PROFESSIONAL UNDERUTILIZATION OF RECOVERY, INC.

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AUTHOR NOTE

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Professional literature since 1960 often reflects extreme misinterpretations of the self-help group, Recovery, Inc., developed by A. A. Low, a psychiatrist. The literature is reviewed, misinterpretations identified, corrections and clarification presented. There are 4 types of distortions: Language, meeting structure, ascribing religious parallels and the nature of self-help groups. Recovery, Inc. is seldom used by mental health professionals. This seems to be due to lack of information about the group and distortions from the literature and brief observations. Failure of therapists to collaborate results in losing critical treatment advantages not found and duplicated in professional services alone.

INTRODUCTION

Recovery, Inc. is an enigma among self-help groups. Few, if any other self-help groups, have been as misunderstood by their supporters, as well as their detractors, and as ignored or undiscovered by so many professionals. This paper will explore from the literature some misunderstandings by professionals about Recovery, Inc. and will cite one study by the author. It will point out certain reasons this self-help organization, the second oldest in age to Alcoholics Anonymous among self-help groups, is not yet more fully utilized.

Before looking at the literature on Recovery, Inc. it will be helpful to gain a wider perspective on professional attitudes towards self-help groups. The emergence of self-help groups presented a quandary for professionals, would they utilize these new entities and work with them or reject them (Dumont, 1974; Levy, 1976; Powell, 1979; Black & Drachman, 1985)? This question has not been settled today with any uniformity.

Katz (1965) pointed out quite early, "...it seems clear that there are powerful restraining psychological influences at work and it will be some time before

the self-help approach will be more widely understood and utilized...." Although he was addressing social workers when he wrote this he could have been describing any of the mental health professions.

Generally there have been strong recommendations by academics and some clinicians to integrate professional treatment and self-help groups to improve mental health services (Huey, 1977; Gottlieb & Schroter, 1978; Hermalin, Melendez, Kamarck, Levans, Ballen, & Gordon, 1979; Powell, 1979; Todres, 1982; Lurie & Schulman, 1983; Coplan & Strull, 1983; Toseland & Hacker, 1985; Black & Drachman, 1985; Kurtz & Chambon, 1987; and Kerson, 1990).

Toseland and Hacker (1983), found that social workers held "...positive or very positive views about self-help groups,...." Powell (1987) pointed out that while professionals may hold positive attitudes this did not necessarily mean they referred patients to self-help groups.

Kurtz, Mann, and Chambon (1987) did an extensive study of professional utilization of self-help groups finding that professionals are less willing to use self-help groups, when the self-help group is offering services that more closely resemble professional services. They found they can work together if the differences between their work are clearly established.

Katz (1993), taking a wary view, points out, "...that there is still a long way to go before professionals broadly accept these groups..." and he likens the process to that of industrial workers faced with learning "...new skills when their plants begin making different products."

In 1973 Grosz found only 37% of Recovery members had been referred by professionals. Psychiatrists accounted for 20% and the remainder were family physicians, social workers, and religious advisers. In 1978 Raiff found that 30% of Recovery members had been referred by physicians and 9% by other professionals and semi-professionals. Levy's (1979) study of 748 mental health agencies' utilization of self-help groups showed Recovery, Inc. as being well above average in the view of professionals referring patients compared to 20 other self-help groups (S. Sachs, personal communication, re: letter from L.H. Levy June 29, 1993). Galanter in 1990 found only 12% of Recovery members referred by psychiatrists.

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At best this is a meager percentage of referrals coming from the professional sector. These declining percentages also may point to a reduction in professional referrals over the 16 years covered by these studies.

The author completed a project in 1989 to introduce Recovery, Inc. to a number of forensic programs. A study was made subsequently of forensic mental health professionals to learn usage patterns of self-help groups and in particular, Recovery, Inc. (Lee, 1993).

Ninety-four percent of these 47 professionals referred patients to Alcoholics Anonymous or Narcotics Anonymous. These forensic professionals utilized nine other self-help groups. In spite of extensive use of other self-help groups only 2% of these therapists had used Recovery, Inc. and 38% reported they had never heard of Recovery, Inc. or had heard only of the name (Lee, 1993).

History of Recovery Inc.

Abraham A. Low, a psychiatrist with psychoanalytic training, began formulating the Recovery method in 1937 when he was the assistant director of the Illinois Psychiatric Institute (Low, 1950). Low was treating in a group, patients diagnosed psychotic who now were ready to return to the community. Later he combined neurotic patients he was treating in the community with his hospital patients (T. Rice, personal communication, January 1994).

During the 1940s he continued refining the method and expanding his concepts. He published *Mental Health Through Will Training* for his patients' use in learning the method through case examples and lectures (Low, 1950). Low began in 1952, 2 years before he died, teaching patients how to run the meetings themselves and how to employ the method's self-help aspects (Low, 1950; Rau & Rau, 1971).

Recovery, Inc. has been a self-help group since that time with members conducting meetings and training the leaders. Groups spread throughout the United States, Canada, the Caribbean (See Low's book, *Mental Health*

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Through Will Training, Spanish language edition [Low, 1976]) as well as England, Wales, and Ireland (C. Jungheim, personal communication, January 1994).

Summary of Recovery Inc. Method

When Low pioneered his treatment method it was some years before Beck and Meichenbaum applied the term cognitive to this treatment approach (Cormier & Cormier, 1985). Low taught his patients a blend of Recovery and self-help methods that were most harmonious. However, this congruence occurred so early that many professionals, especially those firmly entrenched in psychoanalytic theory, had a difficult time accepting Recovery, Inc.

Low also was a semanticist (Collier, 1991; Lee, 1991) who created a special language for his method to reach his patients more effectively. He recognized that language was of utmost importance (Rau & Rau, 1971) for it was fundamental to the cognitive treatment process. Patients would become alarmed by symptoms and would self diagnose their condition in extreme terms (intolerable, uncontrollable, terrible, etc. or of dangerous organic etiology). When Low found that patients were angry towards themselves (fearful temper) or others (angry temper) this brought on tenseness that triggered symptoms. Low described how patients entered a vicious cycle accompanied by defeatism. Symptoms meant danger [the fear of a permanent handicap] and defeatism derived from the belief that the patient had a permanent handicap. Thus more symptoms ensued (Low, 1950). Low (1950) emphasized that each person has a *will* that is always available. By systematically applying the cognitive behavioral concepts he developed, (for example, controlling thoughts, moving or controlling muscles, averageness [lowering expectations] and objectivity [describing symptoms factually]) patients could use their will to take responsibility for their lives and control the tenseness leading to symptoms.

Low (1950) carefully developed his treatment language to be free of alarmist associations and fully understandable to his patients. He knew it was essential to have a non-psychiatric vocabulary since he did not want patients in a self-help mode getting in over their heads with psychiatric terminology they didn't understand.

He taught his patients ways to resolve their problems of distressful symptoms and physical sensations through a variety of cognitive-behavioral techniques. Recovery, Inc. in gaining acceptance among professionals was faced with two problems: 1) The term *cognitive behavioral therapy* was not applied for some years, and 2) cognitive behavioral therapy also suffered from lack of general acceptance among professionals; in large part because the supporting research for cognitive behavioral therapy was not yet available (Cormier and Cormier, 1985).

How Recovery, Inc. Meetings Function

Low established the self-help component of his approach to enable mentally disordered people, with systematic training, to lead meetings and use the method. He knew they needed firm structure to achieve a secure setting. Meetings, therefore, follow a formal pattern. Everyone sits around a table and takes turns reading aloud a chapter from Low's book, *Mental Health Through Will Training*. Members can participate in a variety of ways according to their level of functioning. Some may sit and listen, while others read, give an example, "spot" (describe what Recovery terms apply to an example presented), and ask questions in the mutual aid period at the end of the meeting.

Structured meetings permit less functional members, or those lacking confidence, to participate flexibly and just to the degree they are capable. New members are asked not to give examples or try to "spot" at meetings until they become familiar with the method through

reading part of Low's book. They are encouraged to ask questions and participate in the mutual aid period. When the members are through reading aloud the leader asks for four volunteers to give examples.

An assistant leader will begin by reading aloud the questions outlining how examples should be presented. Panel members then follow this outline for giving their examples about a triviality of everyday life showing when and where the event took place, who was there and what was said or done. The member then describes the working up process of what nervous or mental symptoms developed and what Recovery methods were used to handle them. As Low taught, all members must relate how they have endorsed the effort they made in using the Recovery method. The member completes the example by describing the differences experienced in their life before Recovery training compared to now. This comparison serves to remind members how much progress they have made and to show other members how systematic practice can help.

The leader asks each experienced member to "spot" or to identify in Recovery terms what methods were employed or should have been used by the person presenting. The member giving the example may accept or reject what is said by others, but it must be done silently.

Low emphasized a vital treatment approach when he told his patients to focus only on trivialities of everyday life. First, it relabels and reduces the problem to a manageable size so as not to overwhelm the patient. Second, it was an astute way Low had of dealing with some extraordinarily complex problems. A triviality of everyday life will often condense and represent the patient's basic life problem. People generally are not threatened by discussing trivialities of everyday life; they are seen as inconsequential events. Focusing on trivialities makes it possible to discuss coping mechanisms that otherwise might be too threatening.

Low gave his patients a diverse range of techniques to handle their problems. He taught patients how they can control their thoughts because they can only think one thought at a time. Therefore, when the patient has an insecure thought this can be replaced by a secure thought. Low taught patients why they cannot change their feelings nor their sensations directly. However, if they systematically change their thoughts this will change feelings and sensations.

Recovery members are taught to use their will to command their muscles to either move or to be controlled depending on the problem they are suffering. Again, the patients' use of will enables them to say yes or no to thoughts and impulses thereby placing them in better control of their own lives (T. Rice, personal communication, January 1994).

Members augment the above Recovery methods when they reinforce their good mental health practices by self-endorsement of effort, not accomplishment.

Analysis of Critical Literature

There have been numerous misunderstandings about Recovery, Inc. by professionals in the literature. Critics and some supporters did not recognize that Low was a pioneer in utilizing cognitive behavioral treatment methods. Most professionals, regardless of whether they supported the organization or criticized it, failed to recognize the importance of Low's treatment method.

Although cognitive behavioral treatment is widely accepted now, Low's methods were not identified with it until recently; in part because the language Low devised for his patients was unfamiliar to most professionals.

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These problems have caused a rift between professionals, who have been so influenced, and this self-help group. These problems fall into four areas:

1.) Unfamiliarity with cognitive behavioral therapy leading to objections to Recovery language and terms.

2.) Lack of appreciation of patients' needs for security and uniformity leading to objections about structure and methods of the organization.

3.) Ascribing religious parallels to the structure of meetings and the enthusiasm of members.

4.) Holding unrealistic expectations due to confusing self-help groups with social or medical agencies.

Some critics (Antze, 1976; Omark, 1982; Powell, 1992) were unable to accept the language Low used as a necessary condition for cognitive therapy. They did not appreciate that Low was writing for his patients' use and not for other professionals. While some have referred to

his work as cognitive, (Wechsler, 1960; Levy, 1976; Kurtz & Chambon, 1987) most, including a supporter, (Dean, 1971), did not understand that Low had worked out a comprehensive system enabling his patients to understand and overcome their difficulties.

Critics (Wechsler, 1960; Levy, 1976; Omark, 1982) also complained that Recovery meetings are too structured. These authors did not appreciate that mentally disordered people, who usually need more structure, attend Recovery, Inc. meetings. Structure promotes learning through repetition and uniformity thereby providing substantial emotional security.

Great misunderstandings occurred about Low's dictum that patients should keep from sabotaging their mental health by refraining from self-diagnosis. Wechsler (1960) and Antze (1976) so misunderstood Low's prohibitions about self-diagnosis that they asserted that Low was telling his patients that they were all well! Low wanted his patients to accept his diagnosis that their condition was not a hopeless, incurable organic disorder. Low particularly emphasized the somatic symptoms of both psychosis and neurosis from the patient's viewpoint. He was keenly aware how somatic symptoms spelled danger of the permanent handicap to his patients. The critics could not understand why Low's patients needed to know that they had no organic pathology. This is far different from telling patients that they were all well.

Reinforcement is an important aspect of cognitive behavioral therapy. Cognitive behavioral therapists have found that when patients reward themselves for exhibiting healthy behavior (reinforcement) this promotes their continued use of such healthy behavior (Cormier & Cormier, 1985). Reinforcement is most effective the closer it occurs to the desired event (Cormier & Cormier, 1985). Low's approach was unique because he put an emphasis on endorsing effort and control, not accomplishment. Low (1950) insisted patients only endorse effort and not accomplishment because everyone can make an effort, but average people may or may not succeed in every attempt to change. Low's distinction is uniquely important for it puts the focus on self-effort and the use of will. It also removes the tendency for patients to seek approval from others. He wanted them to incorporate their own system of self reward and not become dependent on outside approval.

One of Low's bitterest critics, Wechsler (1960), so misunderstood self-endorsement that he distorted what Low said. For example, he wrote, "The emphasis on the power of positive thinking and on inspiration is also analogous to some religious tenets...." Nowhere in Low's writings does one find anything about the power of positive thinking. Furthermore, Wechsler (1960) mistakenly thought patients were seeking praise from other members. What he heard was Low's admonition that leaders should remind members to endorse themselves when in giving an example they fail to state they endorsed themselves.

Other critics (Wechsler, 1960; Antze, 1976) have charged quite mistakenly that Low's method devaluates feelings. Lieberman and Bond (1979) similarly describe Recovery, Inc. as a method that "...encourages 'denial-like' mechanisms...." Low (1950) makes it quite clear that people should cultivate feelings and express them. Too many critics have mistaken temper for feelings, as did Low's patients. Low (1950) said, Feelings call for expression, temper for suppression. The assertion of temper blocks the expression of true feelings (Low, 1950). Low was most insistent that his patients learn how to express their genuine feelings for this is how best to communicate with other people (Low, 1950). Low had an opportunity to correct his patients' misperceptions, but not his critics.

"COGNITIVE BEHAVIORAL THERAPISTS TODAY RELABEL MANY OF THEIR PATIENT'S DISTORTED VIEWS INTO DIFFERENT TERMS, THEREBY ENABLING THE PATIENT TO COPE MORE EFFECTIVELY. LOW'S APPROACH WAS GOOD COGNITIVE BEHAVIORAL THERAPY—NOT DEVALUATING FEELINGS."

Low was working with both post psychotic and seriously ill neurotic patients and he knew they tended to misinterpret both feelings and sensations. He said a person could not change either one directly. However, by changing one's thoughts, feelings, and sensations can be altered. For example, if a patient told Low that he felt people were staring at him, Low might have said the patient must change his insecure thoughts for secure thoughts.

Cognitive behavioral therapists today relabel many of their patient's distorted views into different terms, thereby enabling the patient to cope more effectively. Low's approach was good cognitive behavioral therapy—not devaluating feelings. Many of Low's critics jumped to almost bizarre conclusions about his method seemingly without checking their impressions against what Low wrote.

Wechsler (1960) and Omark (1982) deplored Recovery's lack of a procedure by which patients were discharged or graduated. Both authors seemed to believe that a self-help group should have an admissions service, records, and formal discharge procedures. They thought Recovery, Inc. trapped patients into becoming forever dependent because there were no discharge procedures. Most mental health professionals are more concerned with their chronically disordered mental patients avoiding treatment, discontinuing their medication, and other noncompliant behavior. The author knows of no self-help group that sets a time limit on membership. It is inconceivable for an Alcoholics Anonymous group, for example, to terminate a member upon achieving sobriety. Older members assert how many years of sobriety they have attained precisely to forcefully influence new members as well as to reinforce their own progress. Displaying well role models is one of the special attributes of Recovery, Inc.(Lee, 1966).

One critic (Gartner, 1976) feared long term attendance at Recovery meetings would promote dependency. Dean (1970), Raiff (1982), and Suler (1984) refute this. The author's experience has been that long term membership promotes independence and autonomy. Recovery members who stay in the organization for a number of years take on greater responsibilities and become more self-sufficient over time. Independence building should not be surprising since the Recovery method emphasizes asserting one's will and becoming self-led versus symptom-led.

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Several critics of Recovery, (Wechsler, 1960; Antze, 1976; Spiegel, 1977), have likened Recovery meetings to a religious ceremony. They also thought Recovery members used Low's book as a Bible. These pejorative comments may well have prejudiced professionals unacquainted with the reality.

Suler (1984) said, "Overly dependent members may almost deify the founders of the teaching, as some critics have construed Recovery's reverence for Abraham Low." Hurvitz, (1970) writing about Alcoholics Anonymous and Recovery,Inc., came up with a far different conclusion. He saw Alcoholics Anonymous "...as following a religious tradition emphasizing guilt, estrangement, penance and reunion; while Recovery has a secular tradition emphasizing will and responsibility."

Galanter (1990) saw Recovery, Inc. as being a zealous cult. What Galanter failed to appreciate was the history of Recovery, Inc. since Low died. First, many of Low's original patients have actively trained leaders and administered the organization. They were keenly aware, when Low was alive, of the many attacks on his method. They grasped the problem he faced with other psychiatrists wanting to take over and manipulate his method. Recovery patients knew Low's method helped them and they wanted to preserve the method he had devised. Newer members have all learned this history. Recovery members had good reason to be apprehensive when there have been so many misunderstandings about the Recovery method.

Frustration in many Recovery members led to an attempt to sell Recovery to professionals by some over-enthusiastic supporters. What Galanter thought was zealousness was an expression of frustration. Members of Recovery, Inc. find the method works and are unable to see why so many professionals cannot see it, too.

Many of the Recovery members the author has talked to over 28 years have expressed disappointment that more professionals have not collaborated with Recovery for their patients. Patients report how helpful close affiliation has been when it occurs, not only for them but for the therapist too, as Dean (1971) reported.

Possibly all of the above factors contributed to the lack of understanding about Recovery, Inc. The central issue is that so many professionals have overlooked Recovery, Inc. as a vital established community resource while others have rejected it. In a time when we especially need all of our mental health assets this is a serious loss.

Recommendations

Due to the cognitive behavioral basis in Recovery methods it is valuable for a therapist to use these concepts with their patients. The therapist can count on the other members of Recovery, Inc. to support the authority of the patient's own therapist. A wide range of patients with different diagnoses are able to benefit from a joint or collaborative program (Lee, 1971). As Barter (1993) points out, "Many psychiatrists and mental health professionals unfamiliar with Recovery, Inc. assume that Dr. Low's techniques work only for the neurotic and the 'worried well.' In fact, severely mentally ill individuals have been involved with Recovery's method and have been helped by it."

One major advantage for patients under professional treatment is to have an ongoing support group focused on a similar approach to help augment professional sessions. The Recovery group reinforces individual therapy and provides many opportunities for patients to increase their coping skills. Recovery, Inc. uniquely supports the therapist even when the therapist's approach differs from Recovery methods.

Katz (1993) said, "...professional services cannot [provide]: the powerful element of peer support, the effects of individual role models in the group, and the interactions occasioned by the giving and receiving of help." Therapists referring patients to Recovery, Inc. can work in unison to furnish those critical factors not found in professional services alone. This will enrich the present mental health system by giving it the best of both professional and self-help resources.

"MANY PROFESSIONALS, POSSIBLY DUE TO THEIR OWN UNCLEAR PROFESSIONAL ROLE DEFINITIONS, HAVE LOOKED ON THIS SELF-HELP GROUP AS A RIVAL RATHER THAN A VITAL COLLABORATIVE RESOURCE FOR THEIR PATIENTS."

Conclusions

Mental health professionals under utilize Recovery, Inc. for four reasons:

1.) Some of the earliest literature on Recovery, Inc. was highly prejudicial against this self-help group due to gross misunderstandings of Low's method. Some of Low's critics were unable to understand cognitive behavioral therapy as a treatment system. Subsequently, many professionals have been influenced by strong anti-Recovery biases in the literature.

2.) The four types of misapprehensions identified from the critical literature may reveal that other professionals have followed a parallel process and formed erroneous opinions about this self-help group just as did the authors cited.

3.) Many professionals are unaware of Recovery, Inc. They lack basic information about the second oldest self-help group in the mental health field.

4.) The dynamism and longevity of self-help groups has demonstrated for five decades that they are an integral part of the mental health arena. Nevertheless, many professionals, possibly due to their own unclear professional role definitions, have looked on this self-help group as a rival rather than a vital collaborative resource for their patients.

REFERENCES

Antze, P. (1976). The role of ideologies in peer psychotherapy organizations: Some theoretical considerations and three case studies. *Journal of Applied Behavioral Science. 12,* 323-346.

Barter, J. T. (1993). Uniqueness of Recovery, Inc. Newsletter, Abraham A. Low Institute. p.3. Black, R.B., & Drachman, D. (1985). Hospital social workers and self-help groups. *Health & Social Work, 10,* 95-103.

Collier, G. (1991, May 16). *The essential role of language in the Recovery method.* In P. L. Berning (Chair), Conference on mental illness, stigma and self-help, Recovery, Inc., and the pioneering work of Abraham A. Low. Chicago, IL.

Coplon, J. & Strull, J. (1983). Roles of the professional in mutual aid groups. *Social Casework: Journal of Contemporary Social Work, 64,* 259-266.

Cormier, W. H., & Cormier, L. S. (1985). *Interviewing strategies for helpers.* (2nd ed.). Monterey, CA: Brooks/Cole.

Dean, S. R. (1970/71). Self-help group psychotherapy: Mental patients rediscover will power. *International Journal of Psychiatry, 17,* 72-78.

Dean, S. R. (1971). The role of self-conducted group therapy in psychorehabilitation: A look at Recovery, Inc. *American Journal of Psychiatry, 127,* 934-937.

Dumont, M. P. (1974). Self-help treatment programs. *American Journal of Psychiatry, 131,* 631-635.

Galanter, M. (1990). Cults and zealous self-help movements: A psychiatric perspective. *American Journal of Psychiatry, 147,* 543-551.

Gartner, A. (1977). Self-help and mental health. *Social Policy,* 7 (2), 28-40.

Gottlieb, B. H., & Schroter, C. (1978). Collaboration and resource exchange between professionals and natural support systems. *Professional Psychology, 9,* 614-622.

Grosz, H. J. (1973, June 20). Professionals found referring patients to self-help groups. *Psychiatric News,* p.20.

Hermalin, J., Melendez, L., Kamarck, T., Levans, F., Ballen, E., & Gordon, M. (1979). Enhancing primary prevention: The marriage of self-help groups and formal health care delivery systems. *Journal of Clinical Child Psychology, 8,* 125-129.

Huey, K. (1977). Developing effective links between human-services provider and the self-help system. *Hospital & Community Psychiatry, 28,* 767-770.

Hurvitz, N. (1970). Peer self-help psychotherapy groups and their implications for psychotherapy. *Psychotherapy: Theory, Research and Practice,* 7, 41-49.

Katz, A. H. (1965). Application of self-help concepts in current social welfare. *Social Work, 10* (3), 68-74.

Katz, A. H. (1993). *Self-help in America: A social movement perspective.* NJ: Twane.

Kerson, T. S. (1990). Lending a vision: Ways in which self-help efforts promote practice creativity. In H.H. Weissman (Ed.) *Serious play: Innovations & creativity in social work.* Silver Springs, MD: NASW.

Kurtz, L. F., Mann, K. B., & Chambon, A. (1987). Linking between social workers and mental health mutual-aid groups. *Social Work in Health Care, 13,* 69-77.

Kurtz, L. F., & Chambon, A. (1987). Comparison of self-help groups for mental health. *Health and Social Work, 12,* 275-283.

Lee, D. T. (1966). Recovery, Inc: A well role model. *Quarterly of Camarillo, 2* , 35-36.

Lee, D. T. (1971). Recovery, Inc.: Aid in the transition from hospital to community. *Mental Hygiene, 55,* 194-198.

Lee, D. T. (1991, May 16). *Abraham A. Low: pioneer in cognitive behavioral therapy.* In P.L. Berning (Chair), Conference on mental illness, stigma and self-help, Recovery, Inc., and the pioneering work of Abraham A. Low. Chicago, IL.

Lee, D. T. (1993). *Follow-up report on 1989 Recovery project.* Sacramento, CA: State Department of Mental Health, Forensic Services Branch.

Levy, L. H. (1976). Self-help groups: Types and psychological processes. *Journal of Applied Behavioral Science, 12,* 310-322.

Lieberman, M. A., & Bond, G. R. (1979). Problems in studying outcomes. In M. A. Lieberman & L. D. Borman (Eds.), *Self-help groups for coping with crisis.* (p.289). San Francisco: Jossey-Bass.

Low, A. A. (1950). *Mental health through will training.* (15th ed.) 1967. Boston: Christopher.

Low. A. A. (1976). *Mental health through will training.* (Spanish language ed.). Glenco, IL: Willett.

Lurie, A., & Schulman, L. (1983). The professional connections with self-help groups in health care settings. *Social Work in Health Care, 6,* 69-77.

Omark, R. C. (1982). Cycles and balances: personality change versus organizational maintenance. *Psychiatric Quarterly, 54,* 109-122.

Powell, T. J. (1979). Comparisons between self-help groups and professional services. *Social Casework, 60,* 561-585.

Powell, T. J., & Cameron, M.J. (1991). Self-help research and the public mental health system. *American Journal of Community Psychology, 19,* 797-805.

Raiff, N. R. (1978). *Recovery, Inc.: A study of a self-help organization in mental health.* (Doctoral dissertation, University of Pittsburgh, 1978). University Microfilms International, 1979, Ann Arbor, MI (#7917492:170).

Rau, N., & Rau, M. (1971). *My dear ones.* NJ: Prentice-Hall.

Spiegel, D. (1977). The psychiatrist as a consultant to a self-help group. *Hospital & Community Psychiatry, 28,* 771-772.

Suler, J. (1984). The role of ideology in self-help groups. *Social Policy, 14* (3), 29-36.

Todres, R. (1982). Professional attitudes, awareness and use of self-help groups. *Prevention in Human Services, 1,* 91-98.

Toseland, R. W & Hacker, L. (1985). Social workers' use of self-help groups as a resource for clients. *Social Work, 30,* 232-237.

Wechsler, H. (1960). The self-help organization in the mental health field: Recovery, Inc. a case study. *Journal of Nervous and Mental Diseases, 130,* 297-314.