cornerstone for right living, the exact opposite of life during the alcoholic's drinking days. This absolute suggested that "you ask yourself over and over again in judging what you are about to do, say, think, or decide: how will this affect the other fellow?" (AA World Services, 1957). Being unselfish is a focal point and is understood to follow self-care in the hierarchy of adjusted attitudes for right living. Self-centeredness has long been thought by AA to be the root of substance use disorders; AA's antidote to egocentrism has been for the individual with a substance use disorder to help others. Newcomers and old-timers alike still face the challenge of absolute unselfishness and encounter reminders to consider "How will this affect the other fellow?" in signs on the walls of Akron/Cleveland AA meetings today.

The co-founders of AA, Dr. Bob and Bill Wilson, affiliated with the Oxford Group prior to meeting each other: Bill in New York City for 5 months and Dr. Bob in Akron, Ohio, for two and a half years. However, only Bill had achieved sobriety. The difference in their programs lay in service. As Dr. Bob later recounted, "Bill had acquired [the Oxford group's] idea of service; I had not" (AA World Services, 1980, p. 70). This was the missing link to which Dr. Bob attributed his subsequent sobriety. When they met in May 1935, they applied the Oxford Group's fundamental belief in helping others, specifically to helping other alcoholics to stay sober. Bill said, "We had to [help other alcoholics]. We were under awful compulsion. We found that we had to do something for somebody or actually perish ourselves" (AA World Services, 1980, p. 72).

Helping can also be found in AA's steps and notion of service. AA originally consisted of six steps, based on the Oxford framework, with the fifth step calling members to a mission of "helping other alcoholics" (AA World Services, 2001). AA's first non-alcoholic trustee, Mr. Amos, described this step in his report to Mr. Rockefeller in 1938: "He must be willing to help other alcoholics get straightened out. This throws up a protective barrier and strengthens his own willpower and convictions" (AA World Services, 1980, p. 130). In 1939, Bill Wilson further developed these steps into the twelve steps that are known and practiced today. The Twelfth Step evolved to "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."

The symbol for AA, emblazoned on the symbolic coin currently given to members for advancing periods of sobriety, is a triangle within a circle. The triangle represents the three dimensions of AA: service, unity, and recovery. One-third of the triangle represents service, which in the context of AA is defined as "anything whatever that legitimately helps us to reach fellow sufferers" (AA

World Services, 1957). Forms of AA service, the majority of which do not require any length of sobriety, include making coffee, greeting members at the door, putting away chairs, visiting detoxification centers, volunteering at local AA Service Centers, welcoming newcomers at meetings, and sharing experiences in sobriety to help a fellow sufferer.

Another form of service in AA is being a sponsor to other alcoholics. Sponsorship was very different historically from today's current practice. Historically, alcoholics could not walk into an AA meeting as they do today. Being "sponsored" was a prerequisite to membership and meant that the newcomer had undergone an indoctrination procedure formulated by early members. AA members would be notified, usually by a family member of the alcoholic, of someone who was in the end stages of alcoholism. Following detoxification, usually in the hospital, several AA members would approach the newcomer and visit this prospect every day. Members shared their experiences in the hope that the newcomer would identify with them. Alcoholics were encouraged to admit that they were powerless over alcohol and then to surrender their will to God—in the presence of one or more AA members. Following this surrendering experience, the alcoholic was allowed to join fellow members at AA meetings. This early practice evolved into the practice known today as sponsoring, which involves ongoing partnership between a novice and a more experienced alcoholic. A sponsor, uniquely positioned based on common suffering, helps another alcoholic solve one problem and one problem only: how to stay sober. This includes assisting the other alcoholic through the suggested twelve steps of recovery. While there are no explicit rules, a good sponsor should preferably be a year or more away from the last drink/drug and should seem to be enjoying sobriety (AA World Services, 1957).

Helping others, then, has constituted a core part of AA from its founding. One might say that helping others and surrendering to a higher power were seen to be the active ingredients of the program from the start. In the following sections, we address the health and mental health benefits of helping generally, as well as recovery benefits to helpers in mutual help groups.

3. Research on Helping in the General Population

By now, a moderately persuasive evidence base suggests health benefits for helpers in the general population. Jane Allyn Piliavin (2003), reviewing the literature to determine whether there are payoffs to performing community service in terms of self-esteem, depression, and longer life, concludes, "essentially [the answer is] yes: One does well by doing good" (p. 227). Likewise Post (2005), in a similar review of altruism research, concludes that "a strong correlation exists between well-being, happiness, health, and longevity of people who are behaviorally compassionate, so long as they are not overwhelmed by helping tasks" (p. 66; we address this latter point in Section 5). Indeed, voluntary participation in community service has been related to better outcomes among a rangé

of samples, including youth, college students, adults, and the elderly, and for a range of outcomes. Still, there are some limitations associated with this work. Few if any randomized trials have been conducted on adults and the elderly, so evidence for the helper therapy principle in those populations is largely limited to observational research. Furthermore, the available data show some variation in effects across interventions and outcome variables. This suggests that not all forms of giving positively affect all outcomes, though there is no real consensus on what kinds of volunteering are most effective, and which psychological, behavioral, and physical outcomes we can expect to be affected. Part of this confusion may be attributable to the lack of theoretical development in this area.

Some evidence for the conclusions of Piliavin (2003) and Post (2005) comes from experimental studies of volunteering among youth. For example, in an experimental study, Calabrese and Schumer (1986) assigned ninth-grade students, all of whom wanted to do community service, into a volunteer group (who designed their own community service project; $n = 25$) and a control group (who were simply followed; $n = 25$). Results showed that volunteers had lower levels of discipline problems and alienation at follow-ups than controls. Moreover, alienation increased among volunteers terminating their participation at 10 weeks in a post-termination follow-up. Observational studies on youth and college students have likewise found suppressed delinquency, better civic values, and increased educational attainment among students engaging in volunteer work of various kinds (e.g., Astin & Sax, 1998; Johnson, Beebe, Mortimer, & Snyder, 1998; Uggen & Janikula, 1999). Observational studies have also associated greater *amounts* of service with better achievement and delinquency outcomes, a dose-response relationship that further supports a causal interpretation. Based on such results, reviews have concluded that volunteer programs for adolescents, including peer tutoring and community service programs, can be related to improvements in both academic and social arenas (Elbaum, Vaughn, Hughes, & Moody, 1999; Moore & Allen, 1996; Osguthorpe & Scruggs, 1986; Scruggs, Mastropieri, & Richter, 1985). However, the effects for volunteering do not seem to be as consistent for social and psychological outcomes as they are for academic outcomes (Astin & Sax, 1998; Conrad & Hedin, 1982; Johnson et al., 1998; Osguthorpe & Scruggs, 1986; Scruggs et al., 1985). It is also true that results from youth studies can be hard to interpret since many studies combine volunteering with other interventions, such as instructional lectures and discussions.

Observational studies with adult populations likewise tend to support conclusions that one does well by doing good. Voluntary association membership and altruistic behaviors among adults have been positively associated with greater happiness and life satisfaction (Ellison, 1991; Keyes, 1998), better social functioning (Keyes, 1998), and decreased depression and anxiety (Brown, Gary, Greene, & Milburn, 1992; Rietschlin, 1998; Schwartz, Meisenhelder, Ma, & Reed, 2003). For example, one study, randomly sampling 2,016 members of the Presbyterian Church in the United States, found that giving help was strongly

associated with better mental health; moreover, this association was stronger than the association between *receiving help* and mental health (Schwartz et al., 2003). Another study conducted on adults has suggested that helping actually mediates some or all of the effects for spirituality on health outcomes (Ironson, Solomon, & Bablin, 2002). This study compared the characteristics of long-term survivors of AIDS ($n = 79$) to a comparable (based on CD4 count) HIV-positive group that had been diagnosed for a relatively short time ($N = 200$). Survivors were more likely to be spiritual or religious than comparisons. However, the effect of spirituality/religiosity on survival was mediated at least partly by a greater tendency for spiritual/religious individuals to help others with HIV. Implications of this study are that future investigations of spirituality and health would be advised to control for helping.

Such studies are open, however, to the criticism that individuals who choose to help may already be more functional than individuals who do not. Fortunately, a rigorous, longitudinal study by Thoits and Hewitt (2001) helps address this critique. For this study, the authors used a cross-lagged panel design and two waves of data collected from a national probability sample of American adults ($N = 2,681$) to test two proposals: (a) individuals high on well-being self-select into volunteer work and (b) volunteer work enhances well-being. The data revealed some support for proposal (a), as higher well-being on five of the six measures (i.e., happiness, life satisfaction, self-esteem, physical health, and depression, but not mastery) at Time 1 predicted more volunteer work at Time 2, associations that were partially explained by higher social integration among those high on well-being. Most important, proposal (b) was supported, since volunteer work at Time 2 predicted higher well-being on all six measures at Time 2, even controlling for well-being assessed at Time 1. The latter model also controlled for a large set of demographic covariates and measures of social integration at Time 2. This evidence strongly supports a causal role for volunteer work in well-being, since it helps to establish direction of causality and rule out potential confounds.

Research on volunteering among elderly populations is perhaps most copious of work on any population and again suggests benefits for helping. Empirical work on helping and psychological health among the elderly was subjected to meta-analysis by Wheeler, Gorey, and Greenblatt (1998), who found that the average correlation between helping (or voluntary association membership) and measures of psychological well-being was 0.25 ($p < 0.001$), ranging from 0 to 0.58. The authors also found that, in studies controlling for health and/or socioeconomic status, the average correlation was smaller, but still statistically and clinically significant. Furthermore, volunteers who engaged in direct forms of helping (rather than, for example, simply holding membership) derived greater rewards. Although most of the reviewed work was observational in design, the case for causality is strengthened by one small experimental study ($N = 120$) showing beneficial effects for volunteering among the elderly on positive affect, self-esteem, and social integration (Midlarsky & Kahana, 1994).

Strikingly, researchers have also found associations between more volunteerism among the elderly and lower *mortality rates*. For example, Moen, Dempster-McClain, & Williams (1989), studying 427 women in New York state originally interviewed in 1956, found that those who had participated in clubs and volunteer activities were less likely to have died by 1986. The authors report, "We find that social integration, defined by the number of roles occupied, promotes longevity, but that one form of integration—membership in voluntary organizations—is especially salutary" (p. 635). A more recent study examined the relative contributions of giving versus receiving support to longevity in a sample of 423 married couples (Brown, Nesse, Vinokur, & Smith, 2003). All males in the couple were at least 65. This 5-year study found that mortality was significantly reduced for individuals who reported providing instrumental support to friends, relatives, and neighbors, and for individuals providing emotional support to their spouses. Analyses incorporated an exceptionally comprehensive set of controls: demographic variables, personality variables, social contact, relationship quality, and mental and physical health (including interviewer-rated health). Receiving support tended to have weak effects on mortality, and receiving emotional support had no effect on mortality once giving support was taken into consideration. One factor counting against this study, however, is its limited operationalization of helping: Helping measures were unvalidated and incorporated as few as one or two items. For example, providing emotional support was measured as the average of two questions on whether participants "made their spouse feel loved and cared for" and "were willing to listen if their spouse needed to talk."

In sum, the available research tentatively suggests salutary effects for helping in the general population. The field needs more rigorous experimental studies, better theory, and more attention to defining and measuring helping. Still, the work is promising.

4. Research on Helping and Recovery

4.1. *Helping in Group Therapy and Mutual Help Groups*

Supplementing work on the general population is a separate stream of research examining member-to-member interactions in the course of therapy and in mutual help groups. This work more closely approaches our topic of interest: helping in AA.

It has been often suggested that peers in group therapy constitute a unique and powerful resource. For example, Ferencik (1992) proposed that the emotional support and persuasive power of a peer in therapy can be greater than that of a therapist. He writes, "While [group] leaders possess authority, compared to members they are at a disadvantage. . . . A leader's supportive comments may be suspect as a perfunctory role requirement, something spoken as part of the job and not necessarily heartfelt" (p. 114).

Other advantages, argues Ferencik, are that peers can express a range of responses restricted among therapists by their professional position (such as disclosure of personal experiences and extreme emotional responses) and contribute to unified group action, which may help crystallize issues and mobilize members to act. Relatedly, Yalom (1970) has proposed that therapeutic gain comes primarily from potent therapeutic events combining *both* emotional experience and reflection on that experience—events that are, according to Yalom, typically facilitated by interaction with group members. All of this points up the potential power of mutual help groups like AA. An additional advantage of group therapy, or mutual help groups, may be that peer interactions offer clients an opportunity to *help others* facing a common problem.

The potential curative power of helping for the helper was actually recognized decades ago by Riessman (1965, 1976), who suggested that people who help others in the context of mutual help group involvement benefit from doing so. Riessman also thought that helping benefits the helper most when the helper and recipient share a common problem, since helpers can become committed to solving their problems (and to specific strategies for change) by offering advice and encouragement to others. Around the same time, Yalom (1970) identified "altruism" as one of his 12 curative factors in group therapy; altruism was defined as a sense of having helped other group members through the sharing and giving of oneself. Surprisingly, little empirical work has followed these early insights.

Nevertheless, a few key studies have examined benefits for helpers in mutual help groups. In one, Kenneth Maton (1988) examined giving and receiving help among 144 members of three self-help groups: Compassionate Friends (a group for the bereaved), Multiple Sclerosis, and Overeaters Anonymous. Results showed that providing social support and friendship (assessed using a 5-item self-report scale) was related to higher well-being and more positive group appraisal. Furthermore, individuals who were high on both giving and receiving support reported more favorable well-being and group appraisal than individuals who were high on only one or neither. This finding conflicts somewhat with findings from Brown et al. (2003), who found no additional benefits for receiving emotional support on mortality among the elderly when giving help was taken into account. Maton's findings suggest caution in concluding that there are no benefits to recipients of help.

Similar findings showing positive effects for helping have been reported by Schiff and Bargal (2000), studying 117 participants belonging to 11 mutual help groups in Israel: 87 participants belonged to seven different twelve-step groups (e.g., Overeaters Anonymous and Debtors Anonymous), and 30 participants belonged to four groups not based on twelve-step principles (i.e., groups for hearing and speech impairment, mentally ill individuals, and homosexual individuals). Scores on the study's 3-item helping scale were positively associated with both subjective well-being ($r = 0.25$, $p < 0.05$) and satisfaction with the group ($r = 0.30$, $p < 0.01$). Other important findings were

that twelve-step group members rated their groups more positively on four of six dimensions, and reported much higher group satisfaction, relative to members of non-twelve-step groups. (The authors do not report whether the groups differed on well-being.) Schiff and Bargal conclude that twelve-step groups may have advantages over groups that are not twelve-step based, including powerful ideologies that provide alternative explanations for participants' problems (that is, explanations that do not invoke notions of immorality or sin), and a step-based program offering hope for change—along with, one might add, a concrete plan of action. Still, they admit that methodological issues, such as demographic differences between members of twelve-step and non-twelve-step groups, may also explain the results.

A third study of note was conducted by Schwartz and Sendor (1999). This study was a secondary analysis of a randomized trial exploring the effects of peer counseling on sufferers of multiple sclerosis and examined the experience of those people who delivered the intervention: That is, five lay people with multiple sclerosis trained to listen actively and provide compassionate, unconditional positive regard to people sharing their disease. At 1- and 2-year follow-ups, the trained peer supporters showed higher well-being on several measures (e.g., global life satisfaction, autonomy, mastery, and self-acceptance) than either those they were counseling or individuals in the control group, who received a different intervention. However, results from this study are hard to interpret, given the very small sample of peer supporters. Furthermore, peer supporters also scored higher at year 1 on some measures suggesting poorer functioning (e.g., global fatigue and depression).

A criticism of the preceding studies is that self-report measures of helping cannot be trusted, since people are likely to exaggerate the extent of their helping. In fact, those people most likely to inflate their estimates of helping in the service of social approval may be most likely to inflate their estimates of health and well-being, which could lead to artifactual associations between helping and positive outcomes. Another concern is that the direction of causality cannot be established in the forgoing work: Helping may flow from higher well-being just as easily as higher well-being flows from helping. These concerns are mitigated somewhat by a rigorous study by Roberts et al. (1999), in their longitudinal study ($N = 98$) of a mutual help group for individuals with serious mental illness called GROW. This study used observer ratings to measure both helping behaviors and psychosocial adjustment (in addition to using a self-report measure of social adjustment). Helping was assessed during weekly group interactions; outcomes were assessed from 6 to 13 months post-baseline. Even when controlling for adjustment measures at Time 1 and other important covariates (i.e., age, gender, education, race, months in GROW, and time between interviews), more helping predicted higher adjustment scores on both interviewer-rated ($B = 0.27, p < 0.01$) and self-rated ($B = 0.35, p < 0.001$) instruments at follow-up. Receiving support was a marginally significant predictor of better outcomes in this study ($B = 0.17,$

$p < 0.10$). Again, note that there is some indication of positive effects for receiving help.

One is impressed by the sheer size of effects for helping on adjustment in the forgoing study, given that adjustment at baseline was controlled. Such effects imply the possibility of similarly important effects for peer helping in recovery from substance abuse and dependency. Presently, we turn to research on that topic.

4.2. *Helping and Recovery from Substance Abuse and Dependency*

It is fascinating that, despite the explicit linkages that many recovering people make between helping, recovery, and spiritual growth, there is so little quantitative research on the interplay between growth in these areas. Below are quotes from a qualitative study interviewing five leaders of Pathways, a twelve-step group developed for methadone treatment clients (all quotes from Glickman, Galanter, Dermatis, & Dingle, 2006, p. 532).

I heard I could find a God of my understanding and gee, that opened all kinds of doors for me. Spirituality—I found out what spirituality was. People; I hadn't even realized how isolated I had become and this rejoining with people, the oneness, the unity. That's a wonderful thing. . . .

... I've learned how to love myself again, care for myself, to care for others and the whole process of recovery, the whole program. Doing for others; I don't have the words for it any more. It is just a giving and taking that spirals back and forth, back and forth. You feel God working through other people and it's true; God works through other people and in working through them it works through me.

So as I stay clean and I involve myself in my network it[s] brought me into a higher role. . . . Helping people helps me. I like to do it; I really do. I love to do it.

Research on helping during recovery from substance abuse, although sparse, does indicate benefits for helpers. Early reviews of the AA literature have indicated that both sponsoring another member in AA and engaging in "Twelfth Step work" (broadly, service work) are reliable predictors of better outcomes in AA (Emrick, 1987; Emrick, Tonigan, Montgomery, & Little, 1993; Sheeren, 1988). Emrick et al.'s (1993) review documented an average correlation between drinking behavior outcomes and sponsorship of $r = 0.17$, and an analogous correlation of $r = 0.20$ for engaging in Twelfth Step work. More recent work confirms roles for these forms of service, including a striking study by Crape, Latkin, Laris, and Knowlton (2002). Following an inner-city community sample of former and current injection drug users, this study found that sponsoring another member in NA or AA was related to an almost sevenfold increase in odds of abstinence when first interviewed, and a threefold increase in odds of abstinence at the 1-year follow-up. These effects are much larger than those

indicated in Emrick's review of the available cross-sectional work, suggesting that sponsoring may be more or less powerful depending on sample characteristics and study design. Moreover, it seems unlikely that Crape's effects were attributable to higher NA/CA involvement or treatment attendance among sponsors, since analyses controlled for NA/AA meeting attendance and formal treatment (along with demographic variables, HIV status, and involvement in community organizations). Similarly, Pagano, Friend, Tonigan, & Stout (2004) recently assessed the effects of sponsorship and step work *together* using data from Project MATCH (Longabaugh & Wirtz, 2001), a very large clinical trial investigating the efficacies of three different treatment types in recovery from alcohol dependence. Individuals who reported sponsoring another AA member and/or completing the Twelfth Step in the 90-day treatment period were coded as helpers. In comparison to non-helpers, helpers were twice as likely to remain sober in the year following treatment. Again, it is important to recognize that this association held controlling for AA meetings attended, suggesting that greater attendance on the part of helpers cannot explain their superior outcomes.

Pagano and colleagues' work is particularly compelling because of its longitudinal design, but it merits attention that similar results were produced in a cross-sectional study by Zemore and Kaskutas (2004) involving a community sample of 198 recovering alcoholics. Based on factor analysis of an AA involvement scale, this study created two distinct measures of AA involvement: "AA Achievement" (a 2-item composite aggregating sponsorship and completion of the twelve steps) and "AA Involvement" (a 7-item composite reflecting other indices of involvement, such as reading the literature and meeting attendance). Hence, the study's measure of AA Achievement was a combined sponsorship-step-work measure very similar to Pagano et al.'s (2004) helping measure. Zemore and Kaskutas found that longer sobriety was strongly and positively associated with the combined sponsorship-step-work measure (standardized beta = 0.67, $p < 0.001$), and surprisingly not associated with AA involvement along other dimensions (standardized beta = 0.12, ns). Additionally, longer sobriety was positively associated with more community-related helping (although interpersonal, recovery-related helping decreased with increasing length of sobriety) and higher theistic and non-theistic forms of spirituality. Similar results were also produced in a cross-sectional study by Pagano, Jaber, Kotz, Dean, & Zywiak (2007a). Pagano's study, a retrospective study of "old-timer" alcoholics with more than 20 years of sobriety, found that helping others in AA increased linearly over the first 20 years of sobriety. Interestingly, participants also reported that helping other alcoholics was more important to their sobriety than helping non-alcoholics. This study, however, included a very small sample ($N = 11$).

Studies conducted outside of AA have also found some support for the helper therapy principle among substance-abusing populations. For example, Simpson, Crandall, Savage, & Pavia-Krueger (1981) found results decades ago

supporting helper therapy principles among opiate addicts. Among Simpson's sample, volunteer work at the 6-year follow-up was associated with better scores on a simultaneously assessed, composite outcome that took account of opiate use, other drug use, drug treatment reentry, alcohol use, criminality, and lack of engagement in employment, homemaking, or school. Simpson also found that engagement in community volunteer work increased from pre- to post-treatment, suggesting that treatment may play some role in enhancing helping.

Also looking outside of AA, a more recent and rigorous study (Pagano, Phillips, Stout, Menard, & Piliavin, 2007b) investigated helping among 163 individuals suffering from body dysmorphic disorder over the course of 3 years, about half of whom also had a substance abuse disorder. Using cox proportional hazards regression, this study found that increases in self-reported helping behaviors predicted remission in both substance use and body dysmorphia disorders, although the latter effect was only marginally significant ($p = 0.07$). Medium to large effects were obtained for each (with hazard ratios at 2.59 and 1.51, respectively). A strength of this study is that, although both the sample and the operationalization of helping differed widely across this study and Pagano et al.'s (2004) Project MATCH study, results nevertheless support linkages between helping and recovery from substance abuse. This supports the generalizability of effects for helping on recovery among helpers.

Another important study followed 277 members of Double Trouble in Recovery, a twelve-step fellowship serving individuals with both mental and substance use disorders (Magura et al., 2003b). This study employed a "Helper Therapy Process scale," a 5-item scale measuring perceived helpfulness to others (particularly at meetings) and perceived personal benefits from helping. Impressively, and among nine predictor variables entered in the multivariate analysis, only the Helper Therapy Process scale and drug/alcohol abstinence at baseline were significant predictors of drug/alcohol abstinence at follow-up (for Helper Therapy, $R = 0.12$, $p < 0.01$). Other covariates included measures of involvement in the fellowship, motivation, social support, coping, self-efficacy, and stressful life events. An important caveat, however, is that the Helper Therapy Process scale measures beliefs about the impact of one's helping more than helping behaviors per se, so these results speak more to the therapeutic value of the former than the latter variable. AA stresses that the impact of one's helping on the recipient is quite irrelevant in terms of benefits to the helper from helping. If this were true, then one would expect stronger effects had Magura et al. measured helping behaviors rather than beliefs. On the other hand, the opposite argument also seems plausible: Helpers may benefit most if they feel that their help is having the intended, positive effects. If that were true, then Magura et al. would have found attenuated effects when measuring helping behaviors. Regardless, the distinction between beliefs about helping and helping behaviors should be kept in mind.

In short, there is some (but not a lot of) evidence pointing to beneficial effects for helpers in recovery and for helpers in AA specifically. More tentative, but also intriguing, are results suggesting another role for helping in recovery: Specifically, two studies now suggest roles for helping during treatment in promoting AA *affiliation* after treatment ends. Why should that be? It may be that individuals who help others as part of professional treatment gain experience with the kinds of relationships and interactions that they will be expected to have in AA and its variants. That is, practice with helping may make it easier for people to negotiate the social demands of twelve-step groups.

One study supporting a link between helping and AA involvement was conducted on a treatment population of 279 individuals in northern California (Zemore, Kaskutas, & Ammon, 2004). The sample included individuals dependent on alcohol, drugs, and both. Peer helping during treatment was measured using a 7-item self-report scale tapping the amount of time participants spent, on the day prior, sharing experiences, explaining how to get help, and giving advice on housing and employment. Spending more time helping during treatment was significantly associated with greater AA/NA involvement at the 6-month follow-up, even in multivariate analyses controlling for length of stay. Among those still drinking at follow-up, more helping during treatment also predicted a lower probability of binge (versus moderate) drinking. In other words, helping reduced the likelihood of problematic alcohol use among drinkers. Helping was not otherwise associated with treatment outcomes.

Similar results were found in a second study, which followed 733 treatment seekers at five day hospitals and seven residential treatment sites in northern and southern California (Zemore & Kaskutas, in press). Study participants likewise showed mixed diagnoses of alcohol, drug, and alcohol- and drug-dependence. Spending more time helping during treatment was again significantly related to greater twelve-step involvement at 6 months post-treatment—and hence, indirectly to higher odds of abstinence at 6- and 12-month follow-ups. Results remained robust, as in the northern California study, even in multivariate analyses controlling for treatment duration and any demographic and baseline severity variables predicting outcomes. Diverging from the northern California study, helping activities (although measured using a similar scale) bore no relation to high-volume drinking, suggesting caution in interpreting the prior result.

Both these studies thus are consistent with arguments that peer helping during treatment may facilitate integration into AA post-treatment. However, we should be careful in interpreting these studies since, despite systematic attempts to control for variables that could account for the association between helping and AA involvement, there may yet be unmeasured variables that relate to both helping and AA involvement and that explain the association between these variables. The next section addresses general study limitations in more detail.

5. Helping Can Hurt (and Other Important Cautions)

The research on helping points to some benefits for helpers. However, it makes sense to be cautious about those results for several reasons.

One reason to be cautious concerns the quality of the evidence. Perhaps most important, almost all the work on helping has been observational. The lack of experimental work is particularly striking in research on peer therapy, mutual help groups, and AA, where we know of no experimental studies. Investigators have attacked issues surrounding correlational work (such as ruling out confounds and establishing direction of causality) with varying skill and rigor, and some studies, it must be said, have used a fairly comprehensive set of control variables and/or longitudinal designs (e.g., Roberts et al., 1999). The Thoits and Hewitt (2001) study is a standout here for its use of a cross-lagged panel design, which is probably the best non-experimental design available for establishing causality. Still, it remains that no work definitively establishes a causal role for peer helping in mutual help groups because that work has not completely addressed the problems of correlational designs. For example, studies do typically incorporate some measure of involvement in the group as a control variable, but group involvement is not the same as group satisfaction, and it may be that helping is just a proxy for group satisfaction (which is, rather than helping per se, the therapeutic mechanism). Reverse causality is also a threat: It seems possible that helping others could flow from feeling confident in one's recovery, which may be a stand-in for level of recovery—or may be influential in itself. However, studies have not addressed this possibility. It is hard to imagine a non-experimental study that could fully address these concerns, so experimental work testing helping interventions seems imperative.

Another reason for caution in interpreting helping research is that there is no real consensus on what peer helping is. Table 1 summarizes key studies on helping in AA and other mutual help groups. It is immediately apparent from this table that studies have adopted rather heterogeneous approaches to defining helping. Definitions have varied widely in terms of content, assessing (for example) behaviors related to emotional support, advice, and interpretation; behaviors related to instrumental support of various kinds; behaviors related to avoiding hurting others and violating rules/social norms; behaviors related to thoughts of other people; and thoughts that one's helping helps others. Definitions have also assessed helping in relation to a variety of targets and contexts: for example, interpersonal helping directed toward other mutual help group members, others sharing one's problem, and/or family and friends; participation in community organizations; and forms of helping that do not necessarily involve intimate contact, such as volunteering to pick up trash or avoiding gossiping. Finally, some studies have focused on time spent helping, while others have used Likert-type scales to measure extent of helping, or looked at single-occasion episodes. Studies have also combined these assessments in various ways, with some using domain-specific subscales and others using single scales

Table 1. Helping in AA and Other Mutual Help Groups: Some Key Studies

Study Authors	Scale	Items/Content	Findings
General self-help groups			
Maton (1988)	5-item self-report scale ($\alpha = 0.71$)	Sample item: "I regularly provide emotional support to group members"	Scores related to higher subjective well-being and group appraisal
Roberts et al. (1999)	Observers used a comment-by-comment coding strategy to code instances of "Support" ($\kappa = 0.85$), "Interpretation" ($\kappa = 0.73$), and "Guidance" ($\kappa = 0.70$)	<ul style="list-style-type: none"> "Support": behaviors that have the aim or effect of raising or enhancing another group member's status or are nurturing, encouraging, or approving of another group member "Interpretation": comments that interpret, analyze, evaluate, redefine, reconceptualize, challenge, summarize, or explain another group member's comments or behavior "Guidance": comments which give concrete, direct, and specific suggestions, direction, or guidance about possible courses of action 	<p>Scores related to higher psychosocial adjustment on both self-rated and interviewer-rated instruments</p>

Schiff and Bargal (2000)	3-item self-report scale (alpha = 0.85)	<ol style="list-style-type: none"> 1. "I contribute my own knowledge and experience to the other members" 2. "I help the members of the group a lot through my own knowledge and experience" 3. "The knowledge and experience I acquired as a result of my situation contribute to the group at least the same as the knowledge of a professional" 	Scores related to higher subjective well-being and satisfaction with the group
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Populations with substance abuse problems

Magura et al. (2003b)	5-item self-report scale (alpha = 0.92)	<ol style="list-style-type: none"> 1. "Sharing in meetings gives me self-confidence" 2. "I learn a lot about myself by helping others" 3. "Helping others makes me feel good about myself" 4. "My experiences give hope to other members" 5. "Sharing in meetings helps me deal with my issues" 	Scores predicted higher odds of alcohol/drug abstinence at follow-up
Pagano et al. (2004)	A categorical variable. Individuals were coded as helpers if they indicated sponsoring in AA and/or completing the Twelfth Step	<ol style="list-style-type: none"> 1. "Have you been an AA sponsor in the last 90 days?" 2. "In the last 90 days, which AA steps did you complete?" 	Helpers were significantly less likely to relapse in the year following treatment

(continued)

Table 1. Helping in AA and Other Mutual Help Groups: Some Key Studies (*continued*)

Study Authors	Scale	Items/Content	Findings
Pagano, Zeltner et al. (in press)	Twelve-item self-report scale ($\alpha = 0.85$) measuring helping generally and in AA	<ul style="list-style-type: none"> General helping behaviors: helping at home, work, and AA (nine items). Sample items: "Did you say something positive to someone at [home/work/AA]?", "Did you reach out to someone having a hard time at [home/work/AA]?", "Did you bend policies to get something you wanted at [home/work/AA]?", and "Did you criticize or gossip about someone at [home/work/AA]?" Helping behaviors specific to twelve-step programs (three items). Items: "Did you have a service commitment at a twelve-step meeting?", "Did you guide someone through any of the twelve steps?", and "Did you sponsor someone in a twelve-step program?" 	Engagement in specific AA service activities was linearly related to length of sobriety; general helping was not related to length of sobriety. Participants rated helping in AA as very important to staying sober, whereas helping at home or work was rated as contributing little
Pagano, Philips et al. (2007)	3-item self-report scale (α s = 0.84–0.87)	<ol style="list-style-type: none"> "During the past week, how often have you been patient with others when others were irritating in their actions or words?" "During the past week, how often have you met the needs of friends or relatives?" "During the past week, how often did you think about the problems of others?" 	Scores predicted remission from substance use disorder and body dysmorphic disorder at follow-up (though the latter effect was marginally significant)

Simpson (1988)	Single item	"Doing volunteer work" (wording not specified)	Engagement in volunteer work was higher post-treatment and was associated with better outcomes on a composite measure
Zemore and Kaskutas (2004)	26-item self-report scale measuring helping in recovery (alpha = 0.78), life (alpha = 0.62), and the community (alpha = 0.60)	<ul style="list-style-type: none"> Recovery Helping: helping other alcoholics with their recovery (eight items). Sample items (all items begin, "In the past 7 days, how much time did you spend..."): "giving more support and encouragement?" and "explaining how to get help in the program?" Life helping: helping others with issues not related to recovery (12 items). Sample items (all items begin, "In the past 7 days, how much time did you spend..."): "helping someone get a job or find housing?" and "taking care of family members who are ill?" Community Helping: involvement in community projects (six items). Sample items (all items begin, "In the past 7 days, how much time did you spend..."): "helping out with kids' sports or other after-school activities?" and "volunteering on local, national, or international projects?" 	Greater length of sobriety was related to higher scores on Community Helping and lower scores on Recovery Helping

(continued)

Table 1. Helping in AA and Other Mutual Help Groups: Some Key Studies (*continued*)

Study Authors	Scale	Items/Content	Findings
Zemore et al. (2004)	7-item self-report scale (alpha = 0.73)	Sample items (all items begin, "Yesterday, how much time did you spend..."): "giving moral support or encouragement?" "sharing experiences about staying clean and sober?" and "sharing experiences about other problems?"	During-treatment scores predicted greater AA/NA involvement post-treatment and lower odds of binge drinking among drinkers
Zemore and Kaskutas (2007)	13-item self-report scale (alphas = 0.70-0.75)	Items included those from Zemore et al. (2004) and six additional items. Sample items (all items begin, "On the last day you attended treatment, how much time did you spend..."): "explaining how to get help outside the program?" and "explaining program rules?"	During-treatment scores predicted greater AA/NA involvement post-treatment, and thus indirectly, higher odds of total abstinence

or items. All the studies we reviewed lack rigorous construct validation for helping measures and typically did not use informants or objective markers of helping. This leads us to question, What are we really measuring? What are we saying when we say that "helping others" helps the helper? Given the diversity of measures used here, the answer to that question is not clear.

It seems important to be more explicit and specific in our definitions and to recognize that not all forms of helping may be helpful to the helper. For example, helping that requires personal contact may especially be helpful, and helping directed toward peers sharing one's problem may be most helpful (as proposed by Riessman, 1965, 1970). Of course, we may not be able to tell what forms of helping are most helpful by simply guessing. Ideally, our definition of helping would be informed by a theoretical model linking helping to psychological mediators presumed to relate to recovery. To this point, we have no such model, although many and various proposals have been offered (e.g., that helping helps the helper by enhancing social status, role-related privileges, self-esteem, social bonding, and sense of purpose and/or by decreasing narcissistic self-focus). Some new empirical work tentatively suggests that helping is related to a decrease in depressive symptoms (Zemore and Pagano, 2007), perhaps because helping promotes integration over isolation. Regardless, it will be important for future investigations to develop theoretically based predictions about how helping affects outcomes, to use those predictions to tightly tailor measures of both predictors and outcomes, and to test theoretical models explicitly by including measures of the proposed mediators. In short, developments in theory and measurement are needed to make progress in research on helping. It would also help to have more studies using objective measures of helping, as items on self-report scales are open to self-presentational biases and can be hard to answer reliably (which may lead to large error terms for those items).

A last, but no less important, issue is that helping others can sometimes, it seems, hurt the helper. This merits some emphasis. Steven Post (2005), in his review of the altruism research, takes special pains (as does Piliavin, 2003) to emphasize that helpers can actually suffer if they are overwhelmed by obligations. This point is supported by the study on Presbyterians conducted by Schwartz et al. (2003) and described in this chapter. Results from that study showed that the relationship between feeling overwhelmed by others' demands and poorer mental health was actually *stronger* than the relationship between helping others generally and better mental health. Other investigations suggest similar conclusions. For example, recall the associations between helping and fatigue and depression among helpers in the Schwartz and Sendor (1999) multiple sclerosis study. Even more persuasive are data from Musick, Herzog, and House (1999), which suggest a curvilinear trend in the relationship between time spent volunteering and mortality among older adults: Protective effects emerged for moderate volunteering (i.e., volunteering for less than 40 hours per year or for only one organization), but volunteerism at higher levels was no better than not volunteering at all.

Poorer outcomes at higher levels of helping may result from role strain or the cultivation of negative coping styles (e.g., distraction instead of active confrontation and coping with one's own problems). Relatedly, psychologists Fritz and Helgeson (1998) draw an important distinction between *communion* (a positive, caring orientation toward others) and *unmitigated communion* (the subjugation of one's needs to the needs of others, involving helping at one's own expense). In four studies, they support conclusions that although these forms of communion are correlated, unmitigated communion is distinct from communion and uniquely correlated with negative views of oneself, reliance on others for self-evaluation, and psychological distress. It is not yet clear how much helping is too much or what the causal relations involving over-helping are, but it is certain that one can help too much. Reciprocally, of course, helping (if coming from an unskilled, ill-informed, or ill-intentioned helper) can also hurt the intended target, and this has been recognized in the psychotherapy literature for some time (e.g., Caplan & Caplan, 2001). All this means that helping is not an *unmitigated good*.

6. Implications

We do not ordinarily think of helping others as a way of solving our problems. We tend to think of "getting help," if we think of involving others at all. Despite some limitations, the research reviewed here suggests, nevertheless, that individuals may help themselves by helping others in AA and other mutual help groups, as long as they do not become superhelpers. Helping may even be an important mechanism of action for such groups. This work fits nicely with other work showing a role for peers in recovery, and specifically with research suggesting benefits for involvement in sober recreation during treatment (Moos, Finney, & Cronkite, 1990; Zemore & Kaskutas, in press), sober social networks (Bond et al., 2003; Kaskutas et al., 2002), and general peer support (Laudet, Cleland, Magura, Vogel & Knight, 2004; Laudet, Magura, Vogel, & Knight, 2000; Magura et al., 2003a).

Our conclusions imply that treatment programs may benefit from a stronger emphasis on peer helping. To their credit, interventions aiming to increase peer helping may be more palatable to treatment programs and more palatable on a general ethical basis than interventions targeting spirituality (the focus of other chapters in this section), since helping is something clients can do without committing to a spiritual orientation or practice. However, programs and researchers might want to keep in mind that newly christened, naïve, or ill-intentioned helpers might end up harming, rather than helping, their targets, so effects on targets should always be considered and assessed. Helpers who may be overwhelmed or overextended should also be closely monitored and redirected as necessary.

Research on how to facilitate helping is just emerging, so we are not well positioned to say how helping could be facilitated within treatment

programs. We do know, from both qualitative and quantitative work, that peer helping is relatively more common among social model, residential programs than typical day hospital programs, probably as a result of philosophical differences (Borkman & Kaskutas, 2000; Zemore & Kaskutas, in press). So, observing how social model programs facilitate helping might be productive. Recent data from Project MATCH have also indicated that helping in AA may be related to higher abstinence self-efficacy and purpose in life (in addition to greater length of sobriety and higher religiosity/spirituality; Zemore and Pagano, 2007). This suggests that working to enhance self-efficacy and sense of purpose may help bring people to a place where they are capable of helping others. Good news from that same analysis was that helping was equally likely among men and women, and did not differ by race, age, or other demographic characteristics. This implies that no special demographic credentials are required to help. It may help to have greater confidence, conviction, and time sober, but (as AA itself suggests) all that is really necessary to help others in AA is survival from alcohol problems—and continued sobriety. One's experiences as an alcoholic may have been a burden of the worst kind to the sufferer, but in recovery they can become an invaluable gift to those still suffering. As a result, one's troubled past may become a limitless source of succor for the future.

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