The 'helper-therapy principle' – people who help others receive benefits themselves – has been widely invoked in studies of self-help/mutual aid, but so far there have been few attempts to measure such helping quantitatively. This article reports on the Peer Helper Activity Checklist, developed to measure the extent of peer helping in substance abuse recovery programmes in California. The research found that programme participants had little difficulty in completing the Checklist, and that they reported a range of time spent helping others. More than half the participants (55 per cent) said that they had spent a total of six to twelve hours on the previous day helping their peers; the longer they had been in the programme, the more hours they spent helping others. The Checklist will, for the first time, enable social scientists quantitatively to study peer helping in self-help agencies and allow practitioners to assess the amount of peer helping in their programmes.

An instrument to measure the new volunteerism in self-help agencies

Thomasina Borkman, Dept of Sociology and Anthropology, George Mason University, Fairfax, Virginia
Lee Kaskutas, Alcohol Research Group, Berkeley, California

Introduction

Self-help groups have developed new forms of volunteering where peers with similar experiences help each other within an egalitarian relationship. Riessman describes this as the 'helper-therapy principle' (Riessman, 1965). The helper who provides help is also seen as benefiting from helping others. The California 'social model of substance abuse recovery' is a distinctive kind of self-help agency that translates principles of self-help/mutual aid, including peer helping, into recovery services. This article reports on the development of a new instrument, the Peer Helper Activity Checklist, which was created to measure quantitatively the extent of this form of volunteering in the California

social model substance abuse recovery programmes.

Peer helping compared with conventional volunteering

Carol Munn-Giddings (1998) contrasts the mutuality and interdependence found in the peer giving and receiving within self-help groups with the philanthropic basis of volunteering that historically and currently characterises much volunteer activity. Conventional volunteering often involves a middle or upper class person 'helping' someone less fortunate. She writes:

Self-help is not primarily about philanthropy but about self-determinism and the co-operation of equals (Munn-Giddings and Bradburn, 1997).

Discussion of volunteer labour in US Third Sector literature generally refers to the more typically studied situation of volunteer firemen (Perkins, 1987), to support for administrative and fund raising activities, or to direct services (Cnaan and Goldberg-Glen, 1990), but peer helping is substantively different in that it is volunteering in the direct *'therapeutic' services* among experiential peers. Examining self-help/mutual aid as a form of volunteering is rarely done, since social scientists have focused more on the benefits to individuals of participating in and receiving help from self-help groups or on the effectiveness of self-help/mutual aid in general (Borkman, 1999; Kurtz, 1997; Powell, 1994). Although the 'helper-therapy principle', which emphasises the benefits to an individual of helping someone else, has been a significant idea in the social science literature on self-help/mutual aid, little interest has been shown in studying it quantitatively. We found only two quantitative studies of the extent to which helping others is related to increased benefits of participation in the self-help group. However, we found no studies that measured peer helping activities in a treatment programme until the development of the Peer Helper Activity Checklist reported here (Kaskutas, 1996).

Maton (1988) surveyed the members of three self-help groups (Compassionate Friends, Multiple Sclerosis and Overeaters Anonymous) and found that self-reports of providing support to others in the group were associated with psychological well-being and with a positive appraisal of the benefits of belonging to the group.

Recently, Roberts and other researchers (1999) collaborated in a multi-year longitudinal evaluation of GROW International in Illinois, looking at whether help given and received were associated with psychological adjustment. (GROW is a self-help group for people with serious mental illness that provides a programme of growth with weekly meetings, literature, a caring community and an alternative to the 'sick patient' identity imposed by mental health professionals.) In the investigation, ten research assistants collected data on group interactions (using a standardised and validated observational instrument) at 527

meetings over a twenty-seven month period. They obtained a sample of ninety-eight GROW members who were interviewed at six and at thirteen months of participation and for whom they had observational data on their behaviour in meetings. Two measures of social-psychological adjustment were used, as well as a third self-report instrument for assessing psychiatric symptomatology and general distress.

They found that behaviourally coded transactions of giving help to others significantly predicted social-psychological adjustment. Interestingly, *receiving* help was not significantly related to improved adjustment or to changes in psychiatric symptomatology. This ambitious study is the first to have observed helping behaviours, rather than self-reports of helping others statistically linked to self-helpers' adjustment. Its findings provide empirical support for the 'helper-therapy' principle: those participants who offered help to others showed improvement over time in their psychosocial adjustment.

Self-help agencies: the California recovery programmes

The so-called California 'social model of substance abuse recovery' is a distinctive kind of self-help agency that has translated many principles of self-help/mutual aid from Alcoholics Anonymous into recovery services in a nonprofit agency. It was widespread in the 1960s to 1980s (JSAT, 1998; CDP, 1998). The concept of a self-help agency (Borkman, 1999) refers to paid-staff nonprofits that are formalised, provide services to clients, receive external funding and have substantial budgets, but where the rational-legal basis of authority in the organisation is shared with experiential authority (Crawford, 1998); the technology is self-help/mutual aid instead of professionally based, and the criteria for staff is experiential knowledge based in personal recovery rather than professional training. As self-help agencies, California social model programmes are legally incorporated nonprofit organisations that receive county and state government funding for their services and employ paid staff with experiential knowledge of recovery to provide services to recovering substance abusers.

In the recovery programmes studied, recently detoxified alcoholics and other drug addicts are admitted to the residential programme for a stay of one to three months. Some are ordered by the courts, others are self-referred. Newcomers are regarded as sick, vulnerable and in need of a safe, protective place in which to learn new attitudes and behaviours, which the recovery home provides. Physically, the programme settings are like home, with living rooms, pets and personal effects. Residents are expected to participate in cleaning, cooking (or assisting the paid cook), doing laundry and other housework as an integral part of their 'therapy' and of learning to become self-sufficient and responsible. Furthermore, residents are expected, after some sober time, to learn self-

governance through participation in a residents' council.
Peer helping is viewed as a critical part of the 'therapeutic process' by which newly sober substance abusers can aid their own recovery by helping others (the twelfth step in Alcoholics Anonymous and other twelve-step groups) (Barrows, 1998). The idea of peer helping is encapsulated in their slogan:

To keep it you have to give it away.

The egalitarian peer relationships found in self-help groups and social model recovery programmes are predicated on the value of primary experience. Experiential information, knowledge and wisdom are expressed through participants sharing their 'experience, strength and hope with each other', in the form of narratives about their alcohol/drug using days and their recovery. Regardless of the length of sober time, the participants are peers who have had similar experiences with alcohol/drug use and their negative consequences. They vary in the extent and quality of their sober time and their growth in recovery, but there is no hierarchy of status based on sober time or recovery time. Seasoned members are likely to have more influence and often more respect than newcomers, but the philosophy is that each can learn from the other. Newcomers obviously learn from the seasoned members who have successfully stayed sober and can model effective recovery strategies. Less obviously, newcomers are important to more seasoned members as a reminder of where they came from and what awaits them should they begin drinking or using drugs again.

The recovering staff in these programmes have dual sources of authority: positional authority as staff in a nonprofit organisation and experiential authority derived from recovery. They are closer to being the peers of residents than being authority figures (Room, 1998). Moreover, the educational aspects of the recovery programme are fashioned more in experiential terms than in the didactic terms found in the medical model hospital treatment programme (Kaskutas, Marsh and Kohn, 1998).

Methodology
The Alcohol Research Group in Berkeley, California, was funded by the federal Center for Substance Abuse Treatment to conduct a process evaluation study of two social model recovery homes and a hospital treatment programme. The results of the study have been reported in special issues of two peer reviewed journals: *Journal of substance abuse treatment* (1998) and *Contemporary drug problems* (1998). During the study, which took place in 1995-1996, a preliminary peer helping activity checklist was developed that included a spectrum of helping activities in which residents may engage.

Development of the checklist
To identify items for the checklist, seven observers noted key helping activities they had witnessed during their six months' observation of programme

Table 1: Aggregation of helping activities

Sharing your own experience
Sharing your drinking or drug use story
Sharing your family story or abuse issues
Sharing your own experience about how to stay clean and sober
Sharing your own experience about how to deal with other problems

Being empathetic
Giving moral support and encouragement
Encouraging someone to share
Encouraging others to look at their own issues
Listening to somebody's problems

Telling people how/where to get help
Explaining how to get help at the programme
Explaining how to get help outside the programme
Helping someone with their recovery plan
Explaining programme rules
Showing someone around
Sharing your own experience about how to get a job
Helping someone to get training
Giving advice about housing
Helping peer get kids or family back

Housekeeping
Shopping for supplies
Driving or taking peers to meetings, to appointments or to do errands
Doing maintenance of buildings
Cleaning, gardening or picking up
Cooking or making coffee
Baby sitting or taking care of programme animals
Volunteering to do something that is needed or helping a resident or programme
in a way that is not on the list

Governance
Doing residents' council work

activities (see Kaskutas, 1998, for study methodology). Redundancies were eliminated, and the resulting list was sent to two persons on an expert advisory panel convened for the process evaluation study. These social model experts suggested adding some items and removing others. The final activity checklist contained twenty-five helping activities (see Table 1 above) (Kaskutas, 1996).

The Peer Helper Activity Checklist was pilot tested on two samples: the programmes participating in the process evaluation study (N=75) and in ten social model programmes around California with whom the expert advisory panel was affiliated (as founder, director or consultant) (N=300). Only the second, larger sample will be reported here. Panel members were sent a letter that described the Peer Helping Activity Checklist and asked for their co-operation in obtaining a sample of clients from their programmes who would self-administer the checklist. Instructions on how to administer the checklist to clients were provided (details in Kaskutas, 1996, pages 3-4 and Appendix C). Clients were to be read a letter that described the study as being 'about how people get and give help in alcohol recovery programmes, and that they could fill out a form about their helping activities if they wished' (ibid., page 3). The instructions included reading to the participants that they were to exclude time spent in group sessions when they indicated how much time they spent on each of the helping activities. The actual form that the participant used was worded:

Did you do any of these things yesterday? For each activity, tell us about how much time, if any, you spent doing that yesterday?

The range of possible answers indicated on the form were 0 minutes, 15 minutes, 30 minutes, 45 minutes, one hour, two hours or more. Clients were also asked to state the length of time they had been in the programme. Clients took about fifteen minutes to complete the activity checklist.

Data analysis

The expert advisory panel affiliates returned 335 forms from ten programmes, which were entered into SPSS Windows; distributions with outliers were checked. Thirty-eight cases were removed because their excessive length of stay indicated that they were not in recovery programmes but sober living situations.

The twenty-five activities were then aggregated into five types based on similarity of content: sharing, empathising, helping others seek help, housekeeping and governance (see Table 1). Descriptive distributions of the amount of helping for each of the five types of activities were calculated. In addition, statistical analysis was conducted in order to identify whether the amount of peer helping in the various categories varied according to length of stay. We hypothesised that length of sobriety (operationalised here as length of time in the recovery programme) is positively associated with peer helping (based on the philosophy of experiential recovery). F-tests were used to assess whether there were

significant differences between the amount of peer helping in the various categories and length of stay. A non-parametric regression approach was chosen – Locally Weighted Scatterplot Smoothing (LOWESS) for fitting the data and drawing graphs (see Kaskutas, 1996, for further details) – to analyse the relationship between peer helping and length of stay.

Findings

The mean length of stay for the 297 participants had been fifty-nine days, or about two months. The mean number of clients per programme was twenty-one.

These residential social model programmes typically offer about five or six scheduled one-hour group sessions each day. If one assumes a fifteen-hour waking day, a maximum of ten hours would be available for activities that could include peer helping. The overall amount of peer helping per day was calculated by combining the amount of time from each of the five categories. About a quarter of the participants gave answers indicating that they spent more than ten hours a day on peer helping activities, which suggests some (unknown) overestimation or double-counting of their activities. Some portion of the overestimating is due to the relatively crude categories of answer, rising in fifteen-minute increments (or combinations of fifteen-minute increments), by which residents were able to describe the duration of each helping activity, rather than by giving a precise number of minutes. We initially felt that these closed choice fifteen-minute increments would produce more reliable data than asking for a precise count of minutes. The overestimates also suggest that clients added in the time spent in group sessions when estimating the time spent helping others.

The five categories of peer helping were: sharing, emphasising, housework and errands for the programme, helping others to understand how to get help, and governance tasks. Only 3 per cent of social model residents said that they spent one hour or less on these helping activities; 22 per cent estimated that they spent from 1.1 to 4 hours; 20 per cent said that they spent 4.1 to 6 hours; and over half (55 per cent) estimated that they had spent a total of six to twelve hours on the previous day helping peers.

Next, the mean time spent on each type of helping activity and the overall average time spent helping were calculated, based on length of time in the programme. The average overall time spent on helping activities is 7 hours, ranging from 3.3 hours for those who had been in the programme for one to three days, 5.7 hours for those who had been in for four to ten days and 7 hours for those who had been in for eleven days to one month, to 8 hours for those who had been in the programme for between two and three months. The difference in means is highly significant ($F=5.09$, $p<.001$), as is the test for linearity ($F=20.28$, $p<.001$).

The results of examining the specific categories of helping by length of time in the programme (from Kaskutas, 1996) are summarised below:

Sharing/empathising	3.8 hours average**
Housekeeping and errands	2.7 hours average**

Helping others find help	2.1 hours average* **
Governance	0.4 hours average* **

* denotes significant difference in means
** denotes significant difference in linearity during the first thirty days

Significant differences in the average amount of helping by length of time were found in two helping categories: helping others find help and governance. Significant differences in linearity were found in all four categories of helping, indicating that significant increases in each type of helping activity occurred during the residents' first thirty days in the programme.

Discussion

The major finding is that residents could easily complete the Peer Helper Activity Checklist, and they indicated a range of time spent helping others the previous day; the longer they had been in the programme, the more hours they spent helping others.

Except for the overestimation of time spent by residents in total helping activities, the quantitative findings make sense and are congruent with the qualitative observations and what we know of the philosophy and practices of social model recovery programmes. As previously mentioned, the overestimation of time may be partly due to the method of measurement: this was done in fifteen-minute increments which, across twenty-five activities, can lead to extensive overestimation when all the activities are summed. However, we felt that asking residents to estimate time in units of fifteen minutes would produce more reliable data than asking them literally to count the number of minutes they helped with each of twenty-five activities. We also think that clients might have counted in the help they gave during group sessions. Perhaps they disregarded the verbal instructions not to count activities during group sessions, or perhaps those instructions were not read to them carefully enough. The actual form clients filled out said nothing about not counting in help given during group sessions.

The congruence of the findings with our observations and with the philosophy of these programmes is heartening and represents a form of external validation. For example, the social model philosophy involves teaching residents to take personal responsibility for themselves, including doing their own cleaning, cooking, laundry and other housekeeping. Self-governance – that is, contributing to the group as a community – is also part of the philosophy of self-responsibility, applied by setting up a residents' council (Borkman, 1998). Our findings corroborate the principle. For example, rather than overloading newcomers with housekeeping, all residents are expected to do their share, regardless of their length of time in the programme; we found no significant differences in mean time spent on housekeeping activities by time in the programme. At the other extreme, however, governance is, by virtue of its principles and procedures, related to length of time in the programme. Recovery homes usually have rules stating that newcomers are not eligible to be elected to the residents' council until they have been in the programme thirty

days or more. This was also reflected in our data.

This study represents a promising beginning to the measurement of peer helping which is relevant not only to substance abuse recovery programs but also to other kinds of self-help agencies and self-help organisations. Obviously, some items on the Activity Checklist are specific to the residential recovery programmes studied here, and additional research would be needed to modify them to fit the situation being studied. Other research remains to be done, such as relating the amount of helping to outcomes: do people who help more stay sober? A subsequent study at the Alcohol Research Group is using different observer categories (0 minutes, 1-15 minutes, 16-30 minutes, 31-45 minutes, 45 min-1 hour, more than 1 hour); this methodological improvement should reduce the overestimation found in the original study and give a more accurate measure of time spent in each helping category.

Underlying this analysis is the 'helper-therapy principle' (Riessman, 1965): people who help others receive help themselves. Social model theorists believe that, through the lived experience of being alcoholic and recovering from it by helping others, one in essence becomes 'empowered' to help oneself (as well as others) to stay sober (Borkman et al, 1998). In this article the activity checklist was introduced and related to time spent in the programme; the helper-therapy principle was not tested. Future research needs to validate further the peer helping activity checklist and test the helper-therapy principle. For example, is there a positive relationship between residents helping others and the benefits they receive from the programme? Or can residents spend too much time helping others at their own expense (which the idea of co-dependency would suggest)?

These and other research topics need to be addressed. However, for the first time, an instrument has been developed that will allow social scientists quantitatively to study peer helping in self-help agencies and for practitioners to assess the amount of peer helping in their programmes.

References

Barrows, D. (1998), 'The community orientation of social model and medical model recovery programs', *JSAT*, 15, 1 (January-February), pages 55-64.

Borkman, T. (1999), *Understanding self-help/mutual aid: experiential learning in the commons*, Rutgers University Press.

Borkman, T. (1998), 'Resident self-governance in social model programs', *CDP*, 25, 4 (Winter), pages 741-772.

Borkman, T., et al (1998), 'An historical and developmental analysis of social model programs', *JSAT*, 15, 1 (January-February), pages 7-17.

Cnaan, R., and Goldberg-Glen, R. (1990), 'Comparison of volunteers in public and nonprofit human service agencies', *Nonprofit and voluntary sector quarterly*, 19, 4 (Winter), pages 345-358.

Contemporary drug problems (1998), 25, 4 (Winter). Special issue (ed. Room, J.,) on qualitative research on the social

model approach.

Crawford, S. (1998), 'Experiential authority in a social model organisation', *Contemporary drug problems*, 25, 4 (Winter), pages 807-829.

Journal of substance abuse treatment (1998), 15, 1 (January/February). Special issue (eds Kaskutas, L., and McLellan, A.) on the social model approach to substance abuse recovery.

Kaskutas, L. (1996), *Cost checklist: peer helping and hidden costs in social model programs,* National Evaluation Data and Technical Assistance Center.

Kaskutas, L., (1998), 'Methodology and characteristics of programs and clients in the social model process evaluation', *JSAT*, 15, 1 (January-February), pages 19-26.

Kaskutas, L., Marsh, D., and Kohn, A. (1998), 'Didactic and experiential education in substance abuse programs', *JSAT*, 15, 2 (January-February), pages 43-54.

Kurtz, L. (1997), *Self-help and support groups: a handbook for practitioners*, Sage.

Maton, K. (1988), 'Social support, organizational characteristics, psychological well-being, and group appraisal in three self-help populations', *American journal of community psychology*, 16, pages 53-77.

Munn-Giddings, C. (1998), 'Mutuality and movement: the significance of self-help/mutual aid groups to voluntary action and social change', paper presented at the third international conference of the International Society for Third Sector Research, Geneva.

Munn-Giddings, C., and Bradburn, J. (1998), 'Looking again at self-help: the building blocks of voluntary action?', paper presented at the NCVO National Research Conference and published as part of conference proceedings.

Perkins, K. (1987), 'Volunteer fire departments: community integration, autonomy, and survival', *Human organization*, 46, 4, pages 342-348.

Powell, T. (1994), *Understanding the self-help organization: framework and findings*, Sage.

Riessman, F. (1965), 'The "helper-therapy" principle', *Social work*, 10, 2, pages 27-32.

Roberts, L., Salem, D., Rappaport, J., Toro, P., Luke, D., and Seidman, E. (1999), 'Giving and receiving help: interpersonal transactions in mutual-help meetings and psychosocial adjustment of members', *American journal of community psychology*, 27, 6, pages 841-868.

Room, J. (1998), '"No big shots or little shots here": staffing principles and roles and medical and social model substance abuse treatment facilities', *Contemporary drug problems*, 25, 4 (Winter), pages 773-806.