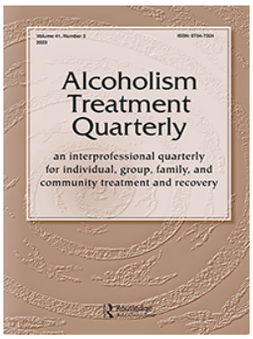

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Giving and Receiving Help Among Persons Entering Sober Living Houses

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ABSTRACT

Giving and receiving help are integral to creating the social environments necessary to support recovery. However, studies assessing the effects of helping behaviors have focused primarily on the benefits derived from giving help to others in 12-step programs and treatment. The current study examined the frequency of giving and receiving help among 188 persons entering sober living houses (SLHs), a type of recovery home that is common in California. Helping was assessed in three contexts: the SLH, 12-step meetings they attended, and interactions with their family and friends. Residents who gave help to others in one of these contexts tended to also receive help in that context. Residents who reported giving or receiving help in one context tended to report giving and receiving help in other contexts. Study findings suggest helping in recovery occurs in a broader, more reciprocal manner than currently conceptualized. Studies should address how giving and receiving help in different contexts affects recovery outcomes. Research is also needed to describe the determinants of giving and receiving help. Considerations for facilitating help among SLH residents are described.

KEYWORDS

Helping; social support; recovery home; Sober living house; recovery capital; social model

Introduction

Giving and receiving help is central to the recovery philosophy of mutual help groups such as Alcoholics Anonymous (AA) (Zemore & Pagano, 2008). Studies show helping has beneficial effects in AA (Pagano et al., 2004) as well as in treatment programs (Zemore & Kaskutas, 2008). Interestingly, studies targeting the effects of specific helping behaviors (e.g., emotional support, practical help, and support for recovery) have tended to focus on the benefits individuals experience when they help others (e.g., Pagano et al., 2004). Conceptually, these studies draw on the "Helper Therapy Theory" developed by Riessman (1965), which emphasized that the therapeutic value of helping others was greater than receiving help. However, the benefits of receiving help from others can be seen in studies using broader measures of social support, such as support for recovery in one's social network and level of involvement in AA (Bond et al., 2003).

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Most of the research on helping in recovery has taken place in 12-step recovery contexts or, to a lesser extent, treatment programs. Yet, helping may be equally or even more important in other contexts, such as residential recovery homes. Recovery homes are alcohol- and drug-free living environments where persons with alcohol and drug problems live together and provide support for recovery. Some recovery homes offer on-site services delivered by professionals or peer counselors, such as case management, recovery groups, and job skills training. Other homes rely more extensively on a social model approach to recovery (Borkman et al., 1998), which emphasizes abstinence from substances, peer support for recovery, sharing experiential learning based on residents' experiences, and involvement in 12-step recovery groups. Because of their emphasis on peer support activities, these types of environments offer excellent opportunities to study the effects of giving and receiving help.

Another reason to study recovery homes is their growing numbers throughout the U.S. The National Alliance of Recovery Residences (NARR) is a provider based organization providing support, consultation, and standards to member houses. They serve a broad range of recovery residences, from those that integrate professional services to those that are entirely peer focused. NARR reports a membership over 25,000 persons who are living in over 2,500 certified recovery residences throughout the United States (National Association of Recovery Residences, 2012). Mericle et al. (2022) aimed to identify the broad range of recovery residences across the country, including those that are members of NARR or other organizations as well as houses that are unaffiliated. They located 10,358 homes, with residences located in every state and Washington, D.C.

Sober living houses

Sober Living Houses (SLHs) are a good example of recovery homes based on social model recovery principles (Wittman & Polcin, 2014). Because SLHs are neither licensed nor required to report their existence to any government agency, it is difficult to ascertain their exact number. However, in California, sober living house associations such as the Sober Living Network (SLN) and California Consortium of Addiction Programs and Professionals (CCAPP) report a combined membership of nearly 800 houses in the state (Wittman & Polcin, 2014)

Most SLHs encourage or require attendance at 12-step meetings, such as AA. Peer support is emphasized, and residents are usually involved in house operations (e.g., cleaning, cooking, and basic maintenance of the house and property). Ideally, residents are also involved in decisions affecting the household. Although resident involvement is important, house operations are overseen by a house manager. This is typically a person in recovery, often with experience living in a SLH environment. The house manager is responsible for the overall operation of the house, including collecting rent, paying bills, facility repairs, facilitating a household environment that supports the recovery process, and enforcement of house rules (e.g. alcohol and drug abstinence, chores, attendance at house meetings and 12-step meetings). House managers receive a small stipend or reduction in rent as compensation for their work.

Research on SLHS

Research on outcomes for SLH residents shows they make improvements in multiple areas of functioning. In addition to reductions in substance use and severity of alcohol and drug problems, improvements have been noted on measures of employment, arrests, and psychiatric symptoms (D. L. Polcin, R. A. Korcha, et al., 2010). Studies of SLHs targeting specific groups have also found favorable results. These include studies of criminal justice involved residents (Polcin et al., 2018), persons attending outpatient treatment while they lived in SLHs (D. L. Polcin, Korcha, et al., 2010), and persons with recent histories of unstable housing (Polcin & Korcha, 2017). Individual level factors associated with substance use outcomes included psychiatric symptoms, social network support for recovery, and involvement in 12-step recovery groups. A more recent study of SLHs (i.e., Mahoney et al., 2023) examined neighborhood characteristics as predictors of outcome. Like earlier studies, the authors found residents made improvements on measures of substance use and psychiatric symptoms. Neighborhood predictors included density of nearby AA meetings and outpatient treatment programs, both of which predicted better outcomes.

Helping and social model recovery

We selected SLHs as sites to study helping because giving and receiving help is central to the social model approach to recovery used in SLHs. Importantly, a measure of social model recovery developed by Polcin et al. (2021), the Recovery Home Environment Scale (RHES), showed the level of social model activity and interaction in the house predicted length of stay and substance use at 6-month follow-up. It is therefore important to better understand the elements of social model recovery, such as helping, and the roles different elements of social model play in effecting outcomes.

Few current studies examine helping from a broad perspective that incorporates multiple types of giving and receiving help in different contexts. For example, studies typically examine the influence of one type of helping (e.g., receiving or giving help) in one social context (e.g., 12-step meetings, treatment programs, or family/friends). Thus, we are unclear about the demographic and other characteristics of persons who give and receive help and whether different types of help in different contexts are correlated. These questions are addressed in the current study and they are essential to the development of new studies assessing how helping in different contexts might interact to influence outcomes.

Purpose

The current study examined giving and receiving help among individuals entering 28 sober living recovery homes (SLHs). Giving and receiving help was assessed among SLH residents in different social contexts, including 12-step meetings, the SLH residence, and with family and friends. Specific Aims included: 1) To document descriptive characteristics of residents associated with giving and receiving help in different social contexts. 2) To assess whether increased giving or receiving help in one social context (12-step, SLH, or family/friends) was associated with increased giving or receiving in others. 3) For each type of help, assess whether giving that type of help and receiving it were correlated. We expected to find that

giving and receiving help within and across different contexts i.e., 12-step, SLH, and family/friends would be highly correlated. The findings would therefore support a bidirectional view of helping where SLH residents were involved in both giving and receiving help in different contexts.

Methods

House and resident sample

Our sample consisted of 188 persons who entered 28 SLHs in Los Angeles County. Participating houses were recruited in different geographical areas of Los Angeles representing diverse economic and geographical areas: West Los Angeles (19%), Central Los Angeles (21%), South Bay/Long Beach (43%), and the San Gabriel/San Fernando Valley (21%). SLHs included 14 houses for men, 7 for women, and 7 for all genders. All houses were members of the Sober Living Network (SLN), which is an association of SLHs mostly located in southern California. SLN provides certification, consultation, and advocacy to member houses that comply with standards for health, safety, good neighbor relations, and good business practices. The final sample had a range of 8 to 24 beds, with the mean number of beds being 13.4 (SD = 3.5). On average, the fees were $1,039, with a range from $500 to $4,000.

Because the study aimed to examine helping in a wide variety of individuals, we employed limited inclusion/exclusion criteria. Most of the instruments we used to study helping were developed primarily using samples of persons with alcohol disorders. We therefore required participants to have a past year alcohol use disorder using DSM-V criteria (American Psychiatric Association, 2013). However, participants were not excluded if they experienced co-occurring drug disorders. Additional criteria included 18 years of age or older and able to provide informed consent.

Procedures

The first step for data collection required recruitment of SLHs. Managers or owners of houses registered with the SLN were contacted using information available from the network and invited to participate. Other houses were already known to the study team through participation in other studies.

New residents entering the homes were invited to participate via information on posted flyers, the house manager, or prior study participants. Baseline assessments were conducted within 30 days of entry into the house. On average, interviews were conducted 16.0 days (SD = 9.0) after entering the houses. All study procedures were approved by the Public Health Institute institutional review board (IRB).

Measures

(1) *Demographic characteristics* included gender, age, race, and days worked the past 6 months.

(2) *Psychiatric severity* was assessed using the Addiction Severity Index psychiatric severity scale (McLellan et al., 1992). Due to the nonnormal distribution of this variable, scores were dichotomized (o versus > 0).
(3) *Alcohol and Drug Use* was assessed using the Time-Line-Follow-Back to determine number of days of alcohol and drug use over the past 30 days (Sobell et al., 1996).
(4) *Substance use disorder and mental health treatment* were assessed using a modification of the TLFB (Sobell et al., 1996). Due to the distributions of these variables, outcomes were dichotomized as 0 (no treatment the past 30 days) versus > 0 (at least one day of treatment the past 30 days).
(5) *Level of involvement in 12-step groups* was assessed using an adapted version of the Alcoholics Anonymous Affiliation Scale (AAAS) (Humphreys et al., 1998). Items assessed standard AA practices such as having a sponsor, attending meetings, abstinence, and working the steps of AA. The wording of items was broadened to include involvement in all 12-step groups in addition to AA. In a study by Pagano et al. (2009) similar items assessing AA involvement were shown to predict giving recovery oriented help to others in AA meetings.
(6) *Helping Measures* were assessed along several different dimensions, including help, help given and received, and the social context of helping (i.e., family/friends, SLH residence, and 12-step recovery groups). All helping measures were drawn from existing scales with published psychometric properties. Scales were adapted when necessary to allow assessments of giving and receiving different types of help. To assess internal consistency for each of the scales used in the current study we conducted Cronbach's alpha. Coefficients ranged from 0.89 to 0.94.
    (a) *Help given to family and friends* consisted of 7 items drawn from a helping scale developed by Moskowitz et al. (2013) that assessed instrumental help given to others. The measure was developed using data obtained from a sample of welfare recipients to study health outcomes. A separate subscale measure, described below, used the same items to assess help received from family and friends. Instrumental help included concrete things that one does for another person. Examples of items included helping others find a job, run errands, watch children, and provide transportation. Response categories were never – 0, sometimes – 1, or frequently – 2. Higher scores indicated more helping. We added five additional items that assessed emotional help given to others from scales developed by Kaskutas et al. (2007), Zemore and Kaskutas (2008), and Schwartz et al. (2003). Examples of emotional help items included offering moral support and encouragement, spending time with someone when they need it, and sharing one's recovery experiences. Scaled scores were calculated by averaging item responses. Cronbach's alpha for the current study was 0.90.
    (b) *Help Received from family and friends* consisted of the 7-item helping scale developed by Moskowitz et al. (2013) assessing instrumental help received from family or friends. Instrumental help included concrete things that were helpful. Items assessed receipt of support and were the same as the items described above except these asked about help received rather than given. Examples of items included receiving help to find a job, run errands, watch children, get a ride, and being taken care of them when sick or injured. As with the items assessing giving help, response categories were never – 0, sometimes –

1, or frequently – 2. Higher scores indicated more helping. Cronbach's alpha was found to be 0.81. Using this measure, the authors showed help received by welfare recipients had a modest stress-buffering effect on health, but only for those exposed to high levels of stress. We added five additional items that assess emotional help given to others from scales developed by Kaskutas et al. (2007), Zemore and Kaskutas (2008), and Schwartz et al. (2003). Examples of emotional help items included receiving moral support and encouragement, someone spending time with you when they need it, and someone sharing their experiences with you. Scaled scores were calculated by averaging item responses. Cronbach's alpha for the current study was 0.91.

(c) *SLH Help Given* was an assessment of how study participants provided instrumental and emotional help to other residents in the SLHs. These assessments included the same items from the family and friends measures described above. The only difference was that instead of referring to help given to family and friends, the items referred to help given to "other residents in your SLH." Cronbach's alpha for the current study was 0.89.

(d) *SLH Help Received* was an assessment of emotional and instrumental help that study participants received from other SLH residents. These assessments included the same items from the family and friends measures described above. The only difference was instead of referring to help received from family and friends, the items referred to help received from "other residents in your SLH." Cronbach's alpha for the current study was 0.89.

(e) *12-Step Help Given* to others was assessed using the Service to Others in Sobriety (SOS) scale developed by Pagano et al. (2009). Twelve items were rated on a 5-point Likert-type scale from 1 (rarely) to 5 (always) over the past month. Scores were obtained by averaging these items. SOS items reflected various helping behaviors provided to others within the 12-step fellowship: spending time with a sponsee, guiding an AA member through the steps, sharing a personal story with another AA member, saying hello to a newcomer, and volunteering for service positions at meetings. Psychometric properties included adequate internal consistency (alpha =.82). Cronbach's alpha for the current study was 0.91.

(f) *12-Step Help Received* consisted of 15 statements that were rated on a 5-point Likert-type scale from 1 (rarely) to 5 (always) over the past month, and the score was obtained as an average of these items. It included the same items in the SOS, except they were reframed to inquire about help received from fellow AA members. For example, questions were reworded to ask about "your sponsor spending time with you, another member of AA helping you work the steps, and an AA member sharing a personal story with you." This scale also included three additional statements, "Encourage you to help others," "Let you know that you were helpful," and "Let you know that you were needed." Cronbach's alpha for the current study was 0.94.

Analysis

One of the study aims was to assess how giving and receiving different types of help in different social contexts (i.e., family/friends, SLHs, and 12-step meetings) varied by demographic and other characteristics. To test for significant differences in helping scores we used ANOVA. We also aimed to understand whether giving and receiving help in one social context (12-step, SLH, or family/friends) was associated with increased giving or receiving it in others. Pearson correlations were used to assess the strength of these associations as well as to test whether giving and receiving each type of help were associated.

In addition to correlation analyses, we used mixed effects models to test the hypothesis that giving help to others in a specific context (family/friends, SLH, and 12-step) would predict receiving that type of help. These models allowed us to account for variability that could be due to the SLHs. Controlling for demographic characteristics and involvement in 12-step groups (AAAS), we expected giving help in each context would predict receiving help in that same context. Three regression models tested these associations using receipt of each type of help as a dependent variable.

Results

Descriptive characteristics

Descriptive characteristics of the sample are shown in Table 1. Over two-thirds of the participants ($N = 188$) were men and a majority (56.1%) were nonwhite. Age was assessed as a categorical variable and a plurality (40.4%) were age 40 or older. Slightly over a quarter of the sample worked over 60 days during the last 6 month, but a plurality (42.3%) worked zero days. Psychiatric severity was dichotomized as 0 versus > 0 on the ASI psychiatric severity scale. Over 88% reported some level of psychiatric symptoms on the Addiction Severity Index Psychiatric scale (>0). About 60% of the sample indicated some treatment for alcohol/drugs over the past 30 days and 12% indicated some mental health treatment over the same period. Majorities reported 30-day abstinence from alcohol (71.35%) and drugs (80.7%).

Helping contexts

Table 1 also shows that giving and receiving help in different contexts (SLHs, 12-step groups, and family/friends) occurred among residents with diverse demographic characteristics, problems, and services received. ANOVA tests comparing means within each type of helping showed few significant differences. The one exception was 12-step help received, which showed differences on five variables. Residents who received higher levels of help in 12-step meetings included those who were female and did not drink in the past 30 days. Those who did not receive mental health treatment over the past 30 days and those with higher scores on the AAAS scale, which measured level of involvement in 12-step meeting, also reported receiving more help. Higher scores on the AAAS were also associated with higher levels of giving help in 12-step meetings and at the SLH. The demographic characteristic most often associated with helping was gender. Compared to men, women gave and received more help at 12-step meetings and gave more help to family and friends.

Table 1. Descriptive characteristics associated with giving and receiving help at baseline ($N = 188$).

Descriptive			*Giving*		*Receiving*		
Characteristics		Mean (SD)			Mean (SD)		
	N (%)	*Family/Friends*	*SLH*	*12-Step*	*Family/Friends*	*SLH*	*12-Step*
Age					F = 1.98 **		
18–29	53 (31.0)	0.73 (0.50)	0.73 (0.46)	2.06 (1.35)	0.88 (0.51)	0.94 (0.43)	2.95 (1.52)
30–40	50 (28.6)	0.91 (0.50)	0.90 (0.41)	2.29 (1.38)	1.14 (0.52)	1.03 (0.45)	3.01 (1.61)
40+	72 (40.4)	0.97 (0.47)	0.80 (0.42)	2.11 (1.32)	0.97 (0.51)	0.84 (0.44)	2.76 (1.66)
Race							F = 1.57*
White	76 (43.9)	0.84 (0.49)	0.82 (0.37)	2.30 (1.18)	0.88 (0.49)	0.89 (0.42)	3.10 (1.33)
Black/African American	24 (14.0)	0.96 (0.57)	0.78 (0.52)	1.78 (1.64)	1.10 (0.55)	0.91 (0.52)	2.25 (1.96)
Latino/Hispanic	63 (35.7)	0.96 (0.45)	0.79 (0.46)	2.12 (1.36)	1.17 (0.47)	0.98 (0.44)	2.79 (1.67)
Mixed/Other	12 (6.4)	0.64 (0.54)	0.82 (0.52)	2.28 (1.60)	0.61 (0.59)	0.87 (0.50)	3.42 (1.66)
Gender		F = 2.27**		F = 1.90**			F = 1.90**
Female	54 (31.6)	1.07 (0.37)	0.95 (0.41)	2.71 (1.16)	1.15 (0.42)	1.06 (0.41)	3.38 (2.68)
Male	121 (68.4)	0.80 (0.52)	0.73 (0.43)	1.90 (1.35)	0.92 (0.55)	0.86 (0.45)	1.64 (1.16)
Days worked							
Past 6 months[a]							
Low	74 (42.3)	0.94 (0.49)	0.82 (0.44)	2.28 (1.32)	1.03 (0.53)	0.90 (0.45)	2.84 (1.61)
Medium	53 (30.3)	0.88 (0.44)	0.75 (0.46)	2.11 (1.37)	1.09 (0.46)	0.92 (0.50)	2.84 (1.59)
High	48 (27.4)	0.79 (0.55)	0.81 (0.40)	1.99 (1.33)	0.86 (0.55)	0.96 (0.37)	3.02 (1.60)
Alcohol Use							
Past 30 Days							F = 1.66*
No use	125 (71.4)	0.92 (0.48)	0.84 (0.45)	2.45 (1.27)	1.04 (0.53)	0.92 (0.46)	3.09 (1.52)
Use	50 (28.6)	0.80 (0.52)	0.71 (0.40)	1.44 (1.26)	0.89 (0.49)	0.94 (0.40)	2.06 (1.66)
Drug Use							
Past 30 days							
No use	141 (80.7)	0.90 (0.48)	0.84 (0.42)	2.32 (1.29)	1.01 (0.52)	0.93 (0.44)	1.99 (1.10)
Use	34 (19.3)	0.81 (0.54)	0.64 (0.46)	1.48 (1.37)	0.94 (0.52)	0.91 (0.46)	1.27 (1.17)
ASI Psych							
No problems	19 (11.4)	0.93 (0.46)	0.93 (0.43)	2.45 (1.46)	1.09 (0.52)	1.12 (0.44)	2.84 (1.70)
Problems reported	152 (88.6)	0.87 (0.50)	0.78 (0.44)	2.11 (1.34)	0.98 (0.53)	0.90 (0.45)	2.88 (1.58)
12-Step Involvement			F = 1.69*	F = 2.50***			F = 2.94***
AAAS Low	93 (52.0)	0.87 (0.55)	0.71 (0.43)	1.59 (1.39)	0.95 (0.54)	0.88 (0.44)	2.11 (1.67)
AAAS High	82 (48.0)	0.91 (0.44)	0.90 (0.43)	2.79 (.96)	1.04 (0.50)	0.96 (0.45)	3.78 (.90)
Drug/Alcohol Treatment							
Past 30 Days							
None	70 (39.8)	0.85 (0.55)	0.76 (0.43)	1.66 (1.32)	0.92 (0.55)	0.91 (0.45)	2.45 (1.68)
At least 1 day	105 (60.2)	0.91 (0.46)	0.83 (0.44)	2.50 (1.26)	1.05 (0.50)	0.93 (0.44)	3.19 (1.47)
Mental Health Treatment							
Past 30 Days							F = 1.52*
None	153 (87.7)	0.92 (0.49)	0.83 (0.44)	2.24 (1.36)	1.04 (0.51)	0.94 (0.44)	2.97 (1.60)
At least 1 day	22 (12.3)	0.66 (0.49)	0.59 (0.37)	1.64 (1.14)	0.69 (0.51)	0.83 (0.50)	2.35 (1.52)

***$p<.001$, **$p<.01$, *$p<.05$.
mean differences were assessed using ANOVA.
[a]Groups for days worked in prior 6 months: Low (0 days), Medium (1–60 days), High (Over 60 days)
ASI (Addiction Severity Index); AAAS (Alcoholics Anonymous Affiliation Scale, modified to include 12-step groups).

Correlations for giving and receiving different types of help

Because we used different measures to assess giving and receiving help in the different contexts (i.e., family/friends, SLHs, and 12-step meetings), we were not able to make direct comparisons of the means for helping between the three contexts. However, analyses of helping measures did reveal a number of correlations between giving and receiving help within and across the different contexts. Overall, there were two distinct findings. First, to the extent that residents were involved in giving help, they were also involved in receiving help. Second, to the extent that residents were involved in giving or receiving help in one domain (friends/family,

Table 2. Baseline correlations between types of helping.

Help Given	Family/Friends	SLH	12-step
Family/Friends	—–	0.338***	.245**
SLH	0.338***	—–	.416***
12-step	0.245**	0.416***	—
Help Received	Family/Friends	SLH	12-step
Family/Friends	—–	0.342***	.234**
SLH	0.342***	—–	.282**
12-step	0.234**	0.282**	—–

***p<.001, **p<.01, *p<.05.

Table 3. Baseline correlation between help given and received for each type of help.

Type of Help	Family/Friends Received	SLH Received	12-step Received
Family/Friends Given	0.627***	0.235**	ns
SLH Given	0.272***	0.685***	.375***
12-Step Given	0.404***	0.257***	.815***

***p<.001, **p<.01, *p<.05.

SLH residents, or 12-step meetings), they were also likely to be involved in giving and receiving help in other domains.

Table 2 shows baseline correlations between different types of helping within giving and receiving categories ($N = 173$). The data show a consistent pattern where giving or receiving help in one context (family/friends, 12-step, or SLH) is associated with helping in the other contexts. The table shows correlations between different types of helping within the giving category ranged from $r = 0.245$, $p < .01$ to $r = 0.416$, $p < .001$.For help received, correlations ranged from $r = 0.234$, $p < .01$ to $r = 0.342$, $p < .001$.

Table 3 shows that for each type of help, (family/friends, SLH, and 12-step), giving that type of help was associated with receiving it. Moreover, these associations were relatively large, $r = 0.627$, $p < .001$ for family/friends, $r = 0.685$, $p < .001$ for SLHs, and $r = 0.815$, $p < .001$ for 12-step groups. Although correlations between giving and receiving help within a specific context were the largest, there were also significant associations between giving and receiving help across different contexts. For example, as residents increased help given to family and friends, they also increased help they received from SLH residents. To the extent that residents reported receiving help at the SLH, they also reported giving help at the house, at 12-step meetings, and during interactions with family and friends. Overall, there were consistent associations within and across different types of giving and receiving help.

Mixed effects models

We constructed mixed effects models to assess the hypothesis that giving help in one of the three contexts would predict receiving help in that context. In this respect, we hoped to show that helping was an interactive dynamic that was bidirectional. Providing help in each of the three contexts was assessed as a predictor of receiving help. Models controlled for other potential predictors, including demographic characteristics (age, race, gender, and education) and involvement in 12-step groups (AAAS).

Table 4 shows that giving help in each context predicted receiving help in that context. For example, giving help to family and friends predicted receiving help from them ($B = 0.60$, SE = 0.08, $p < .001$). Among residents living together in a SLH environment, giving and

Table 4. Multilevel models for help given and received for each type of Help.

Measure	Receiving Help Friends/Family Coef (SE)	Receiving Help SLH Coef (SE)	Receiving Help 12-step Coef (SE)
Age	−.00 (.00)	−.00 (.00)	−.01 (.00)*
Race	−.18 (.06)**	−.06 (.05)	−.05 (.16)
Gender	−.04 (.07)	−.05 (.06)	−.03 (.14)
AA Affiliation Scale	.09 (.05)	−.04 (.03)	.50 (.12)***
Giving Help to Friends/Family	.60 (.08)***	-	-
Giving Help to SLH	-	.69 (.05)***	-
Giving Help to 12-step	-	-	.86 (.08)***

*p<.05, **p<.01, **p<.001.

receiving help were similarly related ($B = 0.69$, SE = 0.05, $p < .001$). Significant relationships between giving and receiving help were also evident at 12-step meetings ($B = 0.86$, SE = 0.08, $p < .001$).

Discussion

Studies of helping behaviors among persons in recovery have focused primarily on the benefits individuals experience when they help others. Although studies have supported the notion that receiving social support is helpful to recovery, fewer studies have looked at receipt of specific types of help in different contexts. In addition, most studies of helping have focused on two contexts: AA meetings and treatment settings. The current study differed from previous studies by examining helping behaviors in a sample of individuals entering SLH recovery homes. These settings are ideal for studying helping because giving and receiving help is integral to the social model approach to recovery used by SLHs. Giving and receiving help among SLH residents was examined in a broad context that included assessments of helping at 12-step meetings and with family or friends, as well as at the SLH.

Helping across demographics and problems

The finding that a limited number of demographic characteristics predicted giving and receiving help suggests that helping is not limited to specific subgroups, but occurs in a variety of relationships. To the extent that future research finds different types of helping to have beneficial effects, those benefits might be generalized broadly to diverse demographic groups. We also found little variation of helping among residents with different problems. None of the six types of helping varied by psychiatric problems, days worked over the past six months, or drug use over the past 30 days. Because psychiatric severity was relatively low for our sample, additional studies with samples that have higher severity could result in different findings. Alcohol use over the past 30 days was not associated with 5 of the 6 types of helping. The one exception was higher levels of help received at 12-step meetings for residents who drank during the past month.

There were a few notable findings for gender. Compared to men, women were more involved in giving and receiving some types of help, which is consistent with findings from Oxford House research (Viola et al., 2009). Compared to men, women gave and received more help at 12-step meetings. They also gave more help to family/friends. The finding that

for women received more help than men at 12-step meetings is consistent with earlier findings from Moos et al. (2006), who found that women who participated in AA for extended periods of time benefited more than men. Interestingly, some theories of personal growth for women (e.g., DeYoung, 2015) suggest women are more likely than men to get social and emotional needs met within personal relationships rather than through separation and autonomy, which are common ways of conceptualizing growth for men (DeYoung, 2015). To the extent that notion is accurate, it would seem to help explain why women report higher frequencies of giving and receiving some types of help.

One caveat about our findings by gender was when it came to helping in a family/friend context, women were more likely than men to be giving help, but not more likely to be receiving it. Although more research is needed to examine the implications of this finding, it might be prudent to consider whether some women are giving to family/friends to a point where it could be counterproductive to their own recovery. For example, it might be important to encourage some women to seek a balance of giving and receiving help with family and friends.

Services received

Giving and receiving help from individuals was largely unrelated to substance use and psychiatric services received prior to entering the house. For example, even though 60% of the sample reported receiving at least one day of alcohol/drug treatment during the 30 days prior to entering the SLH, treatment received was unrelated to giving and receiving help. Five of the six helping scales were unrelated to receipt of mental health services. The one exception was less help received in 12-step meetings for residents who received mental health services. Although helping was unrelated to a broad measure of psychiatric severity (i.e., ASI psychiatric severity scale), persons with more serious problems requiring mental health treatment may have greater difficulty with some aspects of 12 step groups. These findings are consistent with previous studies, which found persons with higher psychiatric severity had greater difficulty working the steps of AA and developing a spiritual life (Polcin & Zemore, 2009).

Reciprocity and helping contexts

Prior research on helping has focused on helping primarily as an individual characteristic that benefits the helper. However, results from the current study suggest helping might be the result of influences from a broader social context. Our data suggest helping is not a one-way interaction consisting of individuals who help others and those who receive help. To the extent SLH residents were involved in giving help to others they also reported receiving help. This was especially evident when we looked at helping within one context. Regression analyses showed that for each helping context giving that type of help predicted receiving it. For example, to the extent that residents provided help to others at the SLH they also reported receiving help from fellow residents. To the extent they provided help to others at 12-step meetings they also reported receiving help from other 12-step members. The same relationships were evident for helping with family and friends.

Although giving and receiving help within a single context had the largest associations, giving and receiving help were correlated across contexts as well. For example, to the extent

residents reported giving help to family and friends, they also reported receiving help in the SLH. The only combination of giving and receiving help in different contexts that was not significant was giving help to family/friends and receiving help in 12-step groups.

In addition to finding associations between giving and receiving help, we found associations among different social contexts. When residents reported giving help at the SLH, they often reported giving help to family/friends and fellow 12-step members. The same dynamic was true for receiving help in different contexts. To the extent that study participants reported receiving help from family and friends they also reported receiving help from other SLH residents. One implication of these findings is that giving and receiving help exists in a more complex environment than previously thought. The appropriate challenge for SLH service providers may be to engage residents in helping activities in any context with the hope that helping in other contexts will emerge as well.

Benefits of recovery housing

Recovery housing is sometimes only considered when individuals need safe, structured, and affordable housing (Mericle et al., 2019, 2022). However, the current study, as well as prior research, shows that recovery housing can provide additional benefits. The current findings show that giving and receiving help among residents of SLHs is a common benefit. Moreover, helping in SLHs is correlated with helping in other forums, including family and friends and 12-step meetings. Oxford Houses have long highlighted the role these houses can play in helping residents develop and a psychological sense of community (Graham et al., 2009). Recent research on SLHs shows that these homes are able to build strong social model environments that promote longer retention and better substance use outcomes (Polcin et al., 2021). An important goal for SLH providers and researchers should include recognizing the myriad of ways SLHs houses benefit residents beyond providing affordable alcohol- and drug-free housing.

Helping behaviors and social model recovery

When SLHs are operated strategically they become excellent forums for promoting social model recovery activities that build interpersonal recovery capital. Polcin et al. (2014) described ways that managers and senior residents who have lived in the houses for longer periods of time can create cultures of recovery that facilitate helping interactions in different social contexts. For example, engagement in 12-step recovery groups is an essential aspect of social model recovery and most SLHs require attendance at 12-step or other mutual-help meetings. Twelve-step related activities, such as sponsorship, volunteer service positions (e.g., disseminating AA literature, setup and cleanup, making coffee), and experiential learning (e.g., sharing ones story) provide ample opportunities to give and receive help in a 12-step recovery context.

Well operated SLHs facilitate helping behaviors in other ways that are often not recognized. For example, a core principle of social model recovery is empowerment of residents in decision making and encouragement of their input into how the house is managed. Resident participation in house meetings where decisions are made should be understood and emphasized as an important way to help build

recovery capital within the household. Similarly, participating in upkeep and maintenance of the house is an important way residents help the overall household. These helping efforts contribute to a sense of ownership that enhances resident commitment, motivation, and sense of community, all of which are important aspects of recovery capital. To the extent the SLH is creating a strong social model environment, residents are more likely to provide emotional support and practical help to one another.

It is unfortunate that some managers of SLH residences see their roles as primarily administrative (Polcin et al., 2020). We suggest house managers and senior residents should understand and implement a broad view of social model that can enhance multiple ways of increasing helping behaviors in SLHs and other forums.

Considerations for research

Potential areas of inquiry for helping among residents of SLHs and other types of recovery residences include a variety of questions. How are different types of giving and receiving help associated with substance use outcomes? Are different types of giving and receiving help associated with other outcomes, such employment, legal problems, and social support for recovery? Are helping effects independent, interactive, or both? Are the effects of different types of helping on outcomes influenced by other factors, such as characteristics of the social environment or management of the SLH? How might SLH and other recovery home providers best facilitate helping?We also need to learn more about the determinants of helping behaviors. To what extent do SLH residents engage in helping interactions because of individual factors, such as personality characteristics? To what extent is the frequency of different types of helping determined by characteristics of the social environment? For example, are there social norms about giving and receiving help that deter or facilitate it in SLH's? To what extent is helping valued as an essential part of developing a recovery community or fellowship? Are there countervailing forces, such as the widespread values in American culture that demand independence and self-reliance? We contend that maximizing the potential beneficial effects of helping will require attention to these questions.

Limitations

The current study was a cross sectional analysis of helping at baseline (within 30 days of entering the house). We described the frequency of different types of helping in different social contexts and how they were associated with each other, but we did not examine how helping behaviors were associated with outcomes. There is a need for studies that assess the trajectories of helping over time and how they are related to different recovery outcomes. The current study was not designed to depict any type of causality related to factors that facilitate or hinder giving or receiving help. The houses that participated in the study were all SLHs located in Los Angeles. Studies of other types of recovery homes in other geographical areas might result in different findings.

Conclusions

The current study examined giving and receiving help among SLH residents. Helping behaviors were examined in the context of interactions with fellow residents at the SLHs as well as interactions with family/friends and peers at 12-step meetings. Associations between descriptive characteristics and helping were limited primarily to 12-step settings. Residents who had higher involvement in 12-step recovery activities reported more giving and receiving help at 12-step meetings and giving more help at the SLH. Giving and receiving help within and across in all three contexts were highly correlated. Research is needed to examine how helping behaviors in different contexts are associated with outcomes among SLH residents.

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