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# The Social-Psychological Implications of Recovery Inc.

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THE SOCIAL-PSYCHOLOGICAL  
IMPLICATIONS OF  
RECOVERY INC.

by  
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A Thesis Submitted to the Faculty of the Graduate School  
of Loyola University in Partial Fulfillment of  
the Requirements for the Degree of  
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## VITA

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In the summer of 1955 she began her graduate studies in the Department of Sociology of Loyola University.

## INTRODUCTION

Mental illness is one of the greatest problems our society faces today. One need is to train former mentally and emotionally disturbed patients in the practices of psychiatric self-help to prevent the recurrence of mental disease and to forestall chronicity of such patients. Recovery Inc. was established to accomplish this purpose. The importance of such an attempt is obvious, yet no organized attempt to analyze Recovery Inc. has been made. The purpose of this thesis is to examine Recovery's therapeutic means of self-help technique through an analysis of the structure and function of Recovery Inc. as seen in the literature of the organization, the interpretation of it by interested writers and by some of the members. Special emphasis will be placed in explaining the techniques of Recovery Inc. in terms of some social-psychological theories of personality development. Various approaches are necessary because of the scarcity of official documentation.

Recovery Inc. has its office at 118 South Michigan Avenue, Chicago. The officers and some Recovery members have been most helpful in supplying literature and information. The members, due to the nature of the organization, wished to remain anonymous and were most careful of names and locations that would reveal their identity.

There is little to be found in libraries regarding Recovery Inc. It is a young organization and has had little professional publicity up to this time. Dr. A. A. Low, the founder, has written concerning it but it has not received

much recognition from professional groups for such reasons as lack of professional staff and its viewpoint on psychoanalysis. Therefore, the resource material is limited. Library sources for this writer include periodicals, the texts listed in the International Index to Periodical Literature, the Psychological Abstracts, and the Reader's Guide to Periodical Literature, the files of the libraries of the University of Chicago, Northwestern University, Illinois Medical School, Loyola University, and Mundelein College were utilized. Popular literature although not scientific in approach afforded information that had to be considered.

Chapter I of this thesis discusses various definitions of group psychotherapy, the historical developments and types of group psychotherapy. Recovery Inc. is then shown as a type of group psychotherapy and is related to other psychotherapeutic groups. The chapter ends giving the significance of Recovery Inc. to Group Psychotherapy Methods and Developments.

Chapter II relates the founding of the organization. Historical notes, publications and projects of Recovery Inc. are cited. Recovery Inc.'s change in policy with a view to today's Recovery Inc. is then shown.

Chapter III analyzes the value orientations of Recovery Inc. Dr. Low's beliefs as well as his attitude towards psychoanalysis are summarized. The expressed value principles of Recovery are then related. The basic character of the organization--group value, the purposes and principles of the organization related to the socio-psychological theories of therapy--complete this chapter.

Chapter IV describes the meeting procedure and Recovery's restrained, specialized language. Social activities of the organization are indicated.

Case studies of a former mental patient and a nervous patient show the application of Recovery's technique. The socio-psychological implications for therapy are cited.

The conclusion suggests an answer to the question what are the results of Recovery Inc. Dr. Low and Reverend John Higgins S. J. are quoted. Further areas of Recovery Inc. needing research are mentioned.

Appendix I summarizes the administrative aspects of the association. The growth of Recovery's membership and the change of attendance at meetings are related. The appendix ends with a discussion of the national office and the establishment of Recovery's branches. Cincinnati, Ohio's Recovery groups are used as examples.

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## CHAPTER I

### GROUP PSYCHOTHERAPY

#### NEED AND VALUE

Two trends of thought converging — one the recognition of the truth long emphasized by Meyer and White, that behavior is the result of the response of the organism as a whole to environmental influences among which people are most important, the other the fact, that the supply of psychiatrists is far below the demand, make the most logical and intensified interest in the application of psychotherapeutic methods to and within a group. Either viewing the needs of the situation theoretically, interpreting psychiatry as dealing primarily with interpersonal relations or practically, recognizing the fact we must either multiply the number of psychiatrists or divide their applicability by treating several patients simultaneously, it is necessary to recognize the need and value of group psychotherapy.<sup>1</sup>

Definition. The term group psychotherapy was first used by J. L. Moreno in 1931, in reference to a suggested plan of penal reclassification based on sociometric principles. The meaning of the term has since been expanded to refer to the clinical treatment of individuals in artificial groups, as well as

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<sup>1</sup>Dr. Winifred Overholser, "Preface" in Moreno Group Psychotherapy, (New York), 13.

the treatment of already formed groups.<sup>2</sup> Bion and Reckman accept both definitions stating that the term group therapy can have two meanings. It can refer to the treatment of a number of individuals assembled for special therapeutic sessions or it can refer to a planned endeavor to develop in a group the forces that lead to smoothly running cooperative activities.<sup>3</sup>

A number of attempts have been made to define group psychotherapy. Ackerman defines it as "a systematic approach to the whole personality, involving some degree of access to unconscious mechanisms and having the potentiality of basic change in the adaptive patterns of personality."<sup>4</sup> S. M. Cotton makes this formulation, "an attempt to reinforce and strengthen the individual's defenses against anxiety by identification with, analysis by, and support from the group."<sup>5</sup> J. Abrahams says, "Group therapy refers to a group process led by someone significantly less involved in the pathology to ameliorate the problems of the group members in relation to themselves and society."<sup>6</sup> S. Slavson states, "Group therapy is treatment in which no discussion is initiated by the therapist, interpretation is given only in very rare instances and under

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<sup>2</sup>Raymond Corsini, "Towards a Definition of Group Psychotherapy, Mental Hygiene 39, (October 1955), 647.

<sup>3</sup>W. R. Bion and J. Reckman, "Intra-group Tensions: Their Study as a Task of the Group," Lancet, 245, (1943), 678-681.

<sup>4</sup>Raymond Corsini, Ibid, 650. See also N. W. Ackerman, "Some General Principles in the Use of Group Psychotherapy" in Current Therapies in Personality Disorders, edited by B. Blueck, (New York, 1946).

<sup>5</sup>Raymond Corsini, Ibid, 650. See also S. M. Cotton, G. P. An Analysis in Failures in Psychiatric Treatment, edited by P. Hoch, (New York, 1949).

<sup>6</sup>Raymond Corsini, Ibid, 650. See also J. Abrahams, "Group Psychotherapy: Implications for Direction and Supervision of Mentally Ill Patients," Mental Health Nursing, edited by T. Muller, (Washington, D. C., 1949).

specific conditions."<sup>7</sup> Corsini believes that a satisfactory definition of group psychotherapy must include four essential elements. (1) Intentionality or formality. This implies an agreement to participate in therapy, without regard to the quality or value of the experience. (2) Changes in social relationships of a type calculated to produce ameliorative personality changes. The social relationships must be of the kind believed to effect therapeutic improvement. (3) The establishment of a protected environment. The individual members are in a new atmosphere of relationships of the kind not ordinarily effected. A certain freedom of verbal or motor behavior exists, in which the individuals are permitted latitudes not ordinarily encountered. The person is free to explore himself and his environment in a permissive and accepting atmosphere. (4) Efficiency of change. It must be accepted that the reason for the establishment of an artificial environment is for the purpose of attaining certain benefits which are not necessarily exclusive to the form of the new arrangement.<sup>8</sup> Thus Corsini defines group psychotherapy as "the intentional establishment of a protected environment in which special relationships are fostered of a kind presumed to result in rapid ameliorative personality changes."<sup>9</sup> Driekers and Corsini point out that group psychotherapy is rapidly expanding and no objective integrative concept has evolved. The field is being reviewed with the intention of clarifying its purposes,

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<sup>7</sup>Samuel Slavson, Group Therapy, (New York, 1943), 2.

<sup>8</sup>Raymond Corsini, Ibid, 653-656.

<sup>9</sup>Raymond Corsini, Ibid, 655.

methods and mechanisms. Group psychotherapy possesses an effective method of this, those in the field are certain,—far more certain than of knowing the reasons for its effectiveness. Group psychotherapy may be able to accomplish what psychiatry has been unable to do — integrate the various dynamic theories into one body of scientific knowledge. It is the medium of group psychotherapy itself that may promote such long overdue integration.<sup>10</sup>

Historical developments: Group psychotherapy is probably as old as man. The cathartic effect of the theatre was noted by Aristotle. The formal treatment of psychiatric patients in groups is of much more recent origin. The earliest formal group therapy was probably conducted by Anton Mesmer whose hypnotic sessions excited the Paris of Benjamin Franklin, points out Hulse.<sup>11</sup> Another reference to the early use of the group method is made by Klapman who reported that Camus and Paquisz, pupils of Dejirene, discovered that patients with nervous disorders improved more rapidly if treated in groups.<sup>12</sup> Thus the recognition of interpersonal relations as an influential factor in the group was noted but group psychotherapy is fundamentally a product of the twentieth century. To Dr. J. H. Pratt goes credit for the first scientific attempt to treat with group therapy patients suffering from physical illness.<sup>13</sup>

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<sup>10</sup>Rudolf Driekers and Raymond Corsini, "Twenty Years of Group Psychotherapy," American Journal of Psychiatry, 110, (February 1954), 573-574.

<sup>11</sup>Rudolf Driekers and Raymond Corsini, Ibid, 567. See also W. C. Hulse, Jewish Social Service Quarterly 25, (1949), 214.

<sup>12</sup>Rudolf Driekers and Raymond Corsini, Ibid, 567. See Also J. W. Klapman, Group Psychotherapy: Theory and Practice, (New York, 1946).

<sup>13</sup>Wilfred C. Hulse, "The Role of Group Therapy in Preventive Psychiatry," Mental Hygiene 36, (October 1952), 532.

The early period of group psychotherapy may be dated from 1900 to 1930. Major steps toward a systematic use of the group method, called at that time "collective counselling," were made in Europe. Driekers reports the early efforts of collective therapy by Hirschfeld with sexual disturbances, Schubert with stammerers, Stransky with neurotic patients, and Walsl with alcoholics. In Russia, Rosenstein, Guilanowsky and Dziertovsky used the group method.<sup>14</sup> Yet in Russia psychotherapy is the least developed of the therapies. It is now stated that the application of psychotherapy has been entirely insufficient and that recent years have clearly revealed its role in the treatment of a number of illnesses.<sup>15</sup>

Alfred Adler, prominent in the development of American Psychiatry, was probably the first psychiatrist to use the group method "distributive analyses." The therapist takes the lead and directs the discussion, interpreting the patient's symptoms on a psychological basis. The patient is methodically and systematically guided and the problem encountered is used in direct discussion in an attempt to objectify attitudes and reactions.<sup>16</sup>

Another early creation of a methodology that later was to become the fully developed sociometrically and psychodramatically based group therapy, was begun by J. L. Moreno.

The development of the group method in Europe never reached the stage of

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<sup>14</sup>Rudolf Driekers and Raymond Corsini, Ibid, 568.

<sup>15</sup>I. D. London, "Therapy in Soviet Psychiatric Hospitals," American Psychologist 8, (February 1953), 79-82.

<sup>16</sup>W. Simon and M. R. Chentin, "Brief Psychotherapy," Mental Hygiene 33, (July 1949), 401-410.

organizational integration. With the advent of totalitarianism, group methods were completely abandoned. Only after the war were they resumed. The use of the group method and democratic evolution therefore seem to be related. If this is true then it is not surprising that the development of group psychotherapy was shifted to the United States and was advanced more rapidly than in any other country. It would seem that group psychotherapy needs a unique social climate — a democratic one; it cannot seem to flourish except in a free atmosphere.<sup>17</sup>

The rapid development in the United States began about 1931. Before that time Burrow, Emerson, Lazell, and Marsh besides Pratt, reported a few instances of the use of the group method. Moreno coined the term "group psychotherapy," giving the new method its formal name. In 1936 the output of papers on this subject increased in geometric proportion. Geller emphasizing this rapid growth of interest, notes that from 1900 to 1919, only eleven papers relating to group therapy were published in this country; in the next decade, twenty; in the thirties, some ninety; and, between 1940 and 1949, over five hundred papers were presented in the various scientific journals. Now more than one hundred twenty-five papers are published annually.<sup>18</sup>

There is no reliable estimate of the number of therapists in this country who use the group method. About half the nation's mental hospitals use group psychotherapy. This had led to the formation of professional organizations, and publishing journals exclusively devoted to group psychotherapy

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<sup>17</sup>Rudolf Driekers and Raymond Corsini, Ibid, 568.

<sup>18</sup>Rudolf Driekers and Raymond Corsini, Ibid, 568. See also J. J. Geller, Group Psychotherapy 3, (1951), 231.

in addition to local conferences and training institutes on this subject. Group psychotherapy is rapidly coming of age, if it is not already mature.<sup>19</sup>

Types: The division of the types of Psychotherapy depends upon the interpretation of the psychotherapist. There are probably as many divisions offered as definitions.

Two differing divisions will be discussed and applied to Recovery Inc.

The first is J. L. Moreno's differentiation. For points of reference Moreno used the three principles: subject, agent and medium of therapy.

He distinguishes between an amorphous group that does not consider the organization of the group in the prescription of therapy and the structured or organized group that does.

The source of influence is either therapist centered or group centered. In the former the therapist treats every member of the group individually; in the latter, every member of the group is a therapeutic agent to one or another member, one patient helping the other.

The two types of media offered by Moreno are the conserved, mechanical, unspontaneous type and the creative type. Motion pictures, and rehearsed drama would be examples of the first; therapeutic motion pictures and psychodrama would be examples of the second.<sup>20</sup>

In using Moreno's classification Recovery Inc. would be placed under the following categories:

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<sup>19</sup>Rudolf Driekers and Raymond Corsini, Ibid, 568.

<sup>20</sup>J. L. Moreno, "Scientific Foundations of Group Psychotherapy" in Moreno's Group Psychotherapy, (New York, 1945), 318-319. For a similar division of types see Joseph Meiers, "Origins and Development of Group Psychotherapy" in Moreno's Group Psychotherapy, (New York, 1945), 269.

The subject would be considered an organized group; the agent -- group centered using a spontaneous or free form of influence in which the leader is extemporaneous and the audience unrestrained; the medium of therapy -- the lecture method using a creative medium in which there is face to face contact.

Hulse sees three classifications in group psychotherapy. He divides them into analytic, didactic and inspirational. In the practice of group therapy there are two distinct poles -- one the repressive-inspirational and the other the psycho-analytically orientated methods. Between these two poles there is a wide range of combination techniques, leaning more to one side or to the other, borrowing from both and including some original ideas by various authors. Those clinics whose approach is derived from Pratt have continued to develop repressive-inspirational methods aimed at removing symptoms rather than their causes. Some are rigidly organized and exercise authoritative leadership over their members. Recovery Inc. is a representative of this.<sup>21</sup>

Recovery Inc. Related to other Psychotherapeutic Groups: Another large group of this type is Alcoholics Anonymous. Alcoholism is regarded by this group as a chronic disease, an incurable allergy to liquor. Its victims can be helped only by total abstinence. A member of this organization must pledge himself to abstain completely. When he relapses and seeks help, another member of Alcoholics Anonymous, himself a former addict of alcohol, will be assigned to watch over him. Medical treatment and means of spiritual rehabilitation are offered to the alcoholic until he is sufficiently recovered to

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<sup>21</sup>Wilfred C. Hulse, "The Role of Group Therapy in Preventive Psychiatry," Mental Hygiene, 36, (October 1952), 533-537.



pick up the threads of his home, social and professional life.<sup>22</sup>

Experts have long attempted to discover what it is that constitutes Alcoholics Anonymous' power. Farber, a friendly critic, frankly admits defeat. "Even with its preposterous ragbag of theory, Alcoholics Anonymous has something of communicable value to offer the social scientists but so far no psychiatrist has been enough of a sociologist and no sociologist has been enough of a psychiatrist to discover what it is."<sup>23</sup> There are those who hold that the explanation of Alcoholics Anonymous' success lies in the field of psychiatry or sociopsychology and that the modus operandi leading to the growth of personality is group action. The membership becomes the socializing primary group for the alcoholic who suffers from isolation.<sup>24</sup>

The use of group psychotherapy in the treatment of alcohol is a relatively recent practice which has gained great momentum since it was popularized by Alcoholics Anonymous. In recognition of the benefits of cooperation with Alcoholics Anonymous many doctors have reached the conclusion expressed by Fox, who states, "one of the most important factors in therapy is placing the patient in contact with other alcoholics."<sup>25</sup>

Recovery Inc. is to mental and nervous patients what Alcoholics Anonymous is to alcoholics. In many ways the backgrounds of the psychoneurotic and

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<sup>22</sup>Wilfred C. Hulse, Ibid, 537.

<sup>23</sup>H. L. Farber, "Blue Plate Gospel," New Republic, 112, (May 21, 1945), 716.

<sup>24</sup>R. Wilson, "Evaluation of Treatment Methods in Alcoholism Therapy," Mental Hygiene, 35, (April 1951), 282.

<sup>25</sup>R. Fox, "Medical Progress: Newer Treatment of Alcoholism," New York Medicine, 1, (March 1, 1945), 11.

alcoholic are similar. Both are emotionally ill. Both must be willing to help themselves. Both gain from interaction of a group made up of like members.

In Recovery Inc. patients are not to waste time worrying about the cause. The theory is that merely knowing the cause won't cure the illness, therefore patients must attempt to cure themselves through will power. This they are able to do by seeing others in the group accomplish the task. The morale or esprit de corps of the group affects each member.

Like the twelve steps in Alcoholics Anonymous there is a definite step by step pattern in Recovery Inc. that gives the patient something tangible to work on day by day. Patients learn how to stop coddling symptoms.<sup>26</sup> They learn to help themselves by helping others, and thus gain personal satisfaction as well as share in the common task for which the group was established and expresses in the substance of interaction.

Reverend John Higgins, S.J., in referring to the comparison often made between the training in self discipline that Recovery Inc. gives and that given in the program of Alcoholics Anonymous says that Recovery Inc. covers a larger area. Physicians, marriage counselors, ministers, priests, and psychiatrists, people who make it their business to counsel adults towards a happier way of life, refer patients and counselees to Recovery Inc. meetings.<sup>27</sup>

Considerable progress in this type of treatment has been made by Dr. Joshua Hierer and his collaborators, who founded a chain of "therapeutic social clubs."

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<sup>26</sup>John Alderquin, "I Conquered Mental Illness," Chicago Tribune, (January 17, 1954), Sunday Supplement.

<sup>27</sup>John J. Higgins, S.J., "Recovery Inc.," Hospital Progress, (March 1955).

While the general tendency is still repressive, the value of spontaneous expression is strongly recognized, and the individual club enjoys a considerable amount of self government. These clubs have become part of the follow-up programs for patients released from mental hospitals. They are closely related to similar clubs maintained by a large number of these institutions in the United States. Warm social relations are encouraged and informal lectures and discussions about problems of mental illness are part of the program.

By admitting relatives of the patients to club meetings, mental hygiene workers have been able to equip the families with better understanding and with the means for giving more adequate care to the home-coming patient. Similar projects are being carried on in Canada. In New York an interesting experiment on this order has been carried on by the Veteran's Administration with the relatives of epileptics.<sup>28</sup>

Blair writes that he would like to emphasize that the therapeutic value of such clubs -- both for the outpatients and for the inpatients -- is now established and he makes a plea for a more general appreciation of the great help such clubs can confer on their members. These clubs provide an environment in which the potentialities for affability and friendliness and the capability for self-expression may once more, often very gradually, blossom forth.<sup>29</sup>

John R. Seeley of Community Surveys, Inc. points out that we have much

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<sup>28</sup>Wilfred C. Hulse, "The Rate of Group Therapy in Preventive Psychiatry," Mental Hygiene, 36, (October 1952), 538.

<sup>29</sup>D. Blair, "The Therapeutic Social Club," Mental Hygiene, 39, (1955), 55-62.

reason to think that personality breakdowns are relatively infrequent in groups whose morale is high; that "morale" is a name for the powerful feeling released in the individual who feels himself a member of a strong and important group; and that such unity is frequently a product of the sharing of social values felt to be important.<sup>30</sup>

This type of group work is an important contribution to the goals of preventive psychiatry. It has succeeded in reaching an even larger number of the population with enlightened intelligent information about the nature of psychic disturbances and their treatment. Attitudes of rejection and fright in the community often prevent the afflicted individual from getting early treatment, impede his return to family and social life, and are responsible for a high percentage of relapses. This work is waging a large-scale campaign against superstition and the magic horror surrounding the mentally ill.<sup>31</sup>

Significance of Recovery Inc. to Group Psychotherapy Methods and Developments: Group psychotherapy and/or group therapy has been defined by its practitioners as a branch of psychiatry and psychotherapy. It is now practiced by people from a great variety of backgrounds including psychiatry, psychology, social work, sociology and education. It varies in intensity from analytic group psychotherapy conducted usually by psychiatrists and on the basis of psychoanalytic theory to many kinds of therapeutic groups very like, if not identical in purpose with, those developed by group workers.<sup>32</sup>

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<sup>30</sup> John R. Seeley, "Social Values and Mental Health" in Rose's Mental Health and Mental Disorder, (New York, 1955), 601-602.

<sup>31</sup> Wilfred C. Hulse, Ibid, 538.

<sup>32</sup> Gordon Allport, "The Limits of Social Service," Columbia University Bicentennial Celebration, June 2-5, 1954, (mimeographed material).

The general goal of all social group work, in whatever setting it is practiced, is to effect changes or adaptations in a particular person's attitudes, relationships and social behavior to the end that he will have greater personal adequacy.<sup>33</sup>

Gordon Allport says we quarrel over the hairlike boundary between case-work and psychotherapy, while most of the world has never heard of either. Specialism is a peculiar hazard in any profession devoted to helping people in distress — distress defies job-analysis.<sup>34</sup>

Although there have been many differences of opinion as to the professional identification and education of workers for the practice of group work, there has been little disagreement in the literature about its basic assumptions: (1) that a sense of belonging is essential to the happiness of all human beings; (2) that certain life experiences and social situations interfere or deny to many individuals the opportunity to have this sense of well being; (3) that principles and techniques for helping people to develop a sense of belonging through participation in a group can be developed from concepts drawn from the social and biological sciences and on the basis of our thinking about our experience in practice; (4) that these concepts, principles and techniques can be learned by people who have the qualification for helping others to make the necessary social adjustments to participate creatively in groups; and, (5) the welfare of society is dependent upon the constructive

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<sup>33</sup>Helen Northen, "Interrrelated Functions of the Social Group Worker," Social Work, Vol. 2, No. 2, (April 1957), 63-69

<sup>34</sup>Gordon Allport, "The Limits of Social Service," Columbia University Bicentennial Celebration, June 2-5, 1954, (mimeographed material).

nature of the interacting processes of its many small groups.<sup>35</sup>

Recovery Inc. utilizes these basic assumptions. Group support and social interaction act as a core of the program. It recognizes the need of a sense of belonging for happiness. The techniques for helping each other to develop a sense of belonging through participation in a group are developed from an interdisciplinary approach as will be shown. Patients themselves help each other to participate creatively in the group. Recovery Inc. is a socio-psychological attempt at promoting self-help for ex-mental patients and "nervous persons" who need psychological and social support.

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<sup>35</sup> Gertrude Wilson, "Social Group Work: Trends and Developments," Social Work, Vol. 1, No. 4, (October 1956), 66-75.

## CHAPTER II

### INITIAL FOUNDING

The inception of Recovery dates back to 1937 when Dr. Low was assistant director of the Psychiatric Institute of the University of Illinois Medical School. Harried for time, Dr. Low one morning walked into the Institute to face about fifty mental patients who had undergone shock treatments and were candidates for discharge or follow-up care. It was impossible to give one hour private treatment to all of them. In desperation he tried an experiment. He asked one of the group a question, got him to answer, others to comment. He turned the group into an interview-debate session and the results were encouraging.<sup>1</sup>

Recovery Inc. as such was founded on November 7, 1937, by thirty ex-patients who regained their health after receiving shock treatments and other therapies at the Psychiatric Institute. This group was the predecessor of the present Psychiatry Department of the Illinois Neuro-psychiatric Institute. Between 1937 and 1940 the organization limited its services to the patients admitted to the wards of the Psychiatric Institute.<sup>2</sup> The search for the name Recovery for this organization shows how the members set out to find a paradoxical riddle! A double name, one that would conceal and at the same time

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<sup>1</sup>Kathleen Rutherford, "Recovery Inc.," America, 95 (September 15, 1956), 532-533.

<sup>2</sup>Abraham Low, Mental Health Through Will Training (Boston, 1950), 16.

reveal their identity. Due to the attitude existing in 1937 toward mental illness a fitting, yet relatively meaningless appellation had to be found. A hunt for the name produced a number of curiosities. Since the members were ex-mental patients, acting as troops fighting the battle of the stigma of mental disease, and had undergone shock treatment, the title Shock Troops was suggested by one member. Another member suggested that since the goal of the organization was to create a social environment without stigma, the title A-Stigmatism was appropriate. A former college student, a member of a fraternity, suggested Stigma XI. Other less imaginative proposals were made such as Sunrise Club, Resurrection, Staybright, the Reconstructed and the Reconditioned. Finally the name Recovery was adopted. Thus Recovery was placed on the envelopes of letters written to members and the Association of Former Patients of the Psychiatric Institute was placed on the inside notice.<sup>3</sup> The duplicity was due to the stigma the former mental patients undergo. This stigma was that mental disease was discriminated against by the members of the community and that the patient was looked at with suspicion, the suspicion that was prompted by the connection the "once insane -- always insane."<sup>4</sup>

The by-laws of the organization were adopted at a special meeting on May 10, 1938. The articles dealt with the name, purpose, membership, dues, assessments, contributions, and rights of members.

The complete title of the organization at this time was "Association of

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<sup>3</sup> Abraham Low, "Duplicity Due to Atrocity of Stigma Situation," Lost and Found, 1 (September 1938), 30-31.

<sup>4</sup> Abraham Low, "The Stigma of Mental Disease," Lost and Found, 1 (July 1938), 20-21.



Former Patients of the Psychiatric Institute of the University of Illinois and the Department of Welfare."

The purposes for which the organization was formed were:

- (1) Promote the general social and economic interests of former patients of the Psychiatric Institute of the Research and Educational Hospitals of the University of Illinois;
- (2) To foster and conduct campaigns with a view to the development of an enlightened and cooperative attitude on the part of the general public towards mental diseases and persons recovered therefrom;
- (3) Aid the Psychiatric Institute to maintain contact with its former patients for the purpose of helping them to effect complete readjustment for themselves;
- (4) Assist physicians of the Psychiatric Institute in follow-up investigations on the ultimate results of treatments.

The membership was composed of three classes. The regular members consisted of (1) former patients who were discharged from the Psychiatric Institute as recovered or improved. If the patient was recommitted he was ineligible for regular membership until he was again discharged as either improved or recovered; (2) attending and resident physicians of the Psychiatric Institute. The associate members consisted of the husbands, wives, parents, grandparents, children, grandchildren, brothers and sisters of former patients. The contributing members consisted of (1) any persons over twenty-one years of age, and (2) of civic organizations.

The regular and associate members were not subjected to the payment of any dues or assessments but were free to make voluntary contributions. The

contributing members had to pay at least two dollars annually,

The last article of the by-laws indicated that the only rights of the associate and contributing members were to attend meetings and to enjoy the educational facilities of the association.<sup>5</sup> Dr. H. Douglas Singer, the Director of the Illinois Psychiatric Institute, endorsed wholeheartedly the founding of Recovery Inc. He indicated in an article in Lost and Found that the establishment of the Association and its journal marked an epoch in the efforts for mental health. The movement was unique in that it presented the united front of many persons who had regained their health. The Association had discovered that it had a broad field of possibilities for service. One of the first problems to be tackled was the popular attitude toward mental disease and those who had experienced it. The members knew the full effects of the prejudices and superstitions that existed. Much had been accomplished in correcting that situation through the efforts of Clifford Beers, who had himself recovered from such an illness, through the formation of the now world-wide committees for Mental Hygiene.<sup>6</sup>

Dr. Singer pointed out due to the fact that Recovery Inc. was composed of members who knew from personal experience the real meaning of mental illness, these members could enhance the possibilities of bringing about a truly popular education and understanding.<sup>7</sup>

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<sup>5</sup> Abraham Low, "Abstract of the By-Laws of the Association," Lost and Found, 1 (July 1938), 20-21.

<sup>6</sup> H. Douglas Singer, "An Appreciation," Lost and Found 1 (July 1938), II.

<sup>7</sup> H. Douglas Singer, Ibid, II.

Historical Notes: In reviewing the first six months of the Association, Lost and Found indicated the growth of membership. In December, 1937, there were thirty-three present at the monthly meeting. In March, 1938, sixty-one ex-patients, and with the influx of relatives the total attendance topped the one hundred mark.

In March, 1938, Dr. D. J. Davis, Dean of the College of Medicine at the University of Illinois, Dr. H. D. Singer, Director of the Psychiatric Institute, and Dr. Major H. Worthington, Superintendent of the Research and Educational Hospitals of the University of Illinois, promised both moral and material support to Recovery Inc. In May, 1938, Dr. Edward F. Dombrowski, Managing Officer of the Chicago State Hospital, and Dr. Conrad Sommer, Medical Director of the Illinois Mental Hygiene Society addressed the group.<sup>8</sup>

In the years 1939 and 1940 attempts were made to influence the public, educating them to the need of Recovery. Public meetings and radio addresses by members were given but met with little response.

Towards the close of 1939, all dreams of influencing the public had faded. The main issues of economic self-help, legislative self-help and social self-help were reinforced and vitalized. Recovery formed a labor exchange for the benefit of its members. It continued to fight the Illinois Commitment Statute, and emphasized self-education rather than public education. In turning from the public Recovery was finding, states Low, that it was attracting the public.<sup>9</sup>

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<sup>8</sup> Abraham Low, "Historical Notes of the First Six Months of the Association," Lost and Found 1 (July 1938), 18-19.

<sup>9</sup> Abraham Low, "After Three Years," Lost and Found, 5 (November-December 1940), 151-159.

In the beginning Recovery had activity but not organization. As it grew there was need for accounts, records, and filing. This is true of the general growth of any association. Recovery followed this sociological pattern. A permanent staff was necessary. A secretary was employed but the greater part of the work was done by Volunteers. With activities multiplying, the need for central coordination became acute. On April 4, 1941, the executive committee appointed a former patient as executive secretary. After three and a half years, Recovery had two salaried employees.<sup>10</sup>

Throughout the years 1937 to 1941 Dr. Low had contacted local and national psychiatric organizations regarding an official investigation of Recovery. He received assurances that did not materialize. If the techniques had singular effectiveness which the members were inclined to ascribe to them, Dr. Low and the Recoveryites thought it was unfair to deny their benefit to the tens of thousands of patients yearly discharged from mental institutions. Yet in order to gain the support of hospitals the Recovery system needed the endorsement of the leading psychiatric organizations. There was no mystery to the lack of active interest on the part of the psychiatric community. Recovery had, in the brief space of four years, evolved an imposing system of after care methods. But the system was too complex to be presented in lectures or articles. To become acquainted with the procedure required a considerable amount of study. It was difficult to induce men busy in practice, teaching and research to divert time from their important activities to an issue that was unfamiliar, novel and perhaps immature.

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<sup>10</sup> Abraham Low, "Recovery is Perfecting its Organization," The Historical Summary of Recovery's Self-Help Project (Chicago, 1948), 119.

By the middle of 1941, Dr. Low decided that since professional recognition was not to be achieved in the near future, the only course open to him was to resign the presidency of Recovery and to liquidate the organization. The ex-patients formed a committee and conferred with representatives of the Illinois Research Hospital and the State Department of Public Welfare insisting on a continuation of the after-care project. The authorities intervened and induced Dr. Low to reconsider his decision. The Department of Public Welfare promised support and invited Recovery to transfer its activities to the Chicago State Hospital. The task of organizing the mammoth population of the hospital on the basis of self-help was feasible only if the staff physicians took active part in the project. They would have to submit to a period of training for the purpose of familiarizing themselves with the various methods. Dr. Low inaugurated classes in group psychotherapy. But the physicians overburdened with their daily routine had little time left for attending classes. Dr. Low could not do all the work without the proper assistance from the staff. By June, 1942, he discontinued the Chicago State Hospital project and liquidated Recovery Inc.

A small group of ten or twelve stalwarts refused to abandon the effort. Liquidation or not, they were determined to continue. They gathered together in regular intervals and studied Lost and Found. By November 1942 the group expanded to include some forty ex-patients and a number of loyal relatives.<sup>11</sup>

Publications: The first publication of Recovery Inc. was its journal Lost and Found. A look at the table of contents gives a general overview of

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<sup>11</sup> Abraham Low, "Epilogue," The Historical Summary of Recovery's Self-Help Project (Chicago, 1943), 133-136.

what is within the magazine. Volume I, Number 3, November 1938, had articles on Group Psychotherapy, The President of the University Endorses the Association, Addresses Read at the Public Meeting of Former Patient, October 27, 1938, The Mental Patient and the Law, The "Court Record," Deprived my Mother of Her Savings, The "Court Record" Exiled Me, The "Court Record" Delayed Treatment for My Boy, Our First Public Meeting and Association News.<sup>12</sup> Volume 2, Number 3, May 1939 contained Group Psychotherapy, Group Instruction, Lost and Found's Advertising Column, Court Commitment from the Viewpoint of the Patient and His Relatives, When Mental Patients are Committed — A Radio Talk, The Mental Patient Returns to His Job — A Radio Talk, Association News, Contributions and the Association Calendar for May, June and July.<sup>13</sup>

A new format appeared in January-February 1940. The publication became a bi-monthly magazine. The size was much smaller than the earlier editions. Articles included Group Instruction, Association Calendar, The Preliminary Draft of the New Illinois Statute for the Care of the Mentally Ill, Recovery's Method of After-Care and Reintegration, Letters to the Editor, Association News, Contributions and Lost and Found's Advertising Column.<sup>14</sup>

In the September-October issue, 1941, of Lost and Found the title "Association of the Former Patients of the Psychiatric Institute of the University of Illinois and the State Department of Public Welfare" was changed to "Recovery Inc. The Association of Former Mental Patients and Their Relatives."

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<sup>12</sup> Abraham Low, "Table of Contents," Lost and Found 1 (November 1938), 1.

<sup>13</sup> Abraham Low, "Table of Contents," Lost and Found 2 (May 1939), 27.

<sup>14</sup> Abraham Low, Ibid, 1.

The contents of this last edition of the Lost and Found remained similar to the other 1940 and 1941 editions.

In June, 1946, the Recovery Journal appeared as "A Periodical for the Study of Self-Help Methods in the After-Care for Nervous and Former Mental Patients." The journal indicated a change in policy emphasizing individual instruction rather than public instruction. A look at the Table of Contents gives a general idea of the subject matter of the magazine. In June, 1947, Volume 2, Number 4, the articles were, "Symptoms Must be Attacked Where They are Weakest," "Muscles and Mental Health," "The Saboteur's Corner," "The Issue of Expansion," Recovery Groups and Recovery Branches, and Letters from our Readers.<sup>15</sup> In consequence of the rising cost of printing, the Journal was discontinued after the eleventh issue. It was succeeded by a phototyped news sheet, the Recovery News which appears eight times a year.<sup>16</sup>

The Recovery News of September 1948, contained an article by Dr. Low "Temperament and Temper" in Dr. Low's column, Personals, News from the various Recovery branches, and notices of coming events.

Today the Recovery Reporter also appears bi-monthly. It contains notices of recent events of Recovery, of national meetings, of current pamphlets and of Recovery Principles. The articles in the Journal in the early period of Recovery emphasize the stigma of mental patients and the need for a change in the commitment law. Later articles emphasize self-help techniques and news from Recovery branches. Thus a significant change is noted in the trend of

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<sup>15</sup> Abraham Low, "Table of Contents," Recovery Journal 2, (June 1948), 5.

<sup>16</sup> Abraham Low, Mental Health Through Will Training (Boston, 1950), 28

articles over a period of years.

Projects: Examples of the literature published by Recovery Inc. in this early period are The New Illinois Statute for the Admission of Mentally Disordered Persons as Proposed by Recovery, the Association of Former Patients of the Psychiatric Institute of the University of Illinois and the State Department of Public Welfare; The Former Patient is not an Offender. This pamphlet contained addresses and essays on "Stigma," "railroading" and court commitment; The Story of Recovery, which was a concise statement of the objectives, growth and activities of the Recovery Association; Dementia Praecox, the Disease of the Split Personality, described the harm done to patients by well-meaning but ill-informed relatives; The Manic Mood Disturbance, catalogued the tragic blunders of ill-advised parents, who, through ignorance, prevented early treatment; The Scare of Heredity, criticized the dismal defeatism of the views on heredity in Mental Disease; The Mental Patient Mismanaged by His Relatives included two case studies, outlining the grievous errors of two mothers who, through ignorance and over-solicitude, contributed to the breakdown and jeopardized the recovery of the patient.<sup>17</sup> The emphasis here on poor handling of patients by families notes the important sociological principle that human behavior is influenced by values which are strongly formed by the primary group, the family. The early pamphlets again indicate an emphasis on the stigma of mental patients.

Commitment law: At a joint meeting of the executive and publication committees October 16, 1940, a motion was carried to devote the November-December issue of the Lost and Found to a presentation and discussion of the preliminary

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<sup>17</sup> Abraham Low, "Association Literature," Lost and Found 4 (September-October 1941), 126.



draft of the new commitment statute to be introduced in the Illinois Assembly. The objective was to invite comment and criticism for the draft. Recovery, in submitting the statute for public inspection, wished to solicit the cooperation of all those who were interest in the welfare of the mental patient, sick or recovered. Welfare agencies were urged to join hands with Recovery in the effort to remove the standing unnecessarily harsh law, Recovery members believed, from the statute books and to help the mental patient and his family to escape the disgrace of the "Court record."<sup>18</sup>

The basic issue for which Recovery is endeavoring is to interest public support in revision of the present outmoded and barbaric commitment law.<sup>19</sup> Paul de Kruif stated in 1939, Recovery's chief fight is for the mass of demented ones who are kept from the chance of cure because their families fear insanity's stigma. Recovery, with the aid of some leading Illinois lawyers, is drafting legislation to remove the brand of lunacy from commitment to state institutions. Once there is law recognizing that insanity is not disgrace but disease, like any other, once the shame of court record is wiped from commitment proceedings, then all mentally sick will be sent early — not as lunatics to madhouses but as patients to hospitals for cure.<sup>20</sup>

The statute was drafted and submitted for suggestions and criticisms to the various welfare organizations. In the meantime, the Illinois Society for Mental Hygiene came forward with a proposal to adopt the basic features of the

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<sup>18</sup>Abraham Low, "The Preliminary Draft of the New Illinois Statute," Lost and Found 3 (November-December 1940), 160.

<sup>19</sup>Pauline Rosenberg, "They Show us Miracles," Hygiea (November 1940), 1038.

<sup>20</sup>Paul de Kruif, "Men Against Insanity," Country Gentleman (1939), 64.

statute in force in New York State, with suitable modifications for their introduction in Illinois. Representatives of Recovery met with a joint committee of the Psychiatric and Mental Hygiene Societies but were unable to reach a compromise. The point at issue was that the New York statute, although generally pervaded by a spirit of humanity, thought Dr. Low, did not go far enough in matters of eliminating the court record. Finally, a compromise was effected as House Bill 631 was submitted to the Illinois Assembly as a result. It was sponsored by Mrs. Bernice Vandervries, member of the House of Representatives, and supported by the leading welfare organizations of the state, including Recovery.<sup>21</sup>

June 12, 1941, House Bill 631 passed the House of Representatives by a vote of 122 to 1. June 24, 1941, it passed the Senate without a dissenting note. A few days later the Attorney General of the State of Illinois issued a ruling to the effect that House Bill 631 was unconstitutional, thereupon Governor Green vetoed the bill.<sup>22</sup>

Labor Exchange: In the May, 1939, issue of Lost and Found an advertising column first appeared. "Advertising space is offered in this column free of charge to former patients in need of work and to employers offering employment."<sup>23</sup> This was begun due to a resourceful ex-patient who had pleaded at a meeting of the association for the shoe repair work of the members. He then

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<sup>21</sup>Abraham Low, "A History of Commitment Laws in the State of Illinois," Lost and Found 4 (September-October 1941), 132.

<sup>22</sup>Abraham Low, "House Bill 631 Passed by Illinois Assembly," The Historical Development of Recovery's Self-Help Project (Chicago 1943), 125-127.

<sup>23</sup>Abraham Low, "Advertising Column," Lost and Found 2 (May 1939), 42.

drew the conclusion that every former mental patient who had services to offer should be given adequate opportunity to advertise his wares and skills. This was considered by Dr. Low as a sign post in the history of Recovery and of psychiatry because the labor exchange project was intended to secure employment for returned patients and through employment to maintain and bolster their morale.<sup>24</sup> There were three distinct subdivisions of the labor exchange. One dealt with services, another with full time positions, a third with short-term, part-time jobs. In the course of time, the discrepancy between the amount of work offered and the number of workers available was so wide that for several weeks in succession applicants for jobs could not be found. Dr. Low explained the favorable employment situation among members of Recovery in this way. Members gained in morale, thus employability. A progressive decline in job applicants took place in direct proportion to the growth of Recovery's social clubs. These clubs re-equipped the patients with a healthy quota of self-confidence and laid the groundwork for their economic success. The spirit of self-help created a situation in which help was no longer needed. As a result, the part-time labor exchange could be liquidated.<sup>25</sup>

Social Clubs: In January 1940, five boys and five girls got together and had a sleigh party. A usual occurrence in January yet unusual in that the boys and girls were former mental patients. They had such a good time that the suggestion was made to have such "get togethers" every two weeks. Thus was

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<sup>24</sup>Abraham Low, "Lost and Found's Advertising Column," Lost and Found 2 (May 1939), 33.

<sup>25</sup>Abraham Low, "Part Time and Short-Term Jobs no Longer Needed by Labor Exchange," The Historical Development of Recovery's Self-Help Project (Chicago, 1943), 94-96.

born the Fortnightly Club, a subsidiary of Recovery. This was Self-Education through fun. Dr. Low regarded it as the most remarkable development in the history of after care. He theorized that the Fortnightly pioneers through fun and gaiety lead to self-management and self-care. According to him self-help and self-care are the ultimate aims of after care. The physician can restore health through treatment; the patient alone can prevent relapses through self-care.<sup>26</sup>

On April 5, 1940, club number two was formed. At this time the club had not found a suitable name but suitable activity had begun. This second club began the sponsor program. Each member pledged himself to sponsor a limited number of merely improved not recovered patients and hold himself responsible for their regular attendance at meetings. They placed themselves under the obligation of visiting patients, keeping in touch with them, taking them to shows, and calling for them on Sundays and taking them to meetings.<sup>27</sup>

In December, 1940, Recovery boasted of three groups which practiced self-education both through fun and through other social activities. The names of the clubs were "Fortnightly Club," "Companion Club" and "Senior Group." They met regularly about two or three times a month and exercised the art of relaxation and frankness. The "club life" which they initiated contributed materially to the growth of Recovery.<sup>28</sup>

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<sup>26</sup> Abraham Low, "The Fortnightly Club, a Venture in Self-Directed After-Care," Lost and Found 3 (March-April 1940), 28-29.

<sup>27</sup> Abraham Low, "Association News," Lost and Found 3 (May-June 1940), 76-77.

<sup>28</sup> Abraham Low, "Turning from the Public Recovery Attracts the Public," Lost and Found 3 (November-December 1940), 158.

Change in Policy: In the January-February 1940 issue of Lost and Found the aim of the Association was stated as to combat the stigma of mental disease as expressed in legal, economic and social discrimination practiced against the mental patient, recovered or otherwise. To eliminate the stigmatizing influence of the law the Association was preparing a new commitment statute to be introduced at the next session of the Illinois legislature. The Association's Labor Exchange had initiated a self-help movement which gave the former patients both economic assistance and moral encouragement. The educational endeavors had for their purpose to bring the message of the former patient before the public. To this end, patients aided by physicians addressed churches and clubs and presented their views and objectives.<sup>29</sup>

In the first issue of the Recovery Journal, June, 1946, the following statement is found "no welfare, a minimum of social activity, a maximum of training" achievement of mental health calls principally for training and practice. Too many social activities distract the group from its primary goal. Welfare activities are also outside of Recovery's scope.<sup>30</sup>

In January, 1947, the Recovery Journal cites again that between 1937 and 1941 Recovery had its headquarters on the premises of the Psychiatric Institute of the Illinois Research and Education Hospitals limiting its membership to patients treated at that Institution. In 1941 it established itself as an independent organization offering its facilities without discrimination to nervous and former mental patients in need of after-care. The aim of the organization

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<sup>29</sup> Abraham Low, "Our Purpose," Lost and Found 3 (January-February 1940), 3.

<sup>30</sup> Recovery Reporter (May-June 1958), 3.

was stated to prevent relapses in mental disease and to combat chronicity in nervous ailments. Its techniques were those of group treatment with the emphasis on self-help.<sup>31</sup>

The Recovery Reporter of May-June, 1958, repeated the policy "no welfare, a minimum of social activity, a maximum of training." It was repeated to acquaint new members and to remind the old. The warning was given that if Recovery was to continue its effective work, all members had to maintain the policies established by Dr. Low.<sup>32</sup> The policy and purpose change that come with Recovery's break with the Psychiatric Institute remains. The Recovery traditions are built on this foundation.

On October 1, 1941, Recovery moved its headquarters from the Illinois Research and Educational Hospital to 64 East Lake Street. The meetings took place at 410 South Michigan Boulevard. Further moves were made to 1140 North La Salle Street, 185 North Wabash Avenue, and to Recovery's present headquarters at 116 South Michigan Boulevard.

Slow Expansion: The first fifteen years of Recovery's expansion were extremely slow. Dr. Low was a very conservative person and believed he first had to prove over a period of time that his methods and group therapy would work.<sup>33</sup> He spent many years after 1937 studying and evaluating the group process and also following the progress of patients over long periods of time to see whether the effect of this method was temporary or permanent. It was not

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<sup>31</sup> Abraham Low, "Purpose," Recovery Journal 2 (January 1947), II.

<sup>32</sup> Recovery Reporter, Ibid, 3.

<sup>33</sup> John Higgins S. J., Recovery Inc. An Answer to Nervous Problems; an Interview with John J. Higgins Given to Martin L. Duggan (St. Louis, 1955), 8.

until 1952 that any major attempt was made to expand the organization. Almost all of the expansion has been since that date. In the December 6, 1952, issue of the Saturday Evening Post an article about Recovery was published. Since that time the organization has grown in leaps and bounds.<sup>34</sup>

Today's Recovery: Today's Recovery has over five thousand members, two hundred seventy-five groups in twenty-eight states.<sup>35</sup> There is hope that Recovery's methods to bring about recovery may help to stem the tide of mental illness, United States' number one social question.<sup>36</sup>

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<sup>34</sup>Recovery Inc.; Informational Pamphlet (Chicago, 1958) 5-6.

<sup>35</sup>Executive Secretary of Recovery Inc., Personal Interview, June 11, 1958.

<sup>36</sup>John J. Higgins S.J., "Group Centered Training for Mental Health," Medical Progress (June 1957), 3.

## CHAPTER III

### VALUE ORIENTATIONS

Dr. Abraham A. Low, Polish born graduate of the University of Vienna, came to the United States in 1921. After some years in general practice, he specialized in neurology and from there went into psychiatry.<sup>1</sup> From 1931 to 1940 he was the Associate Director, and in 1940 and 1941 the active Director of the Psychiatric Institute of the University of Illinois. During these same years he was assistant alienist for the State of Illinois and Associate Professor of Psychiatry at the University of Illinois Medical School. In 1937 he founded Recovery Inc.<sup>2</sup> Low emphasized the priority of the will over drives and in doing so he believed he echoed the principles and teaching of the late Professor Emil Kraepelin, whom Low regarded as founder of modern psychiatry, and those of the late Professor Wilhelm Wundt, father of modern psychology in his eyes.<sup>3</sup>

Attitude toward psychoanalysis: Dr. Low rejected the psychoanalytic doctrine, both as a philosophy and as a therapeutic technique. In point of

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<sup>1</sup>Jack Alexander, "They Doctor One Another," Saturday Evening Post (December 6, 1952), Reprint.

<sup>2</sup>National Headquarters, Recovery Inc.; Informational Pamphlet (Chicago, 1958), 1

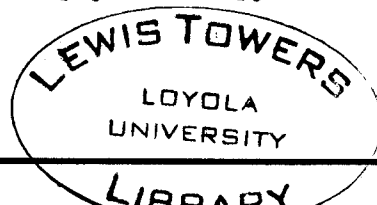
<sup>3</sup>Abraham Low, Mental Health Through Will Training (Boston, 1950), 12. See also John J. Higgins, S.J., "Recovery Inc.," Medical Progress (March 1955), Reprint.



philosophy he could not share the view that human conduct is the result of unconscious drives, sexual or otherwise. To his way of thinking, life is not driven by instincts but guided by will. In point of psychotherapeutic techniques, Low believed, psychoanalysis had to be accounted a failure. Its most startling defect, he said, was the insignificant number of patients which can be reached by the method. Psychoanalytic techniques are available for a small fraction only of the multitude of post-psychotic and psychoneurotic patients. The reason for its restricted availability is the egregious amount of time needed for the administration of the treatment, an overall average of hundreds of hours being required for each individual patient. For patients cared for in private practice there is the added handicap that the time-consuming process involves a necessarily exorbitant expense.<sup>4</sup> This limitation of psychoanalysis is an argument against its usefulness and applicability. Meyers and Schaffer point out that psychotherapy involves intimate communicative interacting between the patient and therapist. Therefore it may be facilitated; if a certain similarity in culturally determined symbols is learned, drives exist in both patient and therapist. Differences in value systems and patterns of communication on the other hand, may hamper the establishment of the therapeutic relationships. At present, it appears possible that lower class patients need to acquire new symbols and values to participate in expressive psychotherapy. Since this is a difficult process, many of them may be considered uncompromising candidates for successful treatment. According to the clinic's staff, they often lack motivation for psychotherapy or are not psycho-

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<sup>4</sup>Abraham Low, Ibid, 12.



logically minded. Perhaps psychiatrists need to acquire new symbols and values in dealing with lower class patients or perhaps new approaches are necessary to bring psychotherapy to such persons.<sup>5</sup> Psychoanalysis seems all but an unavailable method for masses of patients due to the time factor, cost element, and lack of intimate communicative interaction it affords between the patient and the analyst.

One of Low's chief disagreements with psychoanalytical doctrine is summed up in a favorite maxim of his that the past cannot be cured. His patients were not asked to dredge up childhood memories, dreams, guilt feelings of various kinds, or the thoughts that lie beneath the level of consciousness -- in fact, they were not allowed to do this. Dr. Low believed that the endless monologues set off by this kind of encouragement tend to feed the mental sufferer's despairing conviction of imminent calamity. His own approach was to insist that the sufferer cultivate his will power and apply it to the banishment of his troubles.<sup>6</sup>

Dr. Low in 1954 stated that fifty years ago there was no system of psychotherapy. Psychiatrists, in those days, treated their patients with a combination of common sense, reassurance, persuasion, and their own rich personal and professional experience. They obtained excellent results with the common sense approach. Then Freud, around 1900, created a system of psychotherapy. A sys-

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<sup>5</sup>J. K. Meyers and L. Schaffer, "Social Stratification and Psychiatric Practice; A Study of an Out-Patient Clinic," American Sociological Review 19 (June 1954), 310.

<sup>6</sup>Executive Secretary of Recovery, Recovery Inc. Versus Psychoanalysis; Approximative, Non-Verbatim Quotations from Dr. Low's Conversations (Chicago, 1954), 1-7.

tem not based on common sense and personal experience, but on the principle of sexual drives. Dr. Low indicated medicine does not know of any one principle that explains all disease. Freud, having created a principle, which he thought explained all nervous ailments, proceeded to work out the system of treatment called psychoanalysis.

In Low's interpretation psychoanalysis had three main features: (1) The use of an involved, complicated language which may be suited to high-grade intellectuals but which could not be accepted by most people; (2) The high cost of average psychoanalytic treatment which places it out of the range of the masses; (3) The search for the trouble-causing complex may take months and sometimes years because if the psychoanalyst is going to help the patient he must find the sex complex from which, he thinks, the patient is suffering. Thus there is little or no chance for the patient to get an early relief. Thus psychoanalysis may be good for some few intellectuals. For the average wage-earner, and mystical; its cost is prohibitive and it offers no chance for timely relief.

Dr. Low stressed the importance of giving quick relief. A system of psychotherapy that does not provide for speedy relief, he believed, is worthless. It is also, which is worse, harmful because it neglects to ward off preventable mental breakdowns.

Dr. Low believed what was needed was a working psychotherapy which would keep patients well after shock therapy. Thus he created the Recovery system in a style and pattern that would benefit the housewife, wage-earner, and farmer (emphatically not the intellectual).

The psychotherapeutic system produced by Dr. Low is the exact opposite

of the psychoanalytic system. It provides the following three features in which the psychoanalytic system has failed completely, Low believed: (1) A natural, rational, and common sense psychotherapy which is easily understood by the eighth-grader and the average, docile patient; (2) Daily training in Psychiatric Self-Help and Self-Control without any fee being charged for the service; (3) Speedy relief in the overwhelming majority of acute patients. Psychoanalysis claimed, the doctor believed, discovering the true nature of nervous and mental ailments. It boasted of having penetrated down to the very depth of human psychology. It further declared that its approach was that of genuine scientific research. No such claims were advanced by Dr. Low and Recovery. The procedure used by Recovery was and is neither that of truth-seeking nor that of depth-plumbing; nor does it pretend to be a champion of scientific research. Recovery wishes to be judged as a system of psychotherapy solely. As such, the founder believed, it is effective and rational, in contrast to psychoanalysis which is ineffective and irrational.<sup>7</sup>

The publication in which the above information was secured was retracted almost immediately after its printing and distribution to Recovery members. It was considered an unwise publication and recalled by Dr. Low due to the antagonism it could cause for Recovery. Recovery members were asked by the founder to ignore it and to concentrate on Recovery's methods rather than a comparison between Recovery and psychoanalysis.<sup>8</sup>

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<sup>7</sup> Recovery Member. Personal Interview (June 1958).

<sup>8</sup> Recovery Member. Personal Interview (June 1958).

Although part of the publication can also be found in the Recovery News, September, 1954, it must however be considered in this vein.

Dr. Low pointed out that psychoanalysis has well nigh monopolized the field of psychotherapy. Consequently it would be incumbent on a diverging approach to measure its record of accomplishment against that of the recognized procedure. The combination of office treatment with the group methods preached in Recovery achieved a range of availability which dwarfs that of psychoanalysis. Employing the method used in Recovery Inc., one man was enabled to give active psychiatric care to a considerable multiple of the patients serviced in a comparable period by large staffs of psychoanalytic institutions. Clearly, then, the Recovery method is vastly superior to psychoanalysis in the matter of availability to the masses of patients seeking psychiatric care.<sup>9</sup> Judging from the testimony of Recovery members who have been treated both by psychoanalytic methods and Recovery methods, (biased as such a sample might be) the effectiveness of the latter appears superior.

Basic character — group value. Therapeutic effectiveness of the Recovery techniques as distinguished from mere availability is shown in the basic character of the organization. The members know one another. They get together regularly in classes and frequently at parties. They get together in family gatherings and consort socially. If only a negligible number reached the status of apparently cured, the association would not have endured for such a period as twenty-one years.<sup>10</sup> This certainly helps to prove its effective-

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<sup>9</sup> Abraham Low, Mental Health Through Will Training (Boston, 1950), 14.

<sup>10</sup> Abraham Low, Ibid, 14-15.

ness. The group is the key unit in Recovery. New patients occasionally feel that they can accomplish a cure by the mere reading of Dr. Low's book. They may understand the principles but are limited in putting them into practice without the help of others. The patient must really want help and be willing to help himself. For this reason the group method is essential. It is by working with others that the patient will obtain encouragement, understanding, and mutual aid.<sup>11</sup>

Group training is as old as the family. Human beings have learned self-discipline, self-control, and self-reliance by listening to and emulating their parents, sisters, brothers, husbands, and wives. A community group like Recovery can do a good therapy job. Recovery can save the professionals for necessary work with the more seriously ill patients in hospitals and clinics. With little training and common sense, individual members and group leaders can control their influence on one another by transference and counter-transference, without getting involved in the deeper problems of others.

In the best group training techniques, Recovery members receive the constant approval, endorsement, and encouragement of the group that is dedicated to the self-same ideals of self-discipline and group-mindedness. That part of the personality which links an individual to the social community, often referred to as the "self," is a product of social interaction. Baldwin and Cooley contended that self-conceptions are in large part determined by the

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<sup>11</sup>National Headquarters, Recovery Inc.; An Informational Pamphlet (Chicago, 1958), 4-5.

responses of others.<sup>12</sup> According to Mead, the rise of the self depends upon the individual's capacity to look upon himself as an object. Such self-conception is an assumption of the reaction of others. The self thus has its origin in communications and in taking the role of the other.<sup>13</sup> In Mead's terminology this role-taking gradually becomes integrated into a number of self-conceptions each of which is called a "me," each corresponding to the definition of the self by others. During this developmental period the child will often talk to himself as others talk to him. In time a certain communality and consistency in the patterns permit the evolvement of a conception of the "generalized other," which represents social reality as seen by the self.<sup>14</sup>

The importance of these concepts for social interaction can easily be seen. Adaptation, cooperation, and even understanding are functions of the "me's" of the role-taking experiences. Hence, self-criticism as exercised through the "me's" is really social criticism, and behavior modified by self-criticism is really behavior modified socially.<sup>15</sup>

A Recovery member possesses great morale because he feels himself a member of a strong and important group. This unity is a product as well as a cause of the sharing of social values felt to be important by Recovery members.

The cohesiveness of any working group is especially important in group

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<sup>12</sup>Harrison Gaugh, "A Sociological Theory of Psychopathy," in Arnold Rose's Mental Health and Mental Disorder (New York, 1955), 277.

<sup>13</sup>Ellsworth Faris, "The Social Psychology of George Mead," American Journal of Sociology XLIII (1937), 391-403.

<sup>14</sup>George Mead, Mind, Self and Society (Chicago, 1934), 150-154.

<sup>15</sup>Harrison Gaugh, "A Sociological Theory of Psychopathy," in Arnold Rose's Mental Health and Mental Disorder (New York, 1955), 277.

psychotherapy. It is quite normal for human beings to feel ill at ease whenever they fear constant correction and criticism from experts. There are no experts at Recovery meetings. Members are all amateurs and quickly catch the "at home" feeling which helps to produce a friendly group climate and that mutual acceptance which takes members off the defensive and reduces tension. Therefore they are more ready to think about the task at hand and to respond. The informality of Recovery meetings consists mainly in this air of friendliness, which makes everyone relax and feel completely at home.

From the first day, just from looking and listening, Recovery people learn that they are neither the worst nor the best. Many who need or can benefit by group training realize quickly in these group meetings that they are not the sickest persons in the world, as they once thought. People suffering from strong feelings of self-importance soon learn that they are not the best practitioners in the group.

As soon as new members hear some of the background and daily practices of older members of the group, they feel certain that they can do what the others have done. As social creatures, with a common need for feeling secure, for receiving approval, for feeling successful, for being able to handle failure, members can satisfy all these needs much better in the group than by themselves.<sup>16</sup>

Purposes: Dr. Low states that the purpose of Recovery Inc. is to train post-psychotic and psychoneurotic persons in the practice of psychiatric after

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<sup>16</sup>John J. Higgins, S.J., "Group Centered Training for Mental Health," Medical Progress (June 1957), Reprint.



care.<sup>17</sup> The object of the organization, apart from its tendency to save time for the physician and money for the patient is to help prevent recurrences in mental diseases and to forestall chronicity in psychoneurotic conditions. Its techniques place the emphasis on self-help.<sup>18</sup>

Its aims have been stated in various ways: To provide after-care and prevent relapses in post-psychotic patients; to treat chronic psychoneurotic disorders; its entire emphasis is on self-help through will power and group contact.<sup>19</sup>

"Recovery, as it is referred to in its shortened form, is one of a number of group-therapy movements designed to help the victim of mental and emotional illness, through the bolstering influence of the group, to achieve some kind of balance."<sup>20</sup>

As has been previously noted in Chapter II, the purpose of Recovery Inc. has changed from its original aim in 1937. Thus Pauline Rosenberg wrote in 1940, "Thirty former patients under Dr. Low's leadership organized for the purpose of combating the stigma and promoting their economic and social interest."<sup>21</sup> Frank Riley noted in 1943, "To overcome this attitude toward victims

<sup>17</sup> Abraham A. Low, Mental Health Through Will Training (Boston, 1950), 6.

<sup>18</sup> Abraham Low, Ibid, 16.

<sup>19</sup> Norma Lee Browning, "The Amazing Story of Recovery," Chicago Tribune (January 3, 1954), Sunday Supplement.

<sup>20</sup> Jack Alexander, "They Doctor One Another," Saturday Evening Post (December 6, 1952), Reprint.

<sup>21</sup> Pauline Rosenberg, "They Show Us Miracles," Hygiea (November 1940), 959.

of mental illness, which accounts for so many relapses, is the chief function of an unusual Chicago organization called Recovery Inc."<sup>22</sup>

The Recovery Journal in its first issue June, 1946, indicated Recovery's policy "no welfare, a minimum of social activity, a maximum of training."<sup>23</sup>

Recovery's Informational Pamphlet published in 1953 explained that Recovery is not in the welfare field. At one time, many employers would not hire a patient who had been hospitalized for a mental or nervous ailment. However, the general public has become more enlightened and this is no longer a problem. Patients of course make friends with other patients, but basically the Recovery technique tries to help the patient resume his place within his own circle of friends.<sup>24</sup> Recovery's purpose stated in 1946 in the Recovery Journal remains the same today and the same as stated by Dr. Low in his book Mental Health Through Will Training, cited above.

"The Recovery technique supplies a philosophy of life to go by instead of the high pressure way that ruins digestion."<sup>25</sup>

Dr. Low insisted that if Recovery was to formulate a philosophy, it would have to be a philosophy of life, more particularly of daily life. The founder referred to this philosophy as that which keeps the functions of the body and

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<sup>22</sup>Frank Riley, "Recovery Inc.," Saturday Evening Post (January 16, 1943), 66.

<sup>23</sup>Recovery News (May-June 1958), 3.

<sup>24</sup>National Headquarters, Recovery Inc.; Informational Pamphlet (Chicago, 1958), 14.

<sup>25</sup>Merle Oliver, "Recovery Inc. Strengthens the Insecure," Detroit News (January 30, 1955), Reprint.

the daily life of the members in healthy order or throws them into ailing disorder. A patient holds the view that his nervous and mental functions, that is, his thoughts, feelings, sensations, and impulses ought to be governed by a set pattern of concrete order. This theory, Dr. Low believed, is a philosophy, carrying the philosophical belief that life is or ought to be ordered by a stable, relatively unchanging principle. The patient thinks that principle calls for such elements as balance, equilibrium, perhaps for the golden rule and the solid middle road. All of these, he reflects, constitute order which is health. If they are absent or disturbed, it means disorder which is disease. Dr. Low taught that there can be no disagreement concerning this part of the patient's philosophy. It is compounded of common sense and common experience, thus can become part and parcel of the philosophy of Recovery. This really is a part of what is called the psychology of perception, situations defined as real are real in their consequences. Definitions must therefore be made real and in touch and in accord with reality. This is sometimes called reality testing. See the analysis of reality testing on Pages 38 and 39. Reality testing in groups acts as an aid to social self development.

Dr. Low stated order is either stable or unstable. The entire order of a human being's thinking, feeling and action can be transformed, by a mere suspicion, into the exact opposite, from love to hatred, from selflessness to selfishness, from peacefulness to hostility, from trust to distrust. In an adult human being, the order in which life is adjusted is so unstable, that one single element, as suspicion, can lastingly upset it so that it turns into its exact opposite.

In explaining Recovery's philosophy, Dr. Low interprets the word belief

in this way. When an individual uses the word "belief" or "believing" or any of its synonyms, he wants it to be understood that he voices a tentative opinion, that his assumption may be incorrect and if he discovers its incorrectness he is ready to drop and change the belief. The philosophy of Recovery is based unqualifiedly and reservedly on this matter of belief. All its techniques have for their aim the intention to plant in the patient's mind the correct beliefs about nervous health and to purge it of the false beliefs held by himself. The reason for the extreme preoccupation with the subject of beliefs is that it is they which either order or disorder the lives of mature human beings. In Recovery it is an axiom that while a nervous ailment is not necessarily caused by distorted beliefs, nevertheless, if it persists longer than a reasonable time, its continuance, stubbornness and "resistance" are produced by continuing stubborn and "resisting" beliefs. Weak beliefs become firm convictions. In time, the conviction becomes more convincing. It gathers unto itself the strength of dogma and resists every attempt to drop or change it. The longer the conviction lasts the more thoroughly does it disorder the life of the patient. It creates sustained tenseness, panics and vicious cycles, finally, the well known chain of nervous symptoms. The patient must be divested of the conviction of insecurity. The patient may resist the knowledge that nervous ailments require will-training, self-discipline and self-control. He may fight for his own conviction that he needs outside help for an ailment which has nothing to do with will, discipline or control. If he does this, there is a clash of two antagonistic philosophies, mutually exclusive, contradictory and irreconcilable. The one is the philosophy of self-control, the other, that of self-indulgence. If the philosophy of Recovery prevails, the result will be health,

that is, restoration of order. If that of the patient wins, the ultimate outcome will be chronicity, that is, enduring disorder.

The distinction between loose beliefs and firm conviction is basic to an understanding of the Recovery philosophy. The finest demonstration in the Recovery classes that show other patients have regained their health after they changed their beliefs, the most skillful discussion and the most lucid explanation are no match for a solidly entrenched conviction. A person who holds a settled conviction is committed to it; he is ready to defend it, to fight for it; to uphold it against evidence. With a person of this kind there is no discussion, no healthy exchange of views, no realistic testing of opinions. Naive, untested and haphazard convictions must be regarded by the patient as weird, unsound and absurd.<sup>26</sup> This is related to the problem of the perception of self.

The self arises in conduct, when the individual becomes a social object in experience to himself. This takes place when the individual assumes the attitude or uses the gesture which another individual would use and responds to it himself or tends to so respond.<sup>27</sup> Recovery acts as a medium in which its members may, through their interactions, solve their difficulties and achieve emotional growth. To do this members must accept the philosophy of Recovery. Truly this is a dogmatic authoritarian therapy rather than client centered therapy.

Recovery is dedicated to two main propositions. One is that almost any mentally disturbed person, unless his brain or nervous system is physically

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<sup>26</sup> Abraham Low, "The Philosophy of Recovery Inc.," Recovery News (November 1951), 1-4.

<sup>27</sup> George H. Mead, "A Behavioristic Account of the Significance Symbol," Journal of Philosophy XIX (1922), 160.

damaged, can be restored to sanity if he will adhere to its group principles. Recovery is concerned only with the "no-damage" cases. It holds that through the same process, the psychoneurotic's troubles which tend to be chronic, can be reduced and, ultimately, eliminated.

The second principle holds that society, by and large, is gravely at fault in considering any mental disease to be somehow disgraceful. The ex-patient inevitably faces such a stigma even though he may have totally regained his mental balance.<sup>28</sup> Although Recovery can furnish the sufferer with understanding company and friends, others also must help to keep the person from being isolated from family and friends.

"Recovery feels it can fill the gap for psychiatric help. Members save their own sanity by their assistance to each other."<sup>29</sup> A sound principle is that membership in a vital interest group is essential to the mental health of the person. Isolation of the person from social groups is symptomatic of social ill health. One important way to good mental health is the placing of isolates in the type of social group best suited to their personality needs and interests.<sup>30</sup> Recovery Inc. does this.

Trainees must accept Dr. Low's fundamental principles that man has a free will that can control thoughts and impulses, and that nervous persons can be taught self-discipline. The Recovery member learns to regard his nervous symp-

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<sup>28</sup> Jack Alexander, "They Doctor One Another," Saturday Evening Post (December 6, 1952), Reprint.

<sup>29</sup> "Recovery Inc. Active in City," East St. Louis Journal (July 20, 1953), Reprint.

<sup>30</sup> Ernest W. Burgess, "Mental Health in Modern Society" from Arnold Rose's Mental Health and Mental Disorder (New York, 1955), 7.

toms as distressing, but not dangerous; to think of his good health as serious business; to remember that Recovery is strict self-discipline, simple but not easy.<sup>31</sup>

Some of the basic thinking habits that Recovery teaches, expressed in the form of slogans, are "feelings are not facts;" "tenseness intensifies and prolongs nervous symptoms;" "there is no right or wrong in domestic affairs--for our health's sake--if no law has been violated."<sup>32</sup>

Recovery methods work equally well with both the former mental patient and nervous patient, Dr. Low and his followers state. The Association regards a nervous patient as a person who has been diagnosed by a physician as suffering from nervous systems and fears. These symptoms may be dizziness, heart palpitations, tremors, feelings of unreality, nausea, diarrhea, constipation, sweats, throat "locking," sleeplessness, fatigue, or headaches. Particularly distressing to the nervous patient are his panics and depressions, fear of harming himself or others, fear of physical collapse or of losing his mind, fear of being alone or of being with people, and fear of the sustained handicap. In addition, Recovery also deals with the former mental patient that has been discharged from the hospitals as improved or recovered.<sup>33</sup>

Confidential nature: The confidential nature of the organization should

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<sup>31</sup>John J. Higgins S.J., "Recovery Inc.," Hospital Progress (March 1955), Reprint.

<sup>32</sup>John J. Higgins S.J., Recovery Inc., an Answer to Nervous Problems; an Interview with John J. Higgins S.J., Given to Martin L. Duggan (St. Louis, 1955), 14-15.

<sup>33</sup>National Headquarters, Recovery Inc.; Informational Pamphlet (Chicago, 1958), 9-10.

be noted. Although there should be no disgrace attached to being a former mental or nervous patient, this does not have to be announced to the public. Persons interested in the organization are assured that their queries will be kept confidential. A news report of the East St. Louis Journal brings this out clearly. "The missionary in Recovery expansion, a woman who prefers to be known only as 'Mrs. Smith' was here last week to see the East St. Louis chapter off to a start."<sup>34</sup>

Trivial matters: It is important to note that Recovery sticks to trivialities in all its examples. Any major difficulties involving problems which might increase group tension or group resistance are banned. Recovery's often repeated dictum "Life is made up of trivialities--mainly," is the reason for this practice. It is these trivial matters that cause trouble for patients. Once he gets control of the easy trivial symptoms, he is far on the way to handling his problems. The constant practice every day in trivial matters--such as deciding to visit a relative rather than stay home--sets the pattern that enables the nervous person to handle a matter that is not trivial with good control.<sup>35</sup>

Discipline: Recovery's main effect is to discipline the patient, to make him bear, or at least, share the responsibility for his continued invalidism. Essentially it tells the patient: The Recovery method gives you the opportunity to conquer your handicap. If you engage in "sabotage" activities the process of getting well will be delayed and the responsibility for prolonging your suf-

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<sup>34</sup> "Recovery Inc. Active in City," East St. Louis Journal (July 20, 1953), Reprint.

<sup>35</sup> John J. Higgins, "Group Centered Training for Mental Health," Hospital Progress (June 1957), Reprint.



fering will rest on you. The procedure may savor of dictatorial harshness but it is nothing but firm leadership.<sup>36</sup> Recovery is definitely an authoritarian therapy rather than client centered. The rigid discipline used in Recovery either eliminates the domineering type of person or makes him into a better controlled individual by making him act in conformity with the group.<sup>37</sup> One would question because of this whether Recovery is designed to help primarily the submissive who would be willing to accept this authoritarianism. Recovery's method involves the long, slow and painful effort required to change habits, as does most psychological and social therapy. Not all patients who come to the meetings persist. Some, finding that they are not cured after one or two meetings, drop out. But those who have regularly attended meetings and have practiced the disciplines for some months have improved, they believe. A few say they are completely cured, others feel that, though not completely safe, they have learned to spot symptoms and approaching panics and have known how to cope with them.<sup>38</sup> Individual Recovery members interviewed by the reader echo these same statements.

Relationship with physicians: Until Dr. Low's death in 1954, he served as Medical Director of the Recovery organization. Now Recovery has no medical

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<sup>36</sup> John J. Higgins S.J., Recovery Inc.; an Answer to Nervous Problems; an Interview with John J. Higgins S.J. Given to Martin L. Duggan (St. Louis, 1955), 13.

<sup>37</sup> Abraham Low, "The Combined System of Group Psycho-Therapy and Self-Help as Practiced by Recovery Inc.," in Moreno's Group Psychotherapy (New York, 1945) 99.

<sup>38</sup> John J. Higgins, S.J., "Group Centered Training for Mental Health," Hospital Progress (June 1957), Reprint.

director. It was Dr. Low's aim that Recovery, as a self-help method, should be conducted entirely by former patients well trained in his carefully worked out technique. It is a lay organization which works closely in cooperation with individual physicians. The members have been diagnosed by their doctors as nervous or former mental patients. Many patients attend Recovery while simultaneously under the care of a physician or psychiatrist. All such patients must have the permission of their doctors to attend Recovery meetings. Recovery is an after-care program and does not concern itself with medical care or make any medical recommendations.<sup>39</sup>

In this program, there is naturally some danger that such a lay organization might be criticized for trespassing on professional grounds. In principle, Recovery teaches that the patient must follow his doctor's instructions and that Recovery does not take the place of the doctor. In practice, Recovery helps the doctor by teaching its members the basic principles and practices of self-control.<sup>40</sup> Doctors who know and agree with the Recovery program send their patients to Recovery groups because, (1) they realize that they cannot, since the number of patients and cost of individual psychotherapy prohibit it, handle all the patients who come to them, (2) they have confidence in Recovery's training procedures realizing they were developed by an experienced psychiatrist and mental hospital administrator, Dr. Low, and (3) they know the methods have been

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<sup>39</sup> Kathleen Rutherford, "Recovery Inc.," America 95, (September 15, 1958), 562.

<sup>40</sup> National Headquarters, Recovery Inc.; Informational Pamphlet (Chicago, 1958), 6-7.

tested and refined by Dr. Low and Recovery members through years of experience.<sup>41</sup> It must be noted that the above statements refer to doctors who know the Recovery program. There are many who do not know it nor wish to know it because they believe it is trespassing on professional grounds.<sup>42</sup>

Requirements to benefit by Recovery: "Recovery cannot help anyone who does not want help."<sup>43</sup> Anyone who can profit by the program is eligible to become a regular, participating member of the Recovery group. All that is necessary is, (1) that a person who is free to attend and able to follow a meeting, admitting to himself that he wants and needs the help that Recovery can give him, (2) that his own physician approves or does not object to his attending, and (3) that he agree to study the textbook Mental Health Through Will Training by Dr. Low, and (4) he attend meetings regularly and participate in the example period. Those who come find that it favors an objective evaluation of themselves through the comparison of their own problems with those of others, and helps them to socialize and to develop new interests outside their families.<sup>44</sup>

This as a psychotherapeutic situation contains elements of novelty and familiarity which facilitate testing old and new attitudes and ingrain the appropriate ones through practice. The novel aspects, some of which are implied in the discussion of permissiveness, support and stimulation, help the patient

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<sup>41</sup> John J. Higgins S.J., "Recovery Inc.," Hospital Progress (March 1955), Reprint.

<sup>42</sup> Recovery Member, Personal Interview (July 23, 1958).

<sup>43</sup> National Headquarters, Recovery Inc.; Informational Pamphlet (Chicago, 1958), 15.

<sup>44</sup> John J. Higgins S.J., "Group Centered Training for Mental Health," Medical Progress (June 1957), Reprint.

to gain new insights into his attitudes, especially when others fail to respond as he expects. The familiar aspects allow him to test his responses on the spot and transfer what he learns to everyday life. The therapeutic group contains a useful blend of the familiar and the new. This similarity to real life goes along with significant differences; for example, a permissiveness which attenuates the penalty for failure and the relative directness and honesty of the member's reactions which help each to see how his behavior is perceived by others. These qualities make the group especially useful for teaching and improving social skills in which many psychiatric patients are seriously deficient. These properties are closely interrelated. For example, improvement of a member may encourage some and may stimulate envy in others. Antagonisms may be not only stimulating but also supportive in that through them members learn they can maintain a position despite opposition, that they have allies, or that a relationship may survive a battle, or even be strengthened by it.<sup>45</sup>

Relatives: There is a problem of the stigma and shame attached to mental illness. It is felt by many that the incidence of mental illness in their family implies an unsound hereditary structure. They cannot accept this, since it seems to be a direct attack upon their personal integrity. Kaplan and Wolf have attempted to bring the role of the mental patient's family into the foreground as an essential consideration in therapeutic planning. They contend that the patient's inter-personal relationships with his family are of special importance.<sup>46</sup> In the early days of Recovery, when it was affiliated with the Psy-

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<sup>45</sup>Jerome D. Frank, "Group Methods in Psychotherapy," in Rose's Mental Health and Mental Disorder (New York, 1955), 531-532.

<sup>46</sup>A. Kaplan and L. Wolf, "Role of the Family in Relation to the Institutionalized Patient," Mental Hygiene 38 (October 1954), 639.

chiatric Institute, the relatives were asked to attend meetings, held twice a month at the hospital and listen to a lecture by Dr. Low.<sup>47</sup> Dr. Low embodied these lectures in his book Lectures to Relatives of Former Patients, published in 1943. They can also be found in the first publication of Recovery's Lost and Found. The emphasis today is placed on the patient and not on the relatives,<sup>48</sup> although Recovery has done fine work for the families and relatives of patients and nervous people. Few relatives of nervously ill people know how to treat these sick people. They are either much too severe or else over-indulgent. To help relatives reach a happy medium in dealing with their sick, Recovery invites them to come to meetings and learn from other family people what to do with nervous problems, how to behave toward their sick people and how to avoid being the cause of relapses.<sup>49</sup>

Non-Moneyed victims: "Recovery is the poor man's psychiatry."<sup>50</sup> Most of Recovery's members come from the middle and lower middle class.<sup>51</sup> Recovery's cost is low. Members do have to have a copy of Mental Health Through Will Training by Dr. Low. The cost is five dollars. Membership fees are three dol-

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<sup>47</sup>Pauline Rosenberg, "They Show us Miracles," Hygiea, (November 1940), 959.

<sup>48</sup>Executive Secretary, "Personal Interview" (June 11, 1958).

<sup>49</sup>John J. Higgins S.J., Recovery Inc.; an Answer to Nervous Problems; an Interview with John J. Higgins S.J., Given to Martin L. Duggan (St. Louis, 1955), 20.

<sup>50</sup>Kathleen Rutherford, "Recovery Inc.," America 95, (September 15, 1958), 562.

<sup>51</sup>Jack Alexander, "They Doctor One Another," Saturday Evening Post (December 8, 1952), Reprint.

lars per year depending upon one's interest and financial situation. This is requested but not required.<sup>52</sup> It has already been cited that Meyers and Schaffer believe psychiatrists need to acquire new symbols and values or new approaches are necessary to bring psychotherapy to the lower classes.<sup>53</sup> Recovery does not have this problem. It is psychotherapy brought to the lower classes.

Recovery's relationship to religion: Recovery is non-sectarian. Members of a typical group usually include people of different races and religions, all cooperating in one common goal—to regain their nervous and mental health. Recovery methods are made available to nervous and former mental patients of all races and religious creeds. Dr. Low emphasized that Recovery members should rely upon their own religious advisors as their authorities in this field, just as they should rely upon the authority of their own doctor for medical diagnoses and treatment.<sup>54</sup> There is nothing in Recovery that conflicts with religion or prevents a person from using religious motivation.<sup>55</sup> Some have found it disconcerting that religion does not play a part in Recovery's program. Thus writes Reverend Henry J. Anderson, S.J., of Manhattan State Hospital in New York, "It is disturbing to find that the excellent and zealous endeavors of such organizations as Recovery Inc. and Alcoholic Anonymous are hampered by a lack of appre-

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<sup>52</sup> National Headquarters, Recovery Inc.; an Informational Pamphlet (Chicago, 1958), 9.

<sup>53</sup> J. K. Meyers and L. Schaffer, "Social Stratification and Psychiatric Practice; a Study of an Out-Patient Clinic," American Sociological Review 19 (June 1954), 310.

<sup>54</sup> National Headquarters, Recovery Inc.; an Informational Pamphlet (Chicago, 1958), 11-12.

<sup>55</sup> John J. Higgins S.J., Recovery Inc.; an Answer to Nervous Problems; an Interview with John J. Higgins S.J., Given To Martin L. Duggan (St. Louis, 1955).

ciation of the all pervading importance of religion in the prevention of, and recovery from psychological breakdowns. 'He labors in vain'....is as pertinent to human beings today as it was in Christ's time. The God-centered life precludes emotional disorders, barring accident or organic disease. The self-centered life invites them. Let religion not be relegated to playing an ancillary part in the drama of psychological disaster, but let us consider it as an integral in the living of emotionally well-ordered and well-balanced lives."<sup>56</sup>

Reverend Edward Dowling, S.J., believes Recovery Inc. implements a priest's quarry of motives for soul cure (psychotherapy).<sup>57</sup> A religious leader that has no anxiety about cooperation with a therapeutic program such as Recovery Inc. has countless opportunities for detecting family conditions creating neurotic patterns. His constant home visits give chances for expressing attitudes toward family discipline, sibling relations, educational trends, and emergency reactions. He can express these attitudes subtly rather than dogmatically, making the visits a contribution to family morale. He can detect maladjustments in early stages and be available for counsel. His people will often accept these suggestions when they would not listen to a friend or relative.

In general, religious workers have one of two attitudes toward the mental health field. They may believe that a thorough-going religious commitment solves all problems, or they may accept a division of labor in which a cooperative program as Recovery Inc. can deal with problems at a secular level. From this point of view the religious task is no longer primary, but the religious

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<sup>56</sup> Henry J. Anderson S.J., "Letter to the Editor," America 96 (October 13, 1956), 22.

<sup>57</sup> Edward Dowling S.J., "Letter to the Editor," America 96 (October 13, 1956) 22.

orientation will crown and complete the achievement of personal integration at the secular level.

The task of promoting mental health requires the second view rather than the first. A priest, minister, or rabbi, with the first point of view can work a cooperative program, either because he misunderstands the aims, or because he is hostile to those who appear to compete with him, who make uncomfortable demands, or who appear to be dealing with trivial affairs in view of what he regards as a mere ultimate and final commitment. If it is true, in Gettelheim's phrase, that for unraveling emotional difficulties, "love is not enough," so the religious leader, to be of service here, must recognize that "religion is not enough" either.<sup>58</sup>

Clergy of many denominations have indicated high regard for the work of Recovery. Reverend I. Paul Taylor, Methodist minister, states, "Recovery is founded upon sound group therapy and takes nervous people step by step on the road to health and the attainment of emotional and spiritual stability."<sup>59</sup> Reverend E. T. Beruthal, Lutheran minister, says, "Recovery has been a God-send to hundreds of people I have met."<sup>60</sup> "One can find nothing in Dr. Low's lectures and writings that is at variance with Scholastic Philosophy," states Reverend John J. Higgins, S.J.<sup>61</sup>

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R. A. Schermerhorn, "Social Psychiatry," in Rose's Mental Health and Mental Disorder (New York, 1955), 55-56.

<sup>59</sup> Reverend I. Paul Taylor, "Quotes from the Clergy," Detroit News (January 31, 1955), Reprint.

<sup>60</sup> Reverend E. T. Beruthal, "Quotes from the Clergy," Detroit News (January 31, 1955), Reprint.

<sup>61</sup> John J. Higgins, S.J., "Recovery Inc., " Medical Progress (March 1955), Reprint.



John J. Higgins S. J.: Well-known for his outstanding work in Recovery Inc. is Reverend John J. Higgins S. J., student counsellor at Parks' Air College of St. Louis University. Father Higgins explains that in 1927 he had a so-called "nervous breakdown," spent some time in hospitals and has been nettled with various nervous symptoms ever since. The most practical thing for nerves that he has found is Dr. Low's book and the Recovery methods.<sup>62</sup> Concerning Recovery he states, "Recovery is not easy and it is not a panacea, but we are convinced with the doctors that the Recovery program deserves the attention of people interested in public health--because it works."<sup>63</sup> For Recovery to work, it must be noted that the individual must follow the Recovery program in entirety. If he does this the program will work. It is up to the individual to make it work.

Father Higgins has acted as a counselor for Recovery group since 1952. He has written fundamental principles of Recovery in what he calls the A.B.C.'s of Recovery and the Seventeen Points of Recovery. In these seventeen points he makes direct reference to religion in two points. "It is good for me right now to make my health the most important thing in my life (assuming that I know and believe that life is worth living--in preparation for a happy eternity with my heavenly Father)."<sup>64</sup> "My last-but-not-least point is the motto of another great

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<sup>62</sup>John J. Higgins S.J., Recovery Inc.; an Answer to Nervous Problems; an Interview with John J. Higgins S.J., Given to Martin L. Duggan (St. Louis, 1955), 7.

<sup>63</sup>Kathleen Rutherford, "Recovery Inc.," America 95 (September 15, 1956), 582.

<sup>64</sup>John J. Higgins S.J., Recovery Inc.; An Answer to Nervous Problems; An Interview with John J. Higgins, S.J., Given to Martin L. Duggan (St. Louis, 1955), 28.

student of personality and doctor of souls, Ignatius of Loyola, "Work (on the Recovery program) as if everything depended upon you; but pray as if everything depended upon God."<sup>85</sup>

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<sup>85</sup>John J. Higgins S.J., Ibid, 32.

## CHAPTER IV

### TECHNIQUES OF RECOVERY INC. AND THE SOCIO PSYCHOLOGICAL

#### IMPLICATIONS FOR THERAPY

The organized community or social group which gives to the individual his unity of self may be called "the generalized other." The attitude of the generalized other is the attitude of the whole community. Thus for example, in the case of a social group as Recovery Inc., Recovery Inc. becomes a generalized other of its members in so far as it enters as an organized process or social activity into the experience of any one of the individual members of it. There are two stages in the full development of the self. At the first of these stages, the individual's self is constituted simply by an organization of the particular attitudes of other individuals toward himself and toward one another in the specific social acts in which he participates with them. But at the second stage in the full development of the individual's self that self is constituted not only by an organization of these particular individual attitudes, but also by an organization of the social attitudes of the generalized other or the social group as a whole to which he belongs.

What goes to make up the organized self is the organization of the attitudes which are common to the group. A person is a personality, says Mead, because he belongs to a community, because he takes over the institutions of that community into his own conduct. He takes its language as a medium by which he gets his

personality, and then through a process of taking the different roles that all the others furnish he comes to get the attitude of the members of the community. Such in a certain sense, is the structure of a man's personality. There are certain common responses which each individual has toward certain common things, and in so far as those common responses are awakened in the individual when he is affecting other persons he arouses his own self. The structure, then, on which the self is built is this response which is common to all, for one has to be a member of a community to be a self. Mead says such responses are abstract attitudes, but they constitute man's character. They give him his principles, the acknowledged attitudes of all members of the community toward what are the values of that community. He is putting himself in the place of the generalized other, which represents the organized responses of all the members of the group.

It is by means of Recovery's techniques and tested experiences of others that members learn to regain confidence, overcome destructive personality traits and the unreasoning fear that has made them retreat and retreat from life until they are practically helpless.<sup>2</sup> Many of the effective techniques of Recovery Inc. which bring members back from this retreat which emphasize the group aspects of socialization and which consider mental health therapy and recovery as a kind of re-socialization process with new group identifications being developed are explainable in terms of the social-psychological theories of personality development.

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<sup>1</sup>George Mead, "The Self, The Generalized Other and the Individual" in Bur-  
gatta, and Meyer's Sociological Theory; Present Day Sociology From the Past.  
(New York, 1956), 50-62.

<sup>2</sup>Kathleen Rutherford "Recovery Inc." America 95 (September 15, 1956) 561.

There is nothing compulsory about attendance at Recovery's group meetings but attendance is encouraged because according to Dr. Low the patients must make a total effort in order to regain health.<sup>5</sup> A patient must have the willingness to help oneself. Meetings are not social club gatherings although members do profit by meeting and chatting with new friends, the benefits of self-discipline and group discipline are gained from a business-like approach to learning and practicing Recovery methods. Meetings begin with a playing of a half-hour phonograph record of one of Dr. Low's lectures. The lecture describes how a nervous patient gains control through Recovery methods. During this time, members jot down what they consider significant for themselves and then report on their notes in the short discussion period that follows. This discussion is not an evaluation of the methods, but it has real value in that (1) it forces members to concentrate on the talk; (2) it gives all an opportunity to participate; (3) it serves to give due emphasis to the methods of self-help and diverts attention from the severe symptoms described on the record. This again is an example of reality testing in Recovery technique previously discussed in Chapter III on pages 38 and 39. Reality testing acts as an aid to social self-development.

After the brief mutual interchange in which all are encouraged to comment, a chapter or part of a chapter from Dr. Low's text is read. The reader or leader then is asked to tell the group what sentences he considers important enough to underline for future reference. The reading lasts not longer than a half hour. Then the "hat is passed" for the free will offering which is considered an integral part of Recovery's self-help program. If the patients give a little

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<sup>5</sup>National Headquarters Recovery, Inc.; Informational Pamphlet (Chicago, 1958) 13.

to help pay expenses and further the spread of Recovery they appreciate Recovery training all the more. This gives the patient the opportunity to help others. This participation removes the cause of uselessness and improves the self concept.

Next follows the example period in which the first half is devoted to a review of the principles, methods and practices of Recovery and then the leader asks active members for examples of symptoms and how they handled them with Recovery methods.<sup>4</sup> The essentials of a good example are (1) the bare facts of the situation; who, when, where, what, why, how, under what circumstances; (2) the resulting symptoms, (3) the "spotting"; how did the patient handle the symptoms? Did the patient "spot" and "reject" or did he "sabotage"? (4) Before Recovery training what would you have done under the same conditions? The patient is reminded to be group-minded by (1) leaving out the lengthy background of the example unless the other members ask for it after the patient has given the main points of his example and (2) not wearing out the whole group by an interminable questioning of the example-giver. When the essential points of the example have been brought out by due questioning the patient is asked to give others an opportunity to give examples.<sup>5</sup> This cooperation is an indispensable requirement for the proper functioning of Recovery Inc. Individual patients must indicate this social solidarity in action by accommodating to others.

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<sup>4</sup>John J. Higgins, S.J. "Group-Centered Training for Mental Health" Medical Progress (June, 1957) Reprint.

See also: John J. Higgins, S.J. "Recovery Inc." Medical Progress (March, 1955) Reprint.

<sup>5</sup>St. Louis Recovery Office Recovery: How to Give an Example.

This preparation for giving an example in a meeting is a great aid in helping a member to practice Recovery between meetings. It is important to note that only trivial examples are given. Major problems or decisions are not discussed. Professional questions are never attempted to be answered. Members merely retell specific incidents of what they have experienced and how they handled the matter. There is usually something in it that is similar to what others have been experiencing and consequently all derive some benefit from the example.

Only a minimum of examples which describe "sabotage" are allowed. "Sabotage" is a diagnostic, therapeutic or prognostic statement made by the patient.<sup>6</sup> It is the manner in which patients offer resistance to the physician's instructions.<sup>7</sup> One can commit sabotage by merely using expressions which indicate a spirit of defeatism such as "intolerable tenseness". This description in Recovery's lexicon is translated into "failure to relax."<sup>8</sup>

During the last few minutes of the meeting, new and old members and visitors are permitted to ask general questions about the personal experiences described during the example period. This gives the new members and visitors greater insight into Recovery's methods and their effectiveness.

After the meeting which lasts close to two hours members visit with other members and guests either individually or in small groups. This helps the socializing process, gives cohesion to the group, strengthens loyalties and gives

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<sup>6</sup>Abraham Low Mental Health Through Will Training (Boston 1950) 12

<sup>7</sup>Abraham Low, Mental Health Through Will Training (Boston 1950)

<sup>8</sup>Jack Alexander, "They Doctor One Another" Saturday Evening Post (December 6, 1952) Reprint.

opportunities for further discussions on individual problems.<sup>9</sup>

People appear to differ in their ability correctly to interpret the attitudes and intentions of others, in the accuracy with which they can perceive situations from others' standpoint (definition of the situation), and thus anticipate and predict their behavior. This type of social sensitivity rests on what is called the empathetic responses. Empathetic responses are basic to "taking the role of the other" and hence to social interaction and the communicative processes upon which rests social integration. They are central in the development of the social self and the capacity for self-conscious behavior. The kind of interaction experienced in groups such as Recovery Inc. appears to depend heavily upon the degree to which empathetic capacity develops. The group leaders need to develop his empathetic capacity.<sup>10</sup>

Konopka has discussed the necessary qualifications for group workers with children. These qualifications have application to group leaders and thus to group leaders in Recovery. These qualifications are (1) the leader must assume a helping function, (2) the leader must have self-discipline and knowledge to establish purposeful relations with group members (3) the leader must use the inter-acting process and must have the capacity to help balance the group and to allow for conflict and help with its solution, (4) the leader must be able to use program content appropriate to the needs of the members.<sup>11</sup>

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<sup>9</sup> John J. Higgins, S.J., "Recovery Inc." Medical Progress (March 1955) Reprint.

<sup>10</sup> Nelson Foote and Leonard Cottress. Identity and Interpersonal Competence (Chicago, 1955) 54.

<sup>11</sup> G. Konopka, "Group Work with Children and Youth, Unanswered Questions" Social Service Review 30 (September, 1956) 303.



There has been some division of practice concerning group leaders. Recovery's Informational Pamphlet points out that the leader must be a nervous or former mental patient who believes in the self-help method and who is practicing it in connection with his own situation. Dr. Low believed only nervous and former mental patients can adequately understand and share the problems of those in the group. The leader must be thoroughly familiar with Dr. Low's book Mental Health Through Will Training which sets forth the basic techniques on which Recovery operates. In addition to experience in Recovery, each leader must have at least one week of intensive training in the National Office.<sup>12</sup>

Thus Kathleen Rutherford wrote that every group leader in the work must be a recovered patient or one who is on the road to recovery. Unless he himself has suffered a breakdown and has cured himself through Recovery he cannot appreciate the genuine suffering of the patients or know what it costs to take the steps required to rebuild the defeated will.<sup>13</sup> Cohesion and solidarity in the group is accomplished by having all members including the leader share common problems. Hulse said authority of the group is delegated to veteran patients who are put in charge of group meetings.<sup>14</sup>

Yet this ideal is not always accomplished. William Oleksak pointed out that although most groups have accomplished this ideal, the lack of such a lead-

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<sup>12</sup>National Headquarters Recovery Inc. Informational Pamphlet (Chicago 1958) 8.

<sup>13</sup>Kathleen Rutherford "Recovery Inc." America 95 (September 15, 1956), 561-562.

<sup>14</sup>W. C. Hulse "Role of Group Therapy in Preventive Psychiatry" Mental Hygiene 36 (October, 1952) 537.

er in a community does not necessarily deprive its people of the benefits of Recovery. Under certain circumstances the National Office will permit groups to be officially established and conducted by persons who are not or have not been patients. Examples of this are afforded by the Louisville, Cincinnati and Dayton branches of Recovery.<sup>15</sup> Dorothy Kerchner, Assistant Director of Nurses at Longview State Hospital in correspondence with this writer stated "I am a psychiatric nurse. As a leader, I am an exception rather than the rule. My participation is that of a lay individual rather than a nurse."<sup>16</sup>

Leadership is always in some sphere of interest and toward some objective goal seen by leader and follower. There can be no leadership in isolation. It is distinctly a quality of a group situation. Leader and follower must be united by common goals and aspirations, and by a common acceptance of one another. From this it follows that the individual must have membership character in the group which makes him the leader, because leaders and followers are interdependent. The principle of mutual interaction between the leader and the group implies that the individual chosen leader must have certain qualities of personality which, derived as they are from his group-membership character, confer upon him a certain social effectiveness and determine his acceptability.<sup>17</sup> Thus it is understandable why leadership by non-patients is the exception rather than the rule.

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<sup>15</sup>William Oleksak "Letter to the Editor" America 95 (September 29, 1956), 605.

<sup>16</sup>Dorothy Kerchner "Letter to the Writer" July 21, 1958.

<sup>17</sup>Cecil A. Gibb - "The Principles and Traits of Leadership" in Hare, Borghatta and Bale's Small Groups Studies in Social Interaction (New York, 1955) 91-92.

Language as such is simply a process by means of which the individual who is engaged in co-operative activity can get the attitude of others involved in the same activity. Through gestures, that is, through the part of his act which calls out the response of others, he can arouse in himself the attitude of the others. Language as a set of significant symbols is simply the set of gestures which the organism employs in calling out the response of others. Those gestures are primarily parts of the act which stimulate others engaged in the co-operative process to carry out their parts. Gestures can affect the individual as they affect others so as to call out the response which belongs to the other. In taking the attitude of the group, one has stimulated himself to respond in a certain fashion. His response, the "I", is the way in which he acts. If he acts in that way he is, so to speak, putting something up to the group, and changing the group. His gesture calls out then a gesture which will be slightly different. The self thus arises in the development of the behavior of the social form that is capable of taking the attitude of others involved in the same co-operative activity. The language of Recovery Inc. is an essential element of the organization's technique.<sup>18</sup>

Dr. Low insisted upon a vocabulary that is more apt to calm a patient rather than disturb him. The language is not hard to learn. It is made up of common English words but their definitions have been carefully established by Dr. Low so that the patients are all talking about the same thing.<sup>19</sup> With this kind

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<sup>18</sup>George Mead, Mind, Self and Society. (Chicago 1934) 335.

<sup>19</sup>National Headquarters Recovery Inc. Informational Pamphlet (Chicago, 1958)

of terminology the patient is encouraged to discard his self-excusing diction and describe his behavior in frankly accusative terms. From there on he is expected to assume responsibility for his actions, aided by the counsel of veteran Recovery members.<sup>20</sup> This is reality testing discussed previously in Chapter III. Patients with mental and emotional difficulties are troubled in varying degrees with an inability to make accurate appraisals of the situations of daily life, especially normally accurate appraisals of their own dynamics and those of other people. It is the aim of therapy to help the patient to deal more realistically with his environment. Thus the reality principle is fundamental to the work of psychotherapy.<sup>21</sup>

The Residual Symptom of the Recovered Mental Patient: The mental patient leaving the hospital is supposed to be cured. He is, in most instances, if by Mental Health is meant the absence of delusions and hallucinations, of violent impulsiveness and indifferences to group standards. But returning home the patient still suffers from restlessness, tenseness and preoccupation. His inability to relax is aggravated by the sense of being stigmatized. A simple question as "how do you feel" might cause irritation. It may suggest to the patient that the reality of his recovery is doubted. Feeling stigmatized, the patient becomes self-conscious and introspective. A vicious cycle may establish itself. For example, the patient may have difficulty falling asleep on a given night, this is apt to alarm him. The alarm increases the difficulty of sleeping. Then

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<sup>20</sup>Jack Alexander "They Doctor One Another" Saturday Evening Post (December 6, 1952) Reprint.

<sup>21</sup>Claude C. Bowman "Distortion of Reality as a Factor in Morale" in Rose's Mental Health and Mental Disorder (New York, 1955) 393-394.

more alarm, more sleeplessness and more alarm. Feeling stigmatized he correlates his tiredness with the possibility of a relapse and the more he dreads the relapse the more intense becomes his fatigue and vice versa. This has a definite relationship to the weakness of his assurance of group acceptance and group identification.

Patients have reported palpitations, numbness, and head or chest pressures, dizziness, difficulty of concentration, dimness of vision, air-hunger, headaches, nausea and scores of other disturbances. Observations of this sort may give rise to the vicious cycle which has the familiar character of the symptom increasing the fear and the fear intensifying and perpetuating the symptom. While there are no statistics to substantiate the claim it is fair to assume that many recurrences of mental ailments are the direct result of these "residual symptoms" which fanned by the fury of the vicious cycle, instigated by the lack of primary group support, produce anxieties and panics which finally necessitate the much dreaded recommitment. Recovery Inc. insists that the patient prior to leaving the hospital, attend group psychotherapy classes in which he is given adequate instruction on how to face the threat of the residual symptom and the pressure of stigmatization. At the same time, the members of the family are urged to attend discussion courses in which similar instruction is offered. In this manner the pre-discharge care prepared for the after-care effort.<sup>22</sup>

When former mental patients and nervous patients first come to Recovery,

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<sup>22</sup> Abraham Low, Mental Health Through Will Training (Boston 1950) 17-18. See also John J. Higgins, S.J., Recovery Inc.; An Answer to Nervous Problems, An Interview with John J. Higgins, S.J., Given to Martin L. Duggan (St. Louis, 1955) 17-20.

they think their particular problems are unique. They soon learn members experience the same symptoms. They must practice a fundamental Recovery proposition that nervous symptoms are distressing but not dangerous. Recovery helps the nervous patient to find greater satisfaction in controlling his nervous symptoms than in giving in to them. Every act of self-control strengthens his weakened self-confidence. It is by working with others that the patient obtains encouragement, mutual aid and understanding.

The Defeatism of the Chronic Psychoneurotic Patient: Common complaints voiced by psychoneurotic patients are identical or similar to most residual symptoms from which the returned mental patient is likely to suffer. Thus there is the possibility of treating both groups by the same method. The psychoneurotic patient admitted to Recovery Inc. belongs to the category of chronic protracted cases mainly. Patients with symptoms of a few months duration are rarities in the group. Most of Recovery's members have a record of two to twenty years of suffering. These experienced sufferers have seen physicians, attended clinics and were assured that some therapeutic measure would help them. This never materialized so they no longer believed a cure possible. Some therapies, they know, had a transient effect. Thus they treasured the pep talk that made the palpitations milder and the sedative that stopped the dizziness. In order to secure these elusive aids they must complain. Complaining becomes a vital part of their daily routine. In the course of years they develop the art of the expert complainer. These long-term patients crave a sympathetic ear because after years of griping they can no longer secure this from their relatives and friends. Patients lack acceptance and support from these groups. Their ideal is to be explored, analyzed, sounded and probed. They delight in a lengthy

discussion of their fears and frustrations. They expect a hearing, perhaps some temporary relief but not a final cure. They have essentially decided that their case is beyond repair. The chronicity of this group has little to do with the nature of the symptoms, with diagnosis or etiology; it is self-appointed defeatism.

Since Recovery placed the emphasis on self-help action of the patients, in a group supported environment it must ignore investigations and explorations which are not within the province of inexperienced lay persons. Dream experiences, subconscious thought, childhood memories and complexes play little part in the class interviews conducted by the physician and are entirely eliminated from the self-help effort carried on by the patients. The psychoneurotic individual is considered a person who for some reason developed disturbing symptoms leading to ill-controlled behavior. The symptoms are in the nature of intolerable feelings, uncontrollable impulses, obsessive unbearable thoughts, and threatening sensations. Ominously expressive of defeatism is the very vocabulary of the psychoneurotic with its frenzied emphasis on the fatigue that is beyond human endurance, the killing headaches, and the dizziness that drives me frantic. "The first step in the psychotherapeutic management of these chronic patients must be to convince them that the sensation can be endured, the impulse controlled, the obsession checked."<sup>23</sup> The physician attempts to sell the idea of mental health. This only arouses the sales resistance of the patient. The physician is far from convincing. Resistance can however be easily overcome in the group interview. A fellow sufferer explains how he rid himself of

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<sup>23</sup> Abraham Low, "Ibid", 19.

his frightful palpitations after years of invalidism. He cannot possibly be suspected of trying to sell something to the patient. The colleague is convincing, he convinces the novice that chronic conditions are not hopeless.<sup>24</sup> This shows the effect of group identification. The result of intimate association and cooperation is a certain fusion of individualities in a common whole so that one's very self, for many purposes at least, is the common life and purpose of the group. This wholeness can be described by saying that it is a "We"; it involves a sort of sympathy and mutual identification for which "We" is the natural expression. One lives in the feeling of the whole and finds the chief aims of his will in this feeling.<sup>25</sup> This perhaps is the reason why a fellow member often can convince a patient when a professional therapist cannot.

Basic to human social organization is communication involving participation in the other. This requires the appearance of the other in the self, the identification of the other with the self, the reaching of self-consciousness through the other. A person can communicate so that as well as calling out an attitude in the other he assumes this attitude himself. He himself is in the role of the other person whom he is so exciting and influencing. It is through taking this role of the other that he is able to come back on himself and so direct his own process of communication. Role-taking is of importance in the development of cooperative activity. The control of the action of the individual in a cooperative process can take place in the conduct of the individual

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<sup>24</sup>Abraham Low "Ibid", 18-19.

<sup>25</sup>Charles Cooley "Primary Groups" in Hare, Borgotta and Bales Small Groups; Studies in Social Interaction (New York, 1955) 15-16.



if he can take the role of the other. It is this control of the response of the individual himself through taking the role of another that leads to the value of this type of communication from the point of view of the organization of the conduct in the group. And thus it is that social control, as operating in terms of self-criticism, exerts its self so intimately and extensively over individual behavior or conduct, serving to integrate the individual and his actions with reference to the organized social process of experience and behavior in which he is implicated.<sup>26</sup>

Treating the Set-Back: The average patient experiences a considerable improvement in the first or second week of participation in the Recovery program. But this improvement is, as a rule, short-lived. Between meetings the novice is apt to suffer a set-back. Perhaps he is unable to sleep three nights in succession or he is tortured by fatigue. Every patient is warned to be on guard against the unavoidable set-back.<sup>27</sup> If the patient is in a panic, he can call a fellow Recoveryite for help but must limit the call to five minutes to avoid the use of getting sympathy.<sup>28</sup> Recovery members are on call twenty-four hours a day. They are ready and willing to assist fellow members. Help is no further away than the telephone.<sup>29</sup> Here again the importance of group support and mem-

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<sup>26</sup>George H. Mead "The Social Foundations and Functions of Thought and Communication" in Hare, Bergotta and Bates' Small Groups: Studies in Social Interaction. (New York 1955) 20-22.

<sup>27</sup>Abraham Low "The Combined System of Group Psychotherapy and Self-Help as Practiced by Recovery Inc." in Moreno's Group Psychotherapy. (New York, 1945) 93.

<sup>28</sup>John J. Higgins S.J. "Recovery, Inc." Medical Progress (March 1955) Reprint.

<sup>29</sup>"Recovery Inc. Active in City" East St. Louis Journal (July 20, 1953) Reprint.

bership can be seen. Social isolation must be prevented. The telephone technique may serve as the means to do so. The telephone technique is also used by Alcoholics Anonymous and has proven to be an effective means to provide total support necessary to the patient.

The Symptomatic Idiom: In order for the patients to help and teach one another they must learn a language which is not confusing. Language if used glibly, tends to be alarmist and defeatist so this is extremely important. To avoid the fatalistic implications of the language used by the patient which frequently engenders tenseness reinforcing and perpetuating symptoms, Recovery has supplied a terminology all its own. Symptoms speak as features and gestures do. Their language is a one word idiom "danger". This is called the symptomatic idiom. Accepting the suggestions of the symptomatic idiom the patient considers pressure in the head as due to a brain tumor, violent palpitations as presaging sudden death. "In these instances, the implications of the symptomatic idiom are those of an impending physical collapse. If phobias, compulsions, and obsessions dominate the symptomatic scene the resulting fear is that of mental collapse. After months and years of sustained suffering the twin fears of physical and mental collapse may recede, giving way to apprehensions about the impossibility of a final cure. This is the fear of the permanent handicap. The three basic fears of the physical collapse, mental collapse and permanent handicap are variations of the danger theme suggested by the symptomatic idiom.<sup>30</sup>

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<sup>30</sup> Abraham Low "The Combined System of Group Psychotherapy and Self-Help as practiced by Recovery Inc." in Moreno's Group Psychotherapy (New York, 1945) 97.

The Temperamental Lingo: Another source of defeatism is temper. Temper is considered under two divisions. The anger or aggressive temper which comes into play when the patient persuades himself that a person has done evil to him. It appears in various shades such as resentment, impatience, indignation, disgust, hatred. The other is the fearful or retreating temper. This is brought into action whenever he feels that he is wrong, that he defaulted on a moral, ethical or esthetic standard. It may express itself in many different qualities and intensities as discouragement, preoccupation, embarrassment, worry, sense of shame, feeling of inadequacy, despair. The fearful temper is likely to lead either to a feeling of personal inferiority or to the sentiment of group stigmatization. Whether it be of the angry or fearful description, temper reinforces and intensifies the symptom which, in its turn, increases the temperamental reaction. In this manner, a vicious cycle is established between temper and symptom. The temperamental reaction is kept alive mainly by the unsympathetic and unthinking attitude of the relatives. Insinuations such as telling the patient he is a weakling, that he is shamming disease, to "snap out of it" indicating that the symptoms are so easy to deal with that a mere snap would shake them out of existence, are most disconcerting to the psychoneurotic or former mental patient. The net result of this concerted environmental assault is that the patient is continually angry at his detractors and gradually accepting their insinuations becomes ashamed and fearful of himself.

In telling the patient that wrong was done to him or that he is wrong, his temper speaks to him. Temperamental lingo refers to the language the temper uses. Its vocabulary is limited to the terms right and wrong. The patient will be the victim of angry outbursts and fearful anticipations unless he learns to

ignore the threats, warnings and incitements of the temperamental lingo. New symptoms will be precipitated and old ones fortified, tenseness will be maintained and intensified. Temper is most dangerous when it plays on the symptom itself. By labelling feelings as "terrible", impulses as "uncontrollable", sensations as "intolerable", the lingo discourages the patient from facing, tolerating and controlling the reactions. The sound of the labels as uncontrollable are apt to rouse fear and defeatism. If the patient raves about a "splitting" headache, pressures that "I can't stand any longer" the fatalism of the diction is bound to breed a despondency of mood. In order to prevent the temperamental response the patient must be trained to ignore the whisperings of his temperamental lingo.<sup>31</sup>

Language habits are social habits, social in origin and social in structure. Therefore, the more thinking is organized in accordance with language structure, the more likely it is to be socially valid, and to lead toward adequate social behavior that corresponds to the patterns of group living. The reverse may also be true. In the behavior disorders wherever social communication in language suffers disorganization or deterioration, thought may show a corresponding change.<sup>32</sup> Language is important to the development of acceptable norms of behavior and the perception of situations, the interaction within a social situation.

The combined effects of symptomatic idiom and temperamental lingo are check-mated if the patient is made to use Dr. Low's language only. It is called

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<sup>31</sup> Abraham Low Mental Health Through Will Training, (Boston, 1950) 22-23.

<sup>32</sup> Norman Cameron The Psychology of Behavior Disorders: A Bisocial Interpretation (Boston, 1947) 89.

proudly by the members of the Association "Recovery Language." The most important parts of the vocabulary are the words: "sabotage" and "authority." The Authority of Recovery technique is sabotaged if the patient presumes to make a diagnostic therapeutic or prognostic statement. The verbiage of the temperamental lingo (Uncontrollable, unbearable, intolerable) constitutes sabotage because of the assumption that the condition is of a serious nature which is a diagnosis or, that it is difficult to repair, which is prognosis. It is a case of self-diagnosing and consequently sabotage to view palpitations as a sign of a heart ailment, of head pressure as meaning brain tumor, of sustained fatigue as leading to physical exhaustion. Once the physician has made the diagnosis of a psychoneurotic or post psychotic condition the patient is no longer permitted to indulge in the pastime of self-diagnosing. If he does, he is practicing sabotage. Patients are expected to lose their major symptoms after two months of Recovery membership. If, after the two month period the handicap persists in its original intensity the indication is that sabotage is still in action. Clinging to his own mode of thinking he sabotages the effort of Recovery. The significance of group expectation is seen here. The patient must conform to the procedures used by Recovery Inc. to be an acceptable member of the group.

It is comforting to the patient to be called a saboteur considering himself as such he knows that he has not yet learned to avoid resisting the authority of Recovery. The "not yet" is reassuring. It suggests that in time he will learn. Patients warn one another against impatience. They encourage one another to wait until they get well. The most effective slogan handed down from vet-

eran to novice, is "wait till you will learn to give up sabotaging."<sup>33</sup> Self-discipline and self-control are learned by the novice by emulating the veteran Recovery member.

Essential for personal development in modern society is adaptability to view of the constant necessity of acting in new and changing social situations. Adaptability is partly genic or psychogenic in terms of individual differences in flexibility and in social insight in meeting changing conditions. It is partly social in the sense that the person can be induced by information, counseling, and training to change his attitudes and to develop new ways of acting.<sup>34</sup> The patient in Recovery learns to adapt by adopting the techniques of the organization. This is role playing. The patient takes the attitude of the generalized other, in this instance Recovery Inc.

Socialization is also necessary for mental health and social efficiency. The socialized person is one who joins with others in defining the objectives of his society and participates in the attempt to realize them. The socialization of the person takes place through social experience in group life. Socialization finds the best opportunities for expression in situations in the family and in intimate social groups where the members co-ordinate their individual wishes with the objectives of the group.<sup>35</sup> This is certainly provided

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<sup>33</sup> Abraham Low "The Combined System of Group Psychotherapy and Self Help as Practiced by Recovery Inc." in Moreno's Group Psychotherapy (New York, 1945) 98-99, or 356-357.

<sup>34</sup> Ernest Burgess "Mental Health in Modern Society" in Rose's Mental Health and Mental Disorder (New York, 1955) 15.

<sup>35</sup> Ernest Burgess, "Ibid" 15.

to patients by Recovery. Perhaps the language, the formality and authoritarianism of Recovery are not as important in themselves as are the means they provide to give group cohesiveness, security and social identification in the therapy situation.

The "Spotting" Technique: If the patient is to check his sabotaging propensities he must be trained to "spot" the inconsistencies and fallacies of his own language whether it is given formulation in vocal speech or merely conceived in silent thought. To this end, a system or "spotting techniques" was evolved by means of which the members learn to reject the suggestions of the symptomatic idiom and the temperamental lingo whenever a symptom or a temperamental reaction occur. Patients learn to recognize sabotage methods of ignoring or discrediting the initial improvement, disparaging the competence or method of a physician, challenging the physician's diagnosis by either outright insistence on a change of diagnosis or implied insistence on change of diagnosis. Dr. Low saw failure to spot emotionalism and sentimentalism, failure to practice muscle control as sabotage methods.<sup>36</sup> The spotting technique is at the heart of Recovery. If the patient learns to "spot" all the ways in which he allows himself to produce tenseness in his nervous system by permitting trivial happenings and minor worries to upset him he will check his sabotage propensities.<sup>37</sup> This will bring improvement or a better change in the perception of motives and behavior, a further development of the self-concept.

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<sup>36</sup> Abraham Low Mental Health Through Will Training (Boston 1950) 22;9.

<sup>37</sup> Merle Oliver "Patient is Taught to Spot Tensions" Detroit News (January 31, 1955) Reprint.

Dr. Low explains in his column in the Recovery Journal that "spotting in Recovery has two aspects. One is blind spotting, the other spotlighting. If the patient wishes to indulge in "romantic-intellectualism" he will have to blind himself to the realistic meaning of his experiences, in other words blindspot them. If the patient desires to see clearly and realistically he has to turn the full light of logic and reason on them, in other words spotlight them. The romantic-intellectualist blindspots reality, the realist spotlights it."<sup>38</sup> This self-spotting is or may be painful, to spot the erroneous thought or faulty action of another is pleasure. Dr. Low avoided this training called foreign spotting. The patient does not need it. He learns to self-spot as soon as possible. This instant intervention was called by Dr. Low, trigger spotting.<sup>39</sup>

Endorsement: Another term in Recovery language is endorsement. Members naturally get emotional and intellectual satisfaction in doing something which they know is restoring their health, even though the effort is sometimes nervously and physically very painful. Recovery expresses this idea in "Endorse yourself even for small gains."<sup>40</sup>

After a thorough study of Mental Health Through Will Training the patient understands what is meant by "quit using the symptomatic idiom" and the "temperamental lingo"; use instead Recovery language.<sup>41</sup> First the novice must learn

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<sup>38</sup> Abraham Low "Blindspotting and Spotlighting" Recovery Journal (August 1950) 3.

<sup>39</sup> Abraham Low "Self Spotting and Foreign Spotting" Recovery Journal (December, 1950) 3-4.

<sup>40</sup> John J. Higgins, S.J., Recovery Inc. An Answer to Nervous Problems; an Interview with John J. Higgins S.J. Given to Martin L. Duggan (St. Louis, 1945) 19.

<sup>41</sup> John J. Higgins, S.J. "Ibid" 16-17.



the Recovery language, then he must utilize it to its fullest, if he does this he is on the road to his Recovery. The general social process of experience and behavior which the group is carrying on is directly presented to the patient in his own experience so that he is able to govern and direct his conduct consciously and critically, with reference to his relation both to the social group as a whole (Recovery) and to its other individual members. Thus the patient becomes not only self-conscious but also self-critical; thus through self-criticism, social control over individual behavior or conduct operates by virtue of the social origin and basis of such criticism. Self-criticism is essentially social criticism, and behavior controlled by self-criticism is essentially behavior controlled socially. The patient gets the attitude of the group,—"the generalized other."<sup>42</sup> This attitude is reflected in his conduct. Here again the importance of the self concept brought about by group support is seen.

Will Habits: Recovery members train themselves in the mental attitudes, habits of will and specific techniques that will help them handle their nervous problems. Some of the will habits that help and that Recovery teaches are: follow always your doctor's authority; do the thing that you fear or hate to do; endorse yourself even for small gains; keep thoughts of security and reject thoughts of insecurity; have the courage to make mistakes; avoid self-diagnosis; practice "averageness" and avoid the undesirable kind of "exceptionality."<sup>43</sup>

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<sup>42</sup>George H. Mead "The Social Foundations and Functions of Thought" in Hare, Borgotta and Bales' Small Groups: Studies in Social Interaction (New York, 1958) 22-23.

<sup>43</sup>John J. Higgins Ibid 15.

Social Activities: Nervous and former mental patients seem to have an almost unquenchable thirst for social contacts. They need the solidarity and support of a group, understanding and acceptance rather than isolation and rejection. This is shown in a study of psychotic patients at a Veterans' Hospital. Between February and May, 1948, twenty-five psychotic male patients of a Veterans' Administration Hospital attended, two at a time, a single regular luncheon meeting of the Kiwanis Club at Canandaigua, New York. Twelve were veterans of World War I and fourteen of World War II. An investigation of their reactions was attempted. Although each patient reacted differently the experience was pleasant and meaningful to all. In some cases, attendance at the meeting seemed to contribute somewhat toward restoration of confidence in meeting people socially. Younger patients apparently gained widening of the horizon of their social experience. Others indicated that they were stimulated to thinking.<sup>44</sup> This example helps to indicate the necessity of social membership.

Recovery members break through the dismal isolation and loneliness which may be the blight of neurotic or post-psychotic existence. The patients state this explicitly by indicating that formerly they existed, now they live again. New patients are always welcome at Recovery headquarters. Here they are met by other patients and given information about the work of the organization. Apprehensions, anxieties and panics are easily soothed by the calming influence of meeting other patients who have suffered similar disturbances and are now presenting the picture of good health.<sup>45</sup>

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<sup>44</sup> J. House and L. Marquit "Reactions of Mental Patients to Attendance at a Businessmen's Luncheon Club Meeting" Journal of Abnormal and Social Psychology 45 (October, 1950) 742.

<sup>45</sup> Abraham Low Mental Health Through Will Training (Boston 1950) 26-27.

The social functions of Recovery groups vary. Some groups serve simple refreshments at the close of a panel, others do not. Patients do make friends with other patients but basically one of Recovery's aims is to help the patient resume his place within his own circle of friends.<sup>46</sup>

### Case Studies:

Former Mental Patient: The present chairman of the Board of Directors for Recovery Inc. told how Recovery made and kept her well in Recovery's News in August of 1952. She explained that from 1935 to 1940 she followed a dreary existence of trudging from one doctor to another looking for help. Her family in desperation sent her to the Mayo Clinic to find the answer to her puzzling and mysterious ailment. She was told at Mayo's that there was nothing wrong with her.

Confused and depressed she launched on a series of psychiatric treatments involving dream analysis and her sense of unreality only grew. Her Freudian analyst suggested finally contacting Dr. Low, who was at the time, Assistant Director of the Psychiatric Institute.

So in 1940 she was committed to the Institute. By that time she weighed ninety-nine pounds and had to be moved about in a wheel chair. She was unable to follow what went on about her except for very short periods of time. Dr. Low held classes in psychotherapy for the patients at the Institute. The present chairman asked to join these classes after she saw their effects upon other patients. This was the beginning of her learning to help herself.<sup>47</sup> This train-

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<sup>46</sup> National Headquarters. Recovery Inc. Informational Pamphlet (Chicago, 1958) 14.

<sup>47</sup> "Chairman of the Board of Directors" How Recovery Made and Kept Me Well" Recovery News (August, 1952) 1-3.

ing continued through Recovery meetings after her dismissal from the Psychiatric Institute. When Recovery was first liquidated in 1942 it was she who gathered the group of ten or twelve stalwarts who refused to abandon Recovery.<sup>48</sup> She has acted as President of the Association and is today Recovery's Chairman of the Board of Directors.<sup>49</sup>

Nervous Patient: Another example of Recovery practice is that of a young lady who woke up one morning and noticed a feeling of fatigue was with her. Another symptom she had was a lack of appetite. With no desire to eat anything and a feeling of being "all in," she decided to stay in bed a while. Then the thought struck her—this is "sabotage," so she immediately got up and forced herself to eat breakfast. She "spotted" her "sabotage" and got out of bed; she forced herself to eat "commanding her muscles." In doing this she utilized two basic Recovery concepts—spot your thoughts and command your muscles.<sup>50</sup>

The secret of Recovery's claim to successful therapy, whatever its actual extent, is therefore closely allied to social psychological theories of group orientation as the basis of personality organization. The process of re-organizing disorganized personalities in Recovery Inc. certainly seems to be one of group identification, group support, and group cohesiveness which leads to the development of adequate self-concepts which are so essential to adequate social adjustment.

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<sup>48</sup> Abraham Low, The Historical Development of Recovery's Self-Help Project. Chicago, 1943) 134-135.

<sup>49</sup> "Standing Room Only" Recovery Reporter (May-June 1958) 2.

<sup>50</sup> "Examples of Recovery Practice" Recovery News (August 1952) 4-6.

## CONCLUSION

The psychotherapeutic means of self-help technique used by Recovery Inc. have been examined. Basic questions relative to Recovery Inc. as: What is Recovery Inc.?. What is its theoretical base?. How does it work?. What are its principles and techniques?. How are its techniques related to similar techniques?. What are its socio-psychological implications for therapy?. Why is it not better known if it fulfills an important need?, have been considered. One question remains: What are the results of Recovery Inc.? This question can be suggested by the testimonies of the founder of Recovery Inc. and a Recovery member, truly a selective group for quoting purposes. And yet as members of Recovery Inc. they belong to the only group that can suggest an answer to this question.

In 1950 Dr. Low pointed out that reasonably valid conclusions as to the therapeutic effectiveness of the system could be drawn from the very nature of the organization. The patients and relatives know one another and if relapses or continued chronicity were frequent occurrences the membership would inevitably become discouraged and lose confidence. An unfortunate event which took place in October, 1947, illustrates this point. A well-known member of the group relapsed into a depression and one morning ran into the path of a speeding train. It was not clear whether the fatal incident was suicide or an accident. Nevertheless something in the nature of a demoralization swept the or-

ganization. Several of the ex-patients developed severe reactions. One of them had to be hospitalized. The fact that this was the only instance of suicide—if such it was—in a period close to thirteen years, during which many hundreds of patients had joined as active members, ought to be considered an eloquent testimony to the therapeutic efficiency of Recovery techniques. The organization would rapidly disintegrate if it failed to accomplish its therapeutic objectives.<sup>1</sup>

Father Higgins, S.J., a Recovery member himself, who has been a careful student of the practical aspects of psychiatry for over thirty years states, "I can say from my experience in dealing with hundreds of nervous patients, that Recovery Inc. is equalling, in its own area, the excellent work of Alcoholics Anonymous in that field of self-help. With further refinement of its techniques and continued help and co-operating of psychiatrists, Recovery should develop into an even more useful instrument for mental health throughout a tense world."<sup>2</sup>

Perhaps the reason why Recovery Inc. is so little known and recognized by professionals is due to their failure to recognize the social-psychological theories of personality development in which the techniques of Recovery Inc. can be explained.

Further research in relating the social-psychological theories of personality to Recovery Inc. is necessary. Personal interviews with Recovery members could give additional insight. Do Recovery techniques aid more in certain types

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<sup>1</sup>Abraham Low, Mental Health Through Will Training (Boston, 1950), 29-30.

<sup>2</sup>John J. Higgins S.J., "Recovery Inc.," Medical Progress (March 1955), Reprint.

of mental disorders than in others? Which types of personalities are supported by the Recovery methods? All are possible subjects of doctoral dissertation.

Other areas and aspects of Recovery Inc. need research. Research implications in the data found include authority versus patient centered therapy in Recovery Inc.; the importance of language in therapy, and transference in the group rather than to an individual therapist. Only through research on such therapy techniques can we continue our progress in attempting to understand the social and individual development of personality and also to help stem the tide of mental illness, one of the most serious problems our society faces today.

Other areas and aspects of Recovery Inc. need research. Research implications in the data found include authority versus patient centered therapy in Recovery Inc.; the importance of language in therapy, and transference in the group rather than to an individual therapist.

There is hope that Recovery methods may help to stem the tide of mental illness, one of the greatest problems our society faces today.

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Recovery Member, June 12, 1958, June 21, 1958, June 23, 1958, July 23, 1958.

Recovery Member, June 21, 1958.

Recovery Member, June 16, 1958, June 17, 1958, June 19, 1958.

Recovery Member, June 21, 1958.

#### E. PERSONAL CORRESPONDENCE

Rev. William S. Devlin, S. J., M. D., July 14, 1958.

Anna Dowling (Rev. Dowling's secretary) July 11, 1958.

Dorothy Kerchner (Assistant Director of Nurses, Longview State Hospital, Cincinnati, Ohio), July 21, 1958.

Secretary and Training Leader, St. Louis Recovery, July 20, 1953.

Harry L. Weinberg, Assistant Professor of Speech, Temple University, July 16, 1958.

## APPENDIX I

### ADMINISTRATION

Administration is necessary for the orderly working of an organization.

Recovery's administration fulfills this function and strengthens the group basis in which the therapy functions. Membership, finances, the national office, and the branches of Recovery Inc. are, therefore, included as an appendage to this analysis.

Membership: Membership in Recovery has grown throughout the years of its existence: In 1940 Pauline Rosenberg wrote, "Recovery comprises more than one hundred fifty former patients and six hundred relatives and friends who are associate and contributing members."<sup>1</sup> In 1943, "Recovery has grown from thirty members to more than eight hundred since its founding eight years ago."<sup>2</sup> This included however the associate and contributing members. Thus Dr. Low wrote in 1950 that membership in January of that year was three hundred seventy-six.<sup>3</sup> This refers only to the patients. In 1952 after the article in the Saturday Evening Post appeared there was a deliberate attempt made to expand Recovery.<sup>4</sup>

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<sup>1</sup>Pauline Rosenberg. "They Show us Miracles." Hygeia (November 1940), 959.

<sup>2</sup>Frank A. Riley, "Recovery Inc.," Saturday Evening Post (January 16, 1943), 66.

<sup>3</sup>Abraham Low, Mental Health Through Will Training (Boston, 1950), 27.

<sup>4</sup>National Headquarters, Recovery Inc., Informational Pamphlet(Chicago, 1950) 6.

In that article membership was cited at about one thousand.<sup>5</sup> In 1954 Recovery groups were in twelve states of the Union.<sup>6</sup> In 1955 over one hundred groups existed in forty-seven cities in eighteen states, with an active membership of about three thousand.<sup>7</sup> In 1956 the groups increased to one hundred seventy.<sup>8</sup> 1957 showed an increase to over two hundred groups and twenty-four states.<sup>9</sup> In June, 1958, the estimated membership was over five thousand; two hundred seventy-five groups were functioning in twenty-eight states.<sup>10</sup>

Frequency of Recovery Meetings: Dr. Low in Mental Health Through Will Training indicated that patients took part in group discussions either as panel members or listeners on three separate days each week. In 1950 family meetings were held in private homes in various sections of the city on Wednesday nights. Each group comprised from ten to twenty families at these meetings. A panel was held where three or four experienced members discussed a chapter of Dr. Low's book The Techniques of Self-Help in Psychiatric After-Care or an article from the Recovery Journal or its successor the Recovery News. The theme was centered on the topic of symptoms and the proper means of conquering them. Dr. Low did

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<sup>5</sup> Jack Alexander, "They Doctor One Another," Saturday Evening Post (December 6, 1952), Reprint.

<sup>6</sup> Norma Lee Browning, "The Amazing Story of Recovery Inc.," Chicago Tribune, (January 3, 1954), Sunday Supplement.

<sup>7</sup> John J. Higgins, S.J., "Recovery Inc.," Medical Progress (March 1955), Reprint.

<sup>8</sup> Kathleen Rutherford, "Recovery Inc.," America 95, (September 15, 1956), 566.

<sup>9</sup> John J. Higgins, S.J., "Group Centered Training for Mental Health," Medical Progress (June 1957), Reprint.

<sup>10</sup> Executive Secretary, Personal Interview, June 11, 1958.



not attend these family meetings but was able to check on the effectiveness of the procedure through the trained panel leaders.

On Thursday evenings Dr. Low conducted a class in group psychotherapy and Saturday afternoons a public meeting took place at Recovery headquarters. This meeting was attended by patients, relatives and friends. The first half-hour was given over to a panel discussion similar to that held at the Wednesday night gatherings. Dr. Low then in the second half-hour summed up the conclusions reached by the panel, approving or correcting their statements.<sup>11</sup> Since 1954 two hour panel meetings were held daily Monday through Saturday at Recovery's National Headquarters.<sup>12</sup> Group psychotherapy classes were discontinued after Dr. Low's death. An attempt was made to have Recovery meetings held in public meeting places. Host and hostesses would not know all the individuals who wished to be present at the gathering, nor be able to accommodate them.

If an individual wishes to get well he must make a total effort to do so. It is not uncommon for patients first attending Recovery meetings to do so daily for approximately a month.<sup>13</sup> There is nothing compulsory about Recovery attendance but a total effort must be made in order to regain health.<sup>14</sup> This total effort is considered to involve attendance at least weekly.

Finances: Recovery Inc. is financed by membership fees, donations, pro-

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<sup>11</sup>Abraham Low, Mental Health Through Will Training (Boston, 1950), 20.

<sup>12</sup>Norma Lee Browning, "The Amazing Story of Recovery Inc.," Chicago Tribune (January 3, 1954), Sunday Supplement.

<sup>13</sup>Executive Secretary, Personal Interview, June 11, 1958.

<sup>14</sup>National Headquarters, "Recovery Inc.; Informational Pamphlet (Chicago, 1958), 13.

ceeds from the sale of Recovery literature and records and collections at meetings. In 1949 the combined income from these sources netted a total of \$7,233.70. The organization was almost but not quite self-sustaining. The yearly deficit was met by the founder.<sup>15</sup>

Records and pamphlets sold by Recovery not only help support the organization but perform a definite function in Recovery procedure. Various symptoms, fears and obsessions are discussed by Dr. Low in the record and fundamental Recovery principles and techniques that are of value to the patient are explained. Literature available includes: Mental Health Through Will Training; Recovery Informational Pamphlet; Sabotaging Sleep; An Interview with Patients; The Myth of Nervous Fatigue, An Interview with Patients; The Scare of Heredity; Dementia Praecox, The Disease of the Split Personality; The Manic Mood Disturbance; A Set of the 1950-1951 Recovery News; They Doctor One Another; The Recovery Reporter.<sup>16</sup>

The pamphlets are used by members to help verse them on Recovery methods and techniques. They are often quoted at meetings. Pamphlets are available to the general public and are sold in church pamphlet racks. They also serve as one means of support.

National Office: The national office of Recovery Inc. is at 116 South Michigan Boulevard, Chicago 3, Illinois. The services it provides are (1) leader training courses; (2) authorization of official groups; (3) publication of leaders' bulletin and The Recovery Reporter; (4) serves as a clearing-house for

<sup>15</sup>Abraham Low, Mental Health Through Will Training (Boston, 1950), 27.

<sup>16</sup>National Headquarters, List of Literature (Chicago, 1958).

publicity and public relations; (5) formulates and defines official policies; and (6) presents panel demonstrations to outside groups to familiarize the public with Recovery.<sup>17</sup>

Individuals interested in training programs or panel demonstrations contact the national office. The national office trains prospective leaders and authorizes new groups when the leaders are properly educated to lead them. The prospective leader observes the daily meeting until he is capable of directing one himself.

Any interested individual may attend a Recovery meeting as an observer.

Of the six functions provided by the national office, the last--panel demonstrations to outside groups--appears to be the weakest in performance. Members competent to do this give their time to helping individuals already interested in Recovery, rather than acquaint the public who do not have a decided interest in the organization.

Figures on actual panel demonstrations or formalized training programs are not available. Members and permanent workers spend their time in actual Recovery work. Permanent workers could give estimates but it appears to the reader that more time is spent in action than in book work.

Branches: The first two branches of Recovery to function outside the state of Illinois were first, the branch in Muscatine, Iowa, in 1946, and secondly, in Brighton, Michigan, in 1947. Both owe their existence to the initiative of local ex-patients who, acquainted with the work done in Chicago, conceived the

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<sup>17</sup> National Headquarters, Recovery Inc.; Informational Pamphlet (Chicago, 1958), 7-8.

idea of duplicating the effort in their localities. The branches were visited by officers of the Chicago organization in intervals of about six months and the leaders of the branches, in turn, came to Chicago to attend meetings and to perfect themselves in the techniques of panel leadership.<sup>18</sup> This indicates the relationship existing between branches and the Chicago office and their use of the Chicago office as a model.

Today a formal procedure is followed in establishing new Recovery groups. In a city where groups are already established additional groups start as offshoots of the parent group with trained members of the old group providing the leadership. When groups are started in new cities the procedure is as follows: (1) a post office box in the name of Recovery plus the name of the new town is rented; (2) local papers are asked to run news stories and possibly feature material about Recovery, telling where to write for further information; (3) when sufficient response is received, the papers are asked to run an announcement of the time and place of the first meeting. Special letters are sent to those who inquired inviting them to be present. (4) The first meeting is held of new group with a panel of well-trained Recovery members from established groups. Plans are made to train leaders from among the new group members. Follow-up visits are made to the new group until it is functioning as it should. Leaders are trained either at the Chicago headquarters or at an approved leader-training group. New groups are sometimes led by teachers, doctors, or clergymen, but usually a person who needs the help acts as leader.<sup>19</sup> There is a

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<sup>18</sup> Abraham Low, Mental Health Through Will Training (Boston, 1950), 29.

<sup>19</sup> John J. Higgins S.J., Recovery Inc., An Answer to Nervous Problems; An Interview with John J. Higgins S.J., Given to Martin L. Duggan (St. Louis, 1945).

definite rapport established among members because they have mental health difficulties in common. The leader acts as an example of one who has overcome to a certain extent the problems shared by all members. This oneness is important. A teacher, doctor, or clergyman who has not experienced the same difficulties may lead a meeting but may be regarded as an outsider by the members. A nervous patient or former mental patient usually acts as the leader due to these circumstances.

Recovery groups are also established in hospitals. Examples of this are Good Samaritan Hospital and Longview Hospital in Cincinnati, Ohio. Recovery was established in Cincinnati in December of 1953 by Sister Marie Fedalis, head of the psychiatric division at Good Samaritan Hospital, and Dorothy Kerchner, Assistant Director of Nurses at Longview Hospital. Good Samaritan Hospital is a general hospital with a fifty bed psychiatric department. It was in an effort to stop readmissions that these new leaders became interested in Recovery. As of July 21, 1958, there are about two hundred and fifty members and eight groups including two in northern Kentucky affiliated with the Cincinnati groups.

Cincinnati is fortunate in that its older members have stayed and become leaders. In 1955 a group was started at Longview State Hospital for convalescent status patients. This group has changed in character since its beginning. Not only patients who have been in the state hospital belong but others from the community as well. In a like fashion, state hospital patients go to other groups.

The group at the state hospital was originally lead by a nurse. Now it is being lead by a patient leader who has had leader's training. Dorothy Kerchner visited this group quite frequently in the beginning to discuss problems but

now does not find this necessary. She visits every two months now. The patients are referred to Recovery groups in Cincinnati by psychiatrists, general practitioners, social workers, and clergy. Even though one of the groups meets in a state hospital, Recovery technique in Cincinnati in no way differs from Recovery in any other location. Cincinnati has leaders' meetings every six to eight weeks and discuss the problems of the respective groups. Three or four social events are held yearly. These social events are not substitutes for attending the meetings. National Headquarters send the executive-secretary to conduct one leaders' training course a year. The leaders in Cincinnati are either trained in this manner or go to Chicago for training.<sup>20</sup> Dorothy Kerchner, assistant director of nurses at Longview, states, "We at Longview believe the program is wonderful. We have been able to help the patients make the necessary adjustment to society. The group seems to provide the security the patients need besides giving them a set of tools with which to work. We feel the success of the Recovery program depends upon the patients, how hard they are willing to practice since this is an after care and self-help system. The technique is very easy to understand, but hard to practice."<sup>21</sup> The Cincinnati groups are typical of the other Recovery units throughout the country. Constant contact with the national headquarters, and use of the services offered by it, make this possible.

The administrative aspects of Recovery Inc. are essential to the proper functioning of the organization. The administration is related to the therapy techniques and provides the formal aspect of the sociopsychological framework

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<sup>20</sup>Dorothy Kerchner, Letter to the Writer, July 21, 1958.

<sup>21</sup>Dorothy Kerchner, Ibid.

within which group therapy can be successful, especially of the kind Recovery Inc. intends to be.

APPROVAL SHEET

The thesis submitted by Sister Mary Judith Terese, B.V.M. has been read and approved by three members of the Department of Sociology.

The final copies have been examined by the director of the thesis and the signature which appears below verifies the fact that any necessary changes have been incorporated, and that the thesis is now given final approval with reference to content, form, and mechanical accuracy.

The thesis is therefore accepted in partial fulfillment of the requirements for the degree of Master of Arts.

March 22  
Date

Francis A. Cizon  
Signature of Adviser



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# Recovery International

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## Recovery International

<b>Founded</b>	November 7th, 1937
<b>Founder(s)</b>	Abraham Low
<b>Headquarters</b>	• Chicago, Illinois
<b>Area served</b>	United States, Canada, Israel, India and Ireland
<b>Mission</b>	Prevention of relapses in former mental patients and chronicity in nervous patients.
<b>Method(s)</b>	A system of cognitive techniques for controlling behavior and changing attitudes toward symptoms and fears.
<b>Website</b>	Recovery International <sup>[1]</sup>

**Recovery International** (formerly **Recovery, Inc.**, often referred to simply as **Recovery**) is a mental health self-help organization founded in 1937 by neuropsychiatrist Abraham Low in Chicago, Illinois. Recovery's program is based on self-control, self-confidence, and increasing one's determination to act. Recovery deals with a range of people, all of whom have difficulty coping with everyday problems, whether or not they have a history of psychiatric hospitalization. It is non-profit, secular, and although it uses methods devised by Low, most groups are currently led by experienced non-professionals.

## History

In 1937 Abraham Low was on the faculty at the University of Illinois at Chicago, and participants in Recovery were limited to those who had been hospitalized in the Psychiatric Institute at the University. The original thirty-seven founding members had recovered their mental health after receiving insulin shock treatments at the Institute. Low began the groups as part of an attempt to improve the patient's care following discharge from his hospital. In the early years of the organization he encouraged members to advocate for improvements in social policies regarding state mental health regulations. Following backlash from the medical community to these efforts, Low disbanded the group in 1941. His patients, however, asked to be trained to teach Recovery's methods to others and in 1942 Low began to teach members to lead groups in their homes.

The organization separated from the Psychiatric Institute in 1942, operating out of private offices in Chicago. New membership at this time was drawn largely from patients in Low's private psychiatry practice. During the first years following its separation Low remained in close contact with all Recovery groups and received regular reports from group leaders. As the membership and number of meetings grew, it made this level of cooperation with the groups untenable. In 1952, Low allowed expansion of Recovery outside of Illinois, giving control of local groups to former patients who had become group leaders. Following Low's death in 1954, Recovery transitioned completely from a professionally run treatment adjunct, to a peer-run self-help group.

Effective January 1, 2007 Recovery, Inc. formally changed its name to Recovery International. On January 1, 2008 Recovery International Merged with The Abraham Low Institute and provisionally renamed the new organization Recovery International / The Abraham Low Institute (RI/TALI). On January 1, 2009, Abraham Low Self-Help Systems was incorporated, completing the merger of the two organizations.

## **Fundamental concepts**

### **Symptoms**

The causes and classification of mental illnesses are considered irrelevant in the Recovery method. Recovery members are simply viewed as people who have developed disturbing symptom-reactions leading to ill-controlled behavior. Symptoms are threatening sensations; including feelings, impulses, and obsessive thoughts. The phrase, "symptomatic idiom" describes the mental association of danger with symptoms.

The symptomatic idiom implies that there is an impending catastrophe of physical collapse, mental collapse, or permanent handicap. In the first instance, for example, a person may consider heart palpitations as signaling that sudden death is imminent, or that a painful headache is caused by a brain tumor; phobias, compulsions, and ruminations would eventually cause a mental collapse. The fear of permanent handicap insists that there is no cure or relief for one's mental illness and that recovery is impossible.

### **Temper**

Temper is a combination of a feeling and a judgment about oneself or others. The feeling is related to one of the two types of temper, fear or anger. The judgment is that one has been wronged by another, or that one has done something wrong. "Fearful temper" arises from thoughts that one has made a mistake (has done something wrong) which in turn causes feelings such as fear, shame and inadequacy. "Angry temper" results from the belief that one has been wronged which in turn creates feelings of indignation and impatience. There is a two-way relationship between temper and symptoms. Symptoms induce emotions such as fear and anger, which in turn induce temper, which increases the intensity of the symptoms.

"Temperamental lingo" describes language related to judgments of right and wrong, and the use of defeatist language when discussing symptoms. When discussing symptoms, temperamental lingo includes the use of adjectives such as "intolerable," "uncontrollable," "unbearable," and similar language that places an emphasis on the dangerous and fatalistic implications of feelings, impulses, or thoughts.

### **Will**

Free will is fundamental to Recovery's method. The subconscious, as it is known in psychoanalysis, as well as viewpoints emphasizing unconscious motivations, drives, and instincts are considered to be self-defeating. Recovery considers adults as capable of behaving based on deliberate plans, settled decisions, reasoned conclusions and firm determinations. Will gives adults the ability to accept or reject thoughts and impulses. Recovery members achieve mental health by training their Wills to reject self-defeating thoughts and impulses, countering them with self-endorsing thoughts and wellness-promoting actions.

### **External and Internal Environment**

Recovery distinguishes between the External Environment, the realities of a situation, and the Internal Environment, one's own subjective feelings, thoughts, impulses, and sensations. Two components of the Internal Environment, thoughts and impulses, can be directly controlled by Will. Control of thoughts and impulses allows indirect control over sensations and feelings. For instance, thoughts of insecurity and anxiousness can be replaced with thoughts of security. Similarly, a feeling of fear can be disposed by removing the associated belief of danger (symptomatic idiom). While the Internal Environment can be changed with cognitive reframing, changing one's External Environment may or may not be possible.

## **Nervousness**

Recovery focuses on treating former mental patients, sometimes referred to as postpsychotic persons, as well as psychoneurotic persons. The latter group is most often referred to as "nervous" or "nervous patients." Recovery members may refer to themselves as "nervous patients" regardless of whether they are being treated by a physician or other professional. Sociologist Edward Sagarin described this as a compromise between the term neurotic and the more colloquial phrase "nervous breakdown."

## **Common techniques**

*For more details on this topic, see Self-help groups for mental health: Group processes*

Recovery encourages members to cognitively reframe their experiences using several techniques. Spotting, reframing defeatist language, self-endorsement and creating Examples are the most commonly cited in scholarly reviews of Recovery.

### **Spotting**

Spotting is an introspective relabeling of thoughts and symptoms. When a thought arises related to angry temper, fearful temper, or associating danger with a symptom it must be spotted and reframed. Members practice spotting and reacting appropriately to the distressing thought or symptom.

### **Reframing language**

Recovery developed its own language for labeling psychiatric symptoms and responding to them. This language is centered around two concepts, "authority" and "sabotage." It is suggested that members rely on the authority of a physician's diagnosis with respect to their symptoms. For instance, if a member self-diagnoses a headache as being caused by a brain tumor, but a physician has diagnosed it otherwise, then the member is said to be sabotaging the physician's authority. This is similarly true for the member's prognosis, if a member despairs that their condition is hopeless, but a physician has found the prognosis to be good, this is also sabotage of the physician's authority. Using the physician's perspective to reframe defeatist thoughts is intended to help members recognize that they have not lost control, and their situation can be coped with.

### **Self-endorsement**

Members practice self-endorsement of every effort made to use a Recovery method, no matter how small and regardless of the outcome. In this way, similar subsequent efforts will require less work and are more likely to be successful. Similarly members are taught to change their behavior in "part acts" (small steps), to simply "move their muscles" to complete tasks, however small, to eventually complete larger overwhelming tasks.

### **Creating Examples**

The Example format was created by Low as a means to allow Recovery to function as a stand-alone lay self-help group that would not require professional supervision. Members create Examples by following a four part outline, each part requiring a description.

1. Details of an event that caused distress.
2. The symptoms and discomfort that the event aroused.
3. How Recovery principles were utilized to cope with the event.
4. How the member would have behaved in response to the event before joining Recovery.

Examples are a formalized way to practice the Recovery program. A successful outcome is not required to create an Example, as all attempts at practicing Recovery methods are endorsed.

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## Meetings

### 1937–1952

During the first fifteen years of Recovery, Low required members to attend classes and meetings for at least six months at a cost of ten dollars per month, not including the membership dues of two dollars per year. Members would meet at least three days a week and on Wednesdays take part in panel discussions as panelists or audience members held at a private home. Panel discussions would consist of three to four panelists with considerable experience in Recovery discussing a topic from Low's literature, focusing on spotting and conquering symptoms. Dr. Low would address the audience at the end of each panel discussion summing up the discussion and correcting any misinformation given about Recovery. Every Thursday Low would conduct a group psychotherapy class for Recovery members.

No meetings were held between Saturday and Wednesday. Commonly, novice members would have a "setback," a relapse of psychiatric symptoms, during this time. As setbacks were considered unavoidable, the novice members were assigned to a more experienced member to call or visit should they need assistance. If the assistance provided by the experienced member was not helpful, they could contact a chairperson in their area (a member who functioned like the physician's deputy), and if that was still not satisfactory they could contact the physician, Dr. Low.

### 1952–Present

At the meetings, members share examples from their lives that caused nervous symptoms, the thoughts that occurred just beforehand, how they spotted them and reacted to them. Other members offer alternative ways of looking at the situation and suggest how to better handle similar symptoms in the future. Meetings range in size from 6 to 30 members and follow a rigid schedule to ensure adherence to Recovery methods. Each meeting has a leader in a permanent position; leadership duties do not rotate from meeting to meeting. Each meeting is split into five parts. Members introduce themselves by first name only, as is practiced in Alcoholics Anonymous.

### Reading of Recovery literature

The beginning of a meeting is generally reserved for reading from Recovery literature. Members take turns reading sections of a chapter or article. Group leaders will often call on new members during this period, or members who are hesitant to volunteer. After finishing a paragraph a group leader will often ask a member if they experienced any symptoms while reading the literature and will endorse them for the efforts to continue reading despite feelings of discomfort or fear of making mistakes.

### Presentation of Examples

Only members who have read *Mental Health Through Will Training* are allowed to participate in this portion of the meeting. Those participating form a "panel" although they are usually seated face-to-face around a table. The group leader reminds the members that examples should be constructed around day-to-day events as Recovery is a non-professional organization and cannot help people with major problems. This statement is qualified, however, with Low's opinion that the majority of a nervous patient's problems are related to "trivial" incidents. Rather than being a limitation of Recovery's program, this is intended to be a novel treatment approach. A day-to-day trivial event may generalize to other problems experienced by the member. Discussion of trivialities is less threatening than complex problems, making a discussion of coping mechanisms possible.

A survey of groups in Chicago in 1971 and 1977 found that most examples presented were stories of successful application of the Recovery method, less than ten percent represented "problem examples" where the application was not successful.

### **Group participation**

After an Example has been given, the meeting is opened for "group spotting." During this period other members of the panel are allowed to comment on the Example based on Recovery principles. This group leader usually makes the first comments, and if there are no volunteers to continue, he or she may call on panel members to provide commentary. Comments not based on Recovery's concepts or not related to the example are stopped by the group leader. Comments are either classed as positive, praise for application of a Recovery method, or negative, related to an instance where a method was not applied. An Example rarely passes without mention of additional Recovery techniques that could be applied to it. This serves as a constant reminder that Recovery's method can never be practiced perfectly; members can always learn from experience and benefit from group practice.

For example, a person may experience "lowered feelings" (depression) because they are aiming for a perfect performance. Trying to be perfect or trying to appear perfect leads one to feel down if one makes even the slightest mistake. All improvements, no matter how small, are acknowledged and members are encouraged to endorse themselves for their efforts — not for their successes. Longstanding members are encouraged to share their success with the Recovery methods to help newcomers. Low saw the sharing of successes by veteran members as an essential component of meetings, as it demonstrates that distressing sensations can be endured, impulses can be controlled, and obsessions can be checked.

### **Question and answer**

Following the panel presentation, about fifteen minutes are set aside for a question and answer period. Any member may ask a question of the panel during this time, newcomers are especially encouraged to participate. Discussion, however, must be limited to the Examples given and related Recovery concepts. Discussion questioning Recovery's method is not allowed. Discussion of psychological theories outside of Recovery is similarly discouraged. In a case where a member brings up a disagreement between his physician and a Recovery concept, he or she is told that the panel is not qualified to provide an answer not related to the Examples presented. Members are expected to follow the advice of their professional; Recovery is not intended as a substitute for psychiatric services, but a self-directed program that can be used as an adjunct to professional treatment, or alone when professional treatment is not available.

### **Mutual aid meeting**

The formal meeting ends with the question and answer period, and an informal "mutual-aid" gathering usually follows. During this time refreshments are usually served. Members may speak freely with one another and discuss problems or ask for advice, although there is an attempt to keep the discussion within the bounds of Recovery concepts. By convention, discussion of problems are limited to five minutes in an attempt to discourage self-pity and complaining.

## **Demographics**

The results here are from a 1960 survey of groups in Chicago and Michigan. 1,875 surveys were sent; the results are based on the 779 that were returned.

### **Meeting attendance and tenure**

The 1960 survey of members found participation in Recovery to be a regular and long-term activity. About one-third of the respondents had been in Recovery for less than a year, another third had been in Recovery for one to two years, and another third had participated for two years or more. Most members reported attending meetings weekly, although one-third reported that they no longer needed to attend meetings to function adequately. Observation of meetings in Chicago during 1971 and 1977 found the average member attended only about 37% of meetings, and also found that it was common for newcomers to only attend one meeting and never return.

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Recovery does not have a graduation or discharge procedure for members. There is a conflicting goal in Recovery in that while it is intended to rehabilitate members, it also needs to sustain itself to continue this goal, creating a potential danger that rehabilitation of members may be subverted by efforts to maintain the organization's membership. Professional treatment goals, however, generally emphasize the importance of adherence to therapeutic practices. The concern is more commonly that patients will not follow through with them, rather than that they will never stop practicing them.

### **Socioeconomic status**

According to the 1960 survey, most Recovery respondents are middle-aged, middle-class, female and married with an employed spouse. A survey of members from 1971 and 1977 estimated the mean age of members to be 49 years, and found that most of them were lower middle-class or working class. In contrast, studies of similar groups found most members had never been married, but similar to a specific study of Emotions Anonymous that found most of the members were middle class. Other studies of self-help groups for people with serious mental illness found most of the members were unemployed, while others found members to be predominately working class. A ratio of two (or more) females for every male is common in studies of self-help groups for persons with serious mental illness.

### **Hospitalization**

The 1960 survey found few members with extensive histories of treatment for mental illness prior to joining Recovery. Half of the respondents reported no previous hospitalization, and about one-fifth had never been treated professionally for a mental illness. Members who reported being hospitalized reported very few instances of short duration. More recent studies have shown that in self-help groups for serious mental illness, approximately 60% (55–75%) of members had been hospitalized for psychiatric reasons.

### **Reasons for joining Recovery**

Most respondents to the 1960 survey reported having heard of Recovery in the lay press, and joined at the suggestion of a friend or relative. Just one-tenth of the respondents reported having been referred by a physician. They reported joining because of psychological symptoms (fears, delusions, and "nerves"), psychosomatic symptoms (tremors and heart palpitations) and also out of curiosity to see if the organization would help. A survey of members from 1971 and 1977 also found that most members were self-referred.

### **Organizational structure**

From 1952 to 2008, Recovery was run from its office in Chicago by a twelve-member Board of Directors, a number of committees, organization officers, and a full-time paid administrative staff. The Board of Directors was elected at Recovery's annual meeting and served for a period of three years. Authority from the Board of Directors was passed to Area Leaders then to Assistant Area Leaders, District Leaders, and lastly to Group Leaders. Leaders are trained to run Recovery meetings, but are not considered experts or authorities. Policies and practices of Recovery were made by the Board of Directors.

### **Family participation**

In the early years of Recovery, an event was held on Saturday afternoons at Recovery's office in Chicago for Recovery members as well as their relatives and friends. Later, family and friends of members were allowed to attend meetings, although not to participate. In 1943 Low published a book, *Lectures to Relatives of Former Patients* to help assist them with the recovery effort; this information was later reprinted in *Peace Versus Power in the Family: Domestic Discord and Emotional Distress* in 1967.

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## Effectiveness

*For more details on this topic, see Self-help groups for mental health: Effectiveness*

In 1945, Abraham Low found the average member improved considerably after the first or second week in the program as it existed at that time. However, members were required to lose their major symptoms within two months of membership and class attendance. If they did not, this was taken as an indication that the member was still sabotaging the physician's efforts.

A 1984 study found that following participation in Recovery, former mental patients reported no more anxiety about their mental health than the general public. Members rated their life satisfaction levels as high, or higher, than the general public. Members who had participated two years or more reported the highest levels of satisfaction with their health. Members who participated for less than two years tended to still be taking medication and living below the poverty level with smaller social networks.

A 1988 study found that participation in Recovery decreased members' symptoms of mental illness and the amount of psychiatric treatment needed. About half of the members had been hospitalized before joining. Following participation, less than 8% had been hospitalized. Members' scores of neurotic distress decreased, and scores of psychological well-being for longstanding members were no different from members of a control group in the same community. Long-term members were being treated with less psychiatric medication and psychotherapy than newer members.

## Similar psychotherapies

Recovery's methods have been compared to several psychotherapies.

- Behavior modification
- Cognitive behavioral therapy
- Cognitive therapy
- Control theory
- Émile Coué's method
- Rational emotive behavior therapy
- Salutogenesis
- Twelve-step programs

## Awards

- In recognition of Recovery's contributions to its field, the organization was given the Arnold L. van Amerigen Award in Psychiatric Rehabilitation from the American Psychiatric Association in 2000.

## Literature

### Books

- Low, Abraham (1943). *Techniques of Psychiatric Self-help After-care*. Chicago: Recovery, Inc. ASIN B0007HZGLE <sup>[2]</sup>. OCLC 42198367 <sup>[3]</sup>.
  - Low, Abraham (1984). *Mental Health Through Will Training* <sup>[4]</sup>. Willett Pub. ISBN 0-915005-01-8. LCCN 57012246 <sup>[5]</sup>. OCLC 9878531 <sup>[6]</sup>.
  - Low, Abraham (1995). *Manage Your Fears, Manage Your Anger: A Psychiatrist Speaks*. Glencoe, IL: Willett Pub. ISBN 0-915005-05-0. OCLC 33243554 <sup>[7]</sup>.
-



## Periodicals

- *Lost and Found* (Chicago). OCLC 40956089 <sup>[8]</sup>.
- *Recovery Reporter* (Chicago). OCLC 22518904 <sup>[9]</sup>.
- *Recovery News* (Chicago). OCLC 40735981 <sup>[10]</sup>.
- *Recovery Journal* (Chicago). OCLC 48051647 <sup>[11]</sup>.

## References

- [1] <http://www.recovery-inc.org/>
- [2] <http://www.amazon.com/dp/B0007HZGLE>
- [3] <http://www.worldcat.org/oclc/42198367>
- [4] <http://www.archive.org/details/mentalhealththro002066mbp>
- [5] <http://lccn.loc.gov/57012246>
- [6] <http://www.worldcat.org/oclc/9878531>
- [7] <http://www.worldcat.org/oclc/33243554>
- [8] <http://www.worldcat.org/oclc/40956089>
- [9] <http://www.worldcat.org/oclc/22518904>
- [10] <http://www.worldcat.org/oclc/40735981>
- [11] <http://www.worldcat.org/oclc/48051647>

## External links

- Abraham Low Self-Help Systems (<http://www.lowselphelpsystems.org>)
  - Recovery Canada (<http://www.recoverycanada.org>)
  - Recovery Ireland (<http://www.recovery-inc-ireland.ie>)
  - Recovery International channel (<http://www.youtube.com/recoveryintl>) on YouTube
  - Works by or about Recovery, Inc (<http://worldcat.org/identities/lccn-no2004-115218>) in libraries (WorldCat catalog)
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# Abraham Low

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**Abraham Low** (1891–1954), was a Jewish-American neuropsychiatrist noted for his work establishing self-help programs for the mentally ill, and criticism of Freudian psychoanalysis.

## Early years

He was born February 28, 1891 in Baranów Sandomierski, Poland.

Low attended grade school, high school and medical school in France from 1910 to 1918. He continued his medical education in Austria, serving in the Medical Corps of the Austrian Army. He graduated with a medical degree in 1919, after his military service, from the University of Vienna Medical School. After serving an internship in Vienna, Austria from 1919 to 1920, he immigrated to the United States, obtaining his U.S. citizenship in 1927. From 1921 to 1925 he practiced medicine in both New York, New York and Chicago, Illinois. In 1925 he was appointed as an instructor of neurology at the University of Illinois Medical School and became an associate professor of psychiatry. In 1931 Low was appointed Assistant Director and in 1940 became Acting Director of the University's Neuropsychiatric Institute.

From 1931 to 1941 he supervised the Illinois State Hospitals. During this time he conducted demanding seminars with the staff and interviewed the most severe mental patients in the wards. In 1936, Low's *Studies in Infant Speech and Thought* was published by the University of Illinois Press. Some sixty papers are by Low dealing variously with such topics as: Histopathology of brain and spinal cord, studies on speech disturbances (aphasias) in brain lesions, clinical testing of psychiatric and neurological conditions, studies in shock treatment, laboratory investigations of mental diseases and several articles on group psychotherapy had been published in medical periodicals. Wikipedia:Citation needed

In 1954 Low died at the Mayo Clinic in Rochester, Minnesota. His contributions to the psychiatric and mental health communities are often not well known, but his work has and continues to assist numerous individuals in the area of mental health.

## Recovery International

Main article: Recovery International

In 1937, Low founded Recovery, Inc. He served as its medical director from 1937 to 1954. During this time he presented lectures to relatives of former patients on his work with these patients and the before and after scenarios. In 1941, Recovery Inc. became an independent organization. Low's three volumes of *The Technique of Self-help in Psychiatric Aftercare* (including "Lectures to Relatives of Former Patients") were published by Recovery, Inc. in 1943. Recovery's main text, *Mental Health Through Will-Training*, was originally published in 1950. During the organization's annual meeting in June 2007 it was announced that Recovery, Inc. would thereafter be known as Recovery International.

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## References

### External links

- Works by or about Abraham Low (<http://worldcat.org/identities/lccn-n84-181049>) in libraries (WorldCat catalog)
- Abraham Low Self-Help Systems (<http://www.lowselphelpsystems.org>) providers of Power to Change and Recovery International

## Neuropsychiatry

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**Neuropsychiatry** is a branch of medicine that deals with mental disorders attributable to diseases of the nervous system. It preceded the current disciplines of psychiatry and neurology, which had common training. However, psychiatry and neurology subsequently split apart and are typically practiced separately. Nevertheless, neuropsychiatry has become a growing subspecialty of psychiatry and it is also closely related to the field of behavioral neurology, which is a subspecialty of neurology that addresses clinical problems of cognition and/or behavior caused by brain injury or brain disease of different etiologies.

### The case for the rapprochement of neurology and psychiatry

Given the considerable overlap between these subspecialties, there has been a resurgence of interest and debate relating to neuropsychiatry in academia over the last decade. Most of this work argues for a rapprochement of neurology and psychiatry, forming a specialty above and beyond a subspecialty of psychiatry. For example, Professor Joseph B. Martin, former Dean of Harvard Medical School and a neurologist by training, has summarized the argument for reunion: "the separation of the two categories is arbitrary, often influenced by beliefs rather than proven scientific observations. And the fact that the brain and mind are one makes the separation artificial anyway." These points and some of the other major arguments are detailed below.

### Mind/brain monism

Neurologists have focused objectively on organic nervous system pathology, especially of the brain, whereas psychiatrists have laid claim to illnesses of the mind. This antipodal distinction between brain and mind as two different entities has characterized many of the differences between the two specialties. However, it is argued that this division is simply not veridical; a plethora of evidence from the last century of research has shown that our mental life has its roots in the brain. Brain and mind are argued not to be discrete entities but just different ways of looking at the same system (Marr, 1982). It has been argued that embracing this mind/brain monism is important for several reasons. First, rejecting dualism logically implies that all mentation is biological and so immediately there is a common research framework in which understanding—and thus treatment—of mental suffering can be advanced. Second, it removes the widespread confusion about the legitimacy of mental illness: all disorders should have a footprint in the brain-mind system.

In sum, one reason for the division between psychiatry and neurology was the difference between mind or first-person experience and brain. That this difference is artificial is taken as good support for a merge between these specialties.

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## Causal pluralism

Another broad reason for the divide is that neurology traditionally looks at the causes of disorders from an "inside-the-skin" perspective (neuropathology, genetics) whereas psychiatry looks at "outside-the-skin" causation (personal, interpersonal, cultural). This dichotomy is argued not to be instructive and authors have argued that it is better conceptualized as two ends of a causal continuum. The benefits of this position are: firstly, understanding of etiology will be enriched, in particular between brain and environment. One example is eating disorders, which have been found to have some neuropathology (Uher and Treasure, 2005) but also show increased incidence in rural Fijian school girls after exposure to television (Becker, 2004). Another example is schizophrenia, the risk for which may be considerably reduced in a healthy family environment (Tienari et al., 2004).

Secondly, it is argued that this augmented understanding of etiology will lead to better remediation and rehabilitation strategies through an understanding of the different levels in the causal process where one can intervene. Indeed, it may be that non-organic interventions, like cognitive behavioral therapy (CBT), better attenuate disorders alone or in conjunction with drugs. Linden's (2006) demonstration of how psychotherapy has neurobiological commonalities with pharmacotherapy is a pertinent example of this and is encouraging from a patient perspective as the potentiality for pernicious side effects is decreased while self-efficacy is increased.

In sum, the argument is that an understanding of the mental disorders must not only have a specific knowledge of brain constituents and genetics (inside-the-skin) but also the context (outside-the-skin) in which these parts operate (Koch and Laurent, 1999). Only by joining neurology and psychiatry, it is argued, can this nexus be used to reduce human suffering.

## Organic basis

To further sketch psychiatry's history shows a departure from structural neuropathology, relying more upon ideology (Sabshin, 1990). A good example of this is Tourette syndrome, which Ferenczi (1921), although never having seen a patient with Tourette syndrome, suggested was the symbolic expression of masturbation caused by sexual repression. However, starting with the efficacy of neuroleptic drugs in attenuating symptoms (Shapiro, Shapiro and Wayne, 1973) the syndrome has gained pathophysiological support (e.g. Singer, 1997) and is hypothesized to have a genetic basis too, based on its high inheritability (Robertson, 2000). This trend can be seen for many hitherto traditionally psychiatric disorders (see table) and is argued to support reuniting neurology and psychiatry because both are dealing with disorders of the same system.

### Linking traditionally psychiatric symptoms to brain structures and genetic abnormalities. (This table is in no way exhaustive but aims to show some of the neurological bases to hitherto psychiatric symptoms)

Psychiatric symptoms	E.g. Psychoanalytic explanation	E.g. Neural correlates	Source
Depression	Narcissistic	Limbic-cortical dysregulation	Mayberg (1997)
Obsessive Compulsive Disorder	Poor maternal parenting	frontal-subcortical circuitry, right caudate activity	Saxena et al. (1998), Gamazo-Garran, Soutullo and Ortuno (2002)
Schizophrenia	Narcissistic/escapism	NMDA receptor activation in the human prefrontal cortex	Ross et al. (2006)
Visual hallucination	projection	retinogeniculocalcarine tract, ascending brainstem modulatory structures	Mocellin, Walterfang, Velakoulis, 2006
Auditory hallucination	projection	frontotemporal functional connectivity	Shergill et al., 2000
Eating disorder		Atypical serotonin system, right frontal and temporal lobe damage	Kaye et al. (2005), Uher and Treasure (2005)

Bipolar disorder	Narcissistic	Prefrontal cortex and hippocampus, anterior cingulate, amygdala	Barrett et al. (2003), Vawter, Freed, & Kleinman (2000)
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### Improved patient care

Further, it is argued that this nexus will allow a more refined nosology of mental illness to emerge thus helping to improve remediation and rehabilitation strategies beyond current ones that lump together ranges of symptoms. However, it cuts both ways: traditionally neurological disorders, like Parkinson's disease, are being recognized for their high incidence of traditionally psychiatric symptoms, like psychosis and depression (Lerner and Whitehouse, 2002). These symptoms, which are largely ignored in neurology, can be addressed by neuropsychiatry and lead to improved patient care. In sum, it is argued that patients from both traditional psychiatry and neurology departments will see their care improved following a reuniting of the specialties.

### Better management model

Schiffer et al. (2004) argue that there are good management and financial reasons for rapprochement.

## The case for maintaining the separation of neurology and psychiatry

### No psychiatric disorder has been completely- "mapped"

The fact that no complete syndrome has been mapped in the brain or genome is used to suggest that psychiatric disorders are not bona fide and should thus be kept separate (e.g. Baughman and Hovey, 2006). On this issue, it is worth remembering that research into the neural correlates of psychiatric disorders is in its infancy: the answers may still be to come. One reason why they may not have been found so far is that complex mental disorders may result from minute and intricate brain-wide damage and complicated gene-environment interactions, which are only beginning to be understood. Disorders may not exist as tidy, localized neurodysfunction or genetic abnormalities but multi-factorial brain-wide disorders with complex interactions between environment and genetics (e.g. Green, 2001). Such distributed dysfunction may not be resolvable in the living brain with current technology. E.g. disparate behavioral disorders have been linked to identical neurodysfunction with imaging but show significant organic differences following neurohistological analysis (Rempel–Clower et al., 1996). Where physiopathology is extremely small and distributed or neural tissue is actually healthy it may be the disturbed information-processing that should be studied. E.g. Bell, Halligan and Ellis' (2006) work on cognitive deficits in delusions.

### Pragmatic issues

The extent to which neuropsychiatry is practically possible has been questioned. As Sachdev (2005) has noted, psychiatrists and neurologists operate very different patient management strategies, which are skills honed by years of experience:

- Neurologist: Clinical examination skills; empiricism; objectivity; surgery
- Psychiatrist: Rich description of mental phenomena, well developed interviewing skills; understanding multiple causation; appreciation of individual differences; interpersonal context; psychological and behavioral therapies

Sachdev suggests to join them may be to dilute them both. Further, the ability to maintain a competent knowledge and skill base for both neurology and psychiatry with the advent of the inexorable increase in scientific knowledge may not be possible.

## Summary of the arguments for neuropsychiatry

Diseases of the body have a physical manifestation that can often be caused by internal factors, external factors, or a combination of the two. Mental disorders should be no different. Wikipedia:Citation needed and when together neurology and psychiatry's aim was to show that this was the case. Psychiatry departed the union preferring ideology over empiricism, including very environmentally-based etiology as well as espousing that the mind was something fundamentally different from the brain. Neurologists, however, finding no physiopathology for certain disorders left them to the psychiatrists, while themselves pursuing the diseases with clear physiopathology.

However, the cleavage between mind and brain and the causal dichotomies are argued not to be veridical. Psychiatric disorders are increasingly showing organic manifestation and demonstrate causation from something as distant as culture. Thus the reasons for the initial division are argued not to be useful or real ones. The two specialties are both dealing with disorders of the same system. Wikipedia:Citation needed Biological psychiatry and behavioral neurology show how the boundaries are being blurred. It is argued that there can be no objection to a reunion on philosophical or scientific grounds. However, there may be reasons to question whether neuropsychiatry would be practically possible. The differences in patient management, knowledge base and skill competency between neurology and psychiatry mean that being proficient in both may be impossible.

## USA institutions

"Behavioral Neurology & Neuropsychiatry" fellowships are jointly accredited through the United Council for Neurologic Subspecialties (UCNS), in a manner similar to how the specialties of psychiatry and neurology in the United States have a joint board for accreditation, the American Board of Psychiatry and Neurology (ABPN). The American Neuropsychiatric Association (ANPA) is the American medical subspecialty society for neuropsychiatrists, offering fellowships and CME credits. ANPA also publishes the peer-reviewed *Journal of Neuropsychiatry and Clinical Neurosciences*. Recently, new non-profit professional society named Neuropsychiatric Forum (NPF) was founded. NPF aims to support effective communication and interdisciplinary collaboration, develop education schemes and research projects, organize neuropsychiatric conferences and seminars.

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## External links

### Subspecialty Certification

- Behavioral Neurology & Neuropsychiatry, United Council for Neurologic Subspecialties, USA (<http://www.ucns.org/go/subspecialty/behavioral>)

### Journals

- The Journal of Neuropsychiatry and Clinical Neurosciences (<http://neuro.psychiatryonline.org/>)
  - Neuropsychiatric Disease and Treatment (<http://www.dovepress.com/NDT.htm>)
  - Clinical Neuropsychiatry: Journal of Treatment Evaluation (<http://www.clinicalneuropsychiatry.org/>)
  - Cognitive Neuropsychiatry (<http://www.tandf.co.uk/journals/pcnp>)
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### **International/National Organizations**

- Neuropsychiatric forum (<http://npforum.eu/>)
- Neuropsychiatric forum - facebook (<http://www.facebook.com/npforum/>)
- American Neuropsychiatric Association (<http://www.anpaonline.org/>)
- The British Neuropsychiatry Association (<http://www.bnpa.org.uk/>)
- Royal College of Psychiatrists, Special Interest Group in Neuropsychiatry (SIGN) (<http://www.rcpsych.ac.uk/college/specialinterestgroups/neuropsychiatry.aspx>)
- International Neuropsychiatric Association (<http://www.inaweb.org/>)
- Neuropsychiatry in New Zealand (<http://www.neuropsychiatry.co.nz/>)
- Society for Behavioral and Cognitive Neurology (<http://www.sbcnonline.org/>)

### **Specific Neuropsychiatry Programs**

- Royal Melbourne Hospital Neuropsychiatry Unit (<http://www.neuropsychiatry.org.au/>)
  - Neuropsychiatry Program, British Columbia, Canada (<http://psychiatry.vch.ca/bcnp.htm>)
  - University of Pennsylvania Neuropsychiatry Program (<http://www.med.upenn.edu/bbl/>)
  - University of Chicago Neuropsychiatry Program (<http://psychiatry.uchicago.edu/page/neuropsychiatry-program>)
  - Neuropsychiatry Program at Sheppard Pratt, USA (<http://www.neuropsychiatryatsp.org/>)
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