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# An Organizational Ecology of National Self-Help/Mutual-Aid Organizations

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*Although a considerable amount of research on modern self-help/mutual aid has been undertaken during the past several decades, studies have yet to address the question What are the organizational dynamics underlying the institutionalization of self-help/mutual aid? As a partial answer to this question, the author describes the central patterns of growth, decline, and persistence of national self-help/mutual-aid organizations, their formal diversification, and the extent to which subpopulations gain market share. In addition to using an organizational–ecological focus to map the trajectory of voluntary organizations, this article builds on resource partitioning theory by applying its central insights to subtypes of organizations. Expansion of self-help/mutual aid is remarkably similar to the trajectories of commercial and bureaucratic populations, but expectations that generalist concentration fosters growth of specialist organizations are not supported. Specialists dominate generalists except among medical self-help/mutual aid. Implications for future research are discussed.*

**Keywords:** *organizational ecology; self-help/mutual aid; resource partitioning*

During the 1960s and 1970s, decreasing medical-professional hegemony, increasing rationalization within the health care system, and privatization in human services contributed to the unprecedented expansion in the field of community-based health and human services (Conrad, 1992; Scheidlinger, 2000; Scott, Ruef, Mendel, & Caronna, 2000; Wolch, 1996). Drug and rape crisis clinics, legal and medical co-ops, halfway houses and shelters experienced widespread popularity. Under the auspices of the consumer health movement, this field witnessed rapid expansion of a variety of alternative

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health and social welfare organizations, including New Age counseling practices, chiropractic and naturopathic medicine, and acupuncture (Goldstein, 1992; Ruggie, 2004). The most well known of these was self-help/mutual aid: member-designed support groups and organizations for people who experience a common problem, illness, or condition (Katz, 1993).

Seemingly overnight, self-help/mutual aid "evolved from an oddity and suspect human service to a vigorous, diverse endeavor known to all who watch daytime talk shows" (Lieberman & Snowden, 1994, p. 32). Throughout the 1980s and 1990s, forums for discussion of self-help/mutual aid emerged in a wide range of media. Mainstream academic and medical journals such as *Journal of the American Medical Association* and *New England Journal of Medicine* devoted serious attention to self-help/mutual aid. Popular magazines and the press featured stories, anecdotes, and depictions of self-help/mutual-aid members. Clearinghouse listings of organizations available for self-help/mutual aid grew steadily (White & Madara, 2002), and social service agencies regularly referred clients to any number of self-help/mutual-aid groups (Kurtz, 1997). Significantly, the federal government weighed in by funding research and developing programs designed to evaluate the efficacy of self-help/mutual-aid services. In 1987, Surgeon General Everett Koop's Workshop on Self-Help and Public Health, under the auspices of the Department of Health and Human Services, promoted self-help/mutual aid among federal and state, public and private, agencies.

Although self-help/mutual aid has become a part of our national culture and its remarkable growth has been duly noted in the social science literature, less is known about the *organizational* proliferation of self-help/mutual aid in America. Few empirical studies address changes in the numbers and types of self-help/mutual-aid organizations except to broadly reflect on the general perception of the remarkable expansion of the field. Surprisingly, given the representation of self-help/mutual aid as "here to stay" (Katz, 1993) and the extent to which it has become an American institution, understanding of the basic organizational demographics or ecology of self-help/mutual aid is still limited to a handful of studies. One of the central dilemmas, of course, is that self-help/mutual-aid support *groups*, the core phenomena of self-help/mutual aid, spontaneously emerge and dissipate as a function of local grassroots activities (Smith, 2000). The longitudinal survey of these rapidly growing and dissolving groups (in contrast to stable formal organizations), therefore, appears to be a daunting task. Yet if the organizational dynamics of this multidimensional phenomenon are to be understood, then it is important to ask how and why growth and diversification occurred when they did and what organizational, economic, social, and political forces account for their persistence. We can answer this question by surveying national organizations.

Recent studies of self-help/mutual-aid organizations help in this regard. Borkman (1999), Schubert and Borkman (1991), Humphreys and Rappaport (1993), Powell (1987, 1990, 1994), and others have broadened our understanding

of self-help/mutual aid through their emphasis on self-help/mutual-aid organizations. In addition, Davison, Pennebaker, and Dickerson (2000), Leventhal, Maton, and Madara (1988), Luke, Roberts, and Rappaport (1994), Maton (1993), and Maton (1989) provide excellent local ecologies and case studies. However, this research stops short of depicting growth of the field and population overall. The current study partially fills that gap by providing analysis of the growth and decline of self-help/ mutual aid using longitudinal data on the population of established national self-help/ mutual-aid organizations.

I apply an organizational–ecological framework to this population of organizations to describe its growth and diversification and the mechanism by which resources are partitioned. It is particularly important to conduct a systematic survey of the growth, decline, and persistence of self-help/ mutual-aid organizations not only because this area remains underexplored but also because a study such as this lays the groundwork for more explicit comparisons among noncommercial organizational populations and commercial ones. Theoretically, establishing similarities among a variety of different organizational forms reveals that the organizational ecology framework is remarkably versatile and can be extended to help us understand a broad range of very different types of groups, organizations, and social movements. As background to analyses of population development, the first section of the article defines self-help/mutual aid and provides a brief theoretical discussion of organizational ecology and resource partitioning. Past research has examined population diversification, concentration, and resource partitioning in a number of commercial sectors, such as the U.S. recording and film industries (Dowd, 2004; Mezas & Mezas, 2000), micro-breweries (Carroll & Swaminathan, 2000), restaurants (Hannan & Carroll, 1989), and social movements (Haider-Markel, 1997; for a review, see Baum, 1996; Carroll & Hannan, 2000, pp. 269-270). It is theoretically interesting to wonder whether the ecological framing of resource partitioning—which describes why some organizational fields are dominated by a few organizations and how other organizations survive under those conditions (see Carroll & Swaminathan, 2000)—lends itself in the same way to predictions about the expected relationships between various classes of self-help/ mutual-aid organizations as it does in other organizational populations. An important question this study addresses is, Do conditions that generate growth, diversification, and resource partitioning in commercial sectors promote similar patterns in the alternative health and human services sector, at least with respect to this population of organizations?

The second section of the article describes the actual patterns of organizational growth, decline, and persistence in the self-help/ mutual-aid population. Case studies and historical descriptions of the development of self-help/ mutual aid argue that the population experienced “phenomenal growth” during the latter half of the 20th century. Katz (1993) and others (e.g., Powell, 1987; Riessman, 1985) identify the 1960s as a period of considerable expansion

of self-help/mutual aid. I test these observations and examine founding and disbanding rates and formal diversification during a 45-year period, 1955 to 2000. This period marks the emergence of the majority of national self-help/mutual-aid organizations. Subpopulations sprang up during this period and gained access to resources in specialty niches that had not been previously cultivated, such as gastroenterology, abuse and violence, and genetics. Results of analyses are important in that knowledge about changes in the distribution of organizations in the population across specialty niches provides the basis for generating insights into how social processes, such as specialization and resource partitioning, work in both commercial and non-commercial populations. For example, it has been shown that founding rates decline because crowding in organizational populations limits access to resources for new organizations (e.g., see Carroll & Hannan, 2000). However, in mature populations, a few large organizations eventually come to dominate a sector or market, and new organizations are founded to take advantage of specialty niches that remain open (Carroll, 1985). An important question is, Does the emergence of large dominant noncommercial organizations limit access to resources by other organizations? Tucker, Singh, Meinhard, and House (1988) suggest that this might be the case. In this article, I test the prediction that self-help/mutual-aid subpopulations will experience resource partitioning in a manner that mimics businesses and firms: toward increasingly specialized markets.

The third section of this article examines these expectations. I analyze resource partitioning in the self-help/mutual-aid population by determining "market share" (proportion of self-help/mutual aid controlled by different organizations) of specialists and generalists in 18 self-help/mutual-aid subpopulations (Powell, 1987). I examine the extent to which concentration occurs within the two main types of self-help/mutual aid: social welfare and medical. I extend resource-partitioning theory by trying to understand how the theory works with dominant firms in several subpopulations of organizations. In short, I explore cross-population effects. Specifically, I examine trends in specialization among subpopulations and resource concentration among both generalist and specialist organizations (and not just generalists alone as the theory suggests).

Results depict the basic patterns of growth, decline, and persistence of self-help/mutual aid; show that the trajectory of self-help/mutual aid resembles the dynamics and diversification of a variety of commercial and noncommercial organizational populations; and indicate that the relationship among diversification, resource use, and concentration is an unusually complex one. Although the self-help/mutual-aid market overall is dominated by specialists (in contrast to expectations of resource partitioning), the main historical trend in this population is away from increasing specialization and generalist concentration and toward greater generalism among organizations (again, in direct contrast to expectations). There is a strong tendency toward less concentration in both social welfare and medical subpopulations

of the self-help/mutual-aid market and less concentration within specialist populations and (surprisingly) generalist populations. This has several implications. Theoretically, either the population is not mature enough to display the same trends as other populations or the underlying processes are very different from those found in commercial sectors or the use of sub-populations is not suited to resource-partitioning arguments. Substantively, there appears to be growing involvement of outsiders in self-help/mutual-aid organizations (i.e., greater generalism). I discuss these conclusions in the final section.

### ORGANIZATIONAL ECOLOGY: GROWTH, DIVERSIFICATION, AND RESOURCE PARTITIONING

Organizational ecologists tend to slight noncommercial organizations in empirical studies (Smith, 2000), but the question of why there is such diversity of organizational forms is as relevant to nonprofit enterprises as to commercial ones (Carroll & Hannan, 2000). Organizational forms are classes of organizations defined by bounded sets of common organizational features such as their structures, practices, members, and routines (Hannan & Freeman, 1989). Banks, schools, medical practices, unions, and human service agencies are examples of different organizational forms. In this theoretical perspective, new organizational forms emerge and old ones die out because of the operation of selection and adaptation. Selection occurs when social forces in the organizational environment promote organizational forms based on the optimal combination of stable organizational characteristics. Adaptation is the process whereby organizations adjust their routines and structures to fit often turbulent environmental conditions (Carroll & Hannan, 2000). Environmental conditions may be changes in regulatory statutes or shifts in markets. For example, deregulation of banking generated the phenomenon whereby organizations that were not previously known as providing financial services became competitors with those that did (Carroll & Hannan, 2000). Successful selection and adaptation results in greater longevity. Selection processes are expected to explain the rise and decline of noncommercial organizations such as self-help/mutual aid because their formation and subsequent disbanding is based on an organizational structure that has little built-in flexibility for adapting to changing environmental conditions (Twombly, 2003). Changes in the structure of the population occur because association members come and go and create other organized groups to fill a variety of niches.

Organizational forms are embedded in network relationships facilitating resource flows (Carroll & Hannan, 2000). Commonalities consist of core and peripheral features, usually goals, authority relations, technologies, and strategies that are encoded in organizational structures and routines (Scott, 2003). Organizational forms resonate at a cultural level (i.e., people recognize what

a bank, school, medical practice, or human service agency is). The form is therefore a kind of identity (Carroll & Hannan, 2000). Organizations that are bound by a similar form constitute a population of organizations and experience similar problems with respect to maintaining access to resources. Organizational ecologists analyze the niches of these resources because a central research question focuses on competition among organizations and how this influences the emergence of new organizations and the failure of others. Competition among organizations depends on the extent to which market niches overlap and resources are partitioned. Resource overlap increases competition along these dimensions, whereas specializing—resource partitioning—decreases competition (Carroll & Swaminathan, 2000).

Resource partitioning refers to the extent to which organizations attempt to manage competition for resources to thrive. The theory typically is used to explain the emergence of specialist organizations in industries characterized by a high degree of concentration or dominance by a few large organizations. Organizations do so by targeting services, products, and supplies to various market segments (Carroll & Hannan, 2000). Some target homogeneous segments and others narrow segments. Types of strategies are not mutually exclusive, such that the former (generalists) and the latter (specialists) may partition a niche and share its resources. Carroll and Swaminathan (2000) show how specialist organizations, in the brewing industry, take advantage of concentrated (i.e., monopolized) markets to fashion a niche that protects them from competition with other breweries. Similarly, Haider-Markel (1997) demonstrates that interest groups avoid direct competition by adapting to different issue niches (i.e., specializing), and Ruef, Mendel, and Scott (1998) detail the ameliorative effects of resource partitioning on competition in the health care sector. For both commercial and noncommercial organizations, control of resource niches is important (see Baum, 1996). Market concentration in industries is likely to increase the generalist failure rate because a few large organizations end up using all of a sector's resources. Concentration will lower the founding rate of other generalist organizations, again because a few large generalist organizations dominate resource use, which inhibits the entry of new ones. However, the paradox of generalist concentration is that through the partitioning of resources, specialist organizations thrive because they do not directly compete with generalists. Hence, the founding rate of specialists tends to be high, whereas the failure rate is low (Baum, 1996; Carroll & Hannan, 2000). To apply this expectation to self-help/mutual aid, we must examine its components.

## SELF-HELP/MUTUAL-AID ORGANIZATIONS

Self-help/mutual aid is a multidimensional phenomenon. One of the chief barriers to understanding it is that *self-help* is too often a vague term referencing ideologies, books, and programs in such a way as to "seem to be all

things to all people" (Riessman, 1995, pp. 188-189). Despite the encompassing definition, self-help/mutual aid is nothing without the meetings, chapters, groups, and organizations that constitute it (Borkman, 1999; Schubert & Borkman, 1991). Self-help/mutual-aid organizations are formal structures that are sustained by a differentiated, complex organizational structure composed of these groups, meetings, chapters, boards, volunteers, staff, and affiliated networks (Powell, 1990). The group component, by which self-help/mutual aid is largely known, is designed to address personal stigmatizing conditions or problems, ranging from medical disability to behavioral dysfunction, in a public but intimate, face-to-face interaction setting (Borkman, 1999). Personal stigmatizing conditions or problems might entail amputation (National Amputee Foundation), substance abuse (Alcoholics Anonymous), or disabilities (Autism Network). Self-help/mutual aid is also a process as much as it is a structure. Individuals who experience stigmatizing conditions actively provide support for one another.

This study focuses on national self-help/mutual-aid organizations for several reasons. First, national self-help/mutual-aid organizations are easier to identify, follow over time, and systematically analyze than are local, informal groups. Because informal groups rapidly emerge and dissipate (Scott, 2003), an adequate sample of these groups on a large scale (both spatially and temporally) is impossible. Formal organizations also promote better developed support programs among local chapters, meetings, and groups; provide stability and predictability; and have a more diverse membership and a stronger leadership structure (Borkman, 1999; Powell, 1987, 1990) than do unaffiliated groups. Stability and predictability influence longevity, a key feature in the growth and diversification of organizational populations and an issue of central interest in analyzing the dynamics of self-help/mutual aid. Second, self-help/mutual-aid organizations almost always attempt to establish a national presence to reach as many potential members as possible who share their condition, problem, or illness and, as such, are usually engaged in formalizing their programs and structures (Katz & Bender, 1976; cf. Smith, 2000, p. 180).

Within the population of national self-help/mutual-aid organizations, this study focuses only on member-run organizations. One of the definitive aspects of self-help/mutual aid is that its meetings and chapters are controlled by constituents whose problem or illness the group has been constructed to address (Borkman, 1999; Katz, 1993; Kurtz, 1997). This constraint arises from the premise that experiential knowledge (i.e., fellow sufferers helping fellow sufferers) is essential to self-help/mutual-aid processes. However, some types of conditions require professional involvement, such as those with a complicated medical component (e.g., genetic illnesses). Consequently, self-help/mutual aid can involve expert professionals, an ambiguous relationship that the literature on self-help/mutual aid is at great pains to detail (see Kurtz, 1997). Some researchers regard true self-help as only member-run organizations (Katz, 1993; Kurtz, 1997), whereas others

note that professional involvement forms a continuum with some groups prohibiting professionals (e.g., the 12-step organizations) and other groups welcoming them (Shepherd et al., 1999). More formal organizations, as opposed to small informal groups, may be more likely to have evolved a method for incorporating professionals into their structure and therefore appear to have been co-opted (i.e., not really true self-help). For the purposes of this study, the sample of self-help/mutual-aid organizations was subdivided into categories of specialist and generalist organizations. We tend to think of self-help/mutual-aid organizations as specialists insofar as their technologies (peer support groups) and issue areas are directed at specific constituencies, most often beneficiaries (e.g., individuals, families, friends), for whom a particular condition, problem, or illness is salient. These constituents would constitute their product market, as it were. However, because some self-help/mutual-aid organizations include “interested others” (i.e., onlookers who are not the primary beneficiaries—for example, spouses of cancer patients) and professionals, their product market must be characterized as extensive. These organizations are labeled self-help/mutual-aid generalist organizations. I discuss the dimensions of these categories in detail below. The central point is that specialists and generalists have different strengths and therefore compete in different ways with each other for resources undergirding their services. This shapes the dynamics of the population.

Before I can address how specialists and generalists compete for resources, the broader question of growth and diversification must be explored. How do founding and disbandings affect the growth of the self-help/mutual-aid population? And what kind of diversification takes place? Then we can examine how self-help/mutual-aid organizations differentiate themselves from one another and capture scarce resources. The following data and analyses answer these questions.

#### DATA—CASE SELECTION<sup>1</sup>

I examine self-help/mutual aid using an original database of life histories of all active national self-help/mutual-aid organizations in the United States between 1955 and 2000. The database was constructed from a variety of sources (see Archibald, 2002), including the *Encyclopedia of Associations* (Gale Research Company, 1955-2000), which serves as the source of data for this article. The encyclopedia contains historical information on all self-declared national membership organizations, including voluntary associations devoted to providing health and human services. Each edition and organizational entry of the *Encyclopedia of Associations* consists of a detailed, year-by-year record that includes, but is not limited to, organizational founding date, organizational status (e.g., disbanding and changes in name), organizational competencies in the areas of services and programs, and organizational

resources for all national self-help/mutual-aid organizations. Only self-help/mutual-aid organizations that identified themselves as self-help or those providing peer-to-peer support groups, networks, meetings, chapters, and the like were selected. These were compared with White and Madara's (2002) listings and IRS micro files and consistently overlapped each.<sup>2</sup>

Many of the strengths of the *Encyclopedia of Associations* are discussed in Minkoff (1995). Despite its comprehensive coverage, some national self-help/mutual-aid organizations may not appear in the *Encyclopedia of Associations* because they are too short-lived (i.e., those failing within a year). This criterion limits variation in organizational life spans to at least a year. It is a reflection of the nature of building a national organization rather than a specific bias on the part of the encyclopedia. Martin, Baumgartner, and McCarthy (2006) show that coverage of unions provided by the *Encyclopedia* is comprehensive.

## MEASURES

### FOUNDING, DISBANDING, AND DENSITY

The founding rate is defined as the rate of entry of new organizations into the self-help/mutual-aid population during each observation period during the course of the history of the population. Organizations may be created *de nova*, they may have merged with other organizations, or they may have been reorganized and restructured. Organizational disbanding or failure is defined as exit of an organization from the self-help/mutual-aid population. Organizations are defined as either active or defunct. Of the 589 self-help/mutual-aid organizations active during the course of the 45-year period, 110 disbanded (18.7%). Population density is the total number of active organizations in the population during each observation period (Hannan & Freeman, 1989). This measure is the cumulative total of active organizations at time  $t$ , net disbandings.

### DIVERSIFICATION

Self-help/mutual-aid organizations identify their resource niche (for data collection purposes in the encyclopedia). The resource niche for an organization is composed of all the resources that sustain the population of organizations in it, including constraints that limit it (Hannan & Freeman, 1989). The domain of self-help/mutual aid is organized along two dimensions, social welfare and medical, based on provision of services and resource use. These dimensions consist of a number of organizational populations with social technologies oriented toward addressing a full range of conditions from spina bifida to stuttering.<sup>3</sup> To understand diversification, I examine 18 self-help/mutual-aid subpopulations, defined by Powell (1987) as

### Social Welfare

- Relationship (e.g., marriage, divorce, adoption, widowhood)
- Status (e.g., sexuality, women, race/ethnicity, gender dysphoria)
- Alcohol, drug addiction
- Other addictions (e.g., food, sex, gambling, codependency)
- Reproduction, children (e.g., high-risk pregnancy)
- Abuse, violence (e.g., incest, self-mutilation, destructive relationships)
- Grief (e.g., loss, death)
- Mental illness (e.g., obsession–compulsion, depression)
- Physical disability, autism, retardation
- Legal (e.g., prostitution, family of prisoners)

### Medical

- Cancer
- Neurology (e.g., pain, sleep, stroke, paraplegia, head injury, fatigue)
- Gastroenterology
- Eye, ears, nose, and throat
- Disease, infections, autoimmune disease, diabetes
- Hormones, genetics, metabolic growth and development
- Skin, burns, facial reconstruction
- Respiratory, circulatory, and pulmonary illnesses

## SPECIALISTS AND GENERALISTS

Based on the resource-partitioning literature, I define specialist and generalist organizations in terms of the extent and pattern of their resource use. Some organizations depend on financial resources to survive. For noncommercial organizations, such as self-help/mutual aid, resources are based on human capital typically arising from organizational membership. As noted, one of the defining features of self-help/mutual aid is the extent to which these organizations are member owned (Borkman, 1999). Some types of self-help/mutual aid limit involvement to only those experiencing the focal condition. For the purposes of this study, these organizations are defined as specialist organizations. Others, defined here as generalists, encourage a range of collateral participants, such as caregivers, families, and even professionals. For some self-help/mutual-aid organizations, especially those dealing with medical trauma, genetic dysfunction, cancer, and other life-threatening conditions, participation by medical professionals is essential to securing information, accessing resources, and advancing knowledge of the treatment of traumatic conditions. Generalist self-help/mutual-aid organizations exist insofar as the target of resource mobilization involves constituencies other than members with the focal condition. We might call them general-specialists in comparison to other organizational forms, but because the comparison lies within self-help/mutual aid, they are simply generalists.<sup>4</sup>

## CONCENTRATION OF RESOURCES

Concentrated industries are those with resource monopolies. Industries that experience the greatest concentration have a few large enterprises (typically generalists) that, over the history of the population, gain the greatest share of the market (Boone, Carroll, & Witteloostuijn, 2002). Noncommercial organizations gain market share of human capital. In the following analyses, I focus on market share of membership and the extent to which a few organizations monopolize self-help/mutual-aid constituencies. Carroll, Dobrev, and Swaminathan (2003) use a concentration measure based on the top four largest firms. Following that study, concentration in this article refers to the proportion of the market that is controlled by the four largest self-help/mutual-aid organizations based on the size of the constituency.<sup>5</sup>

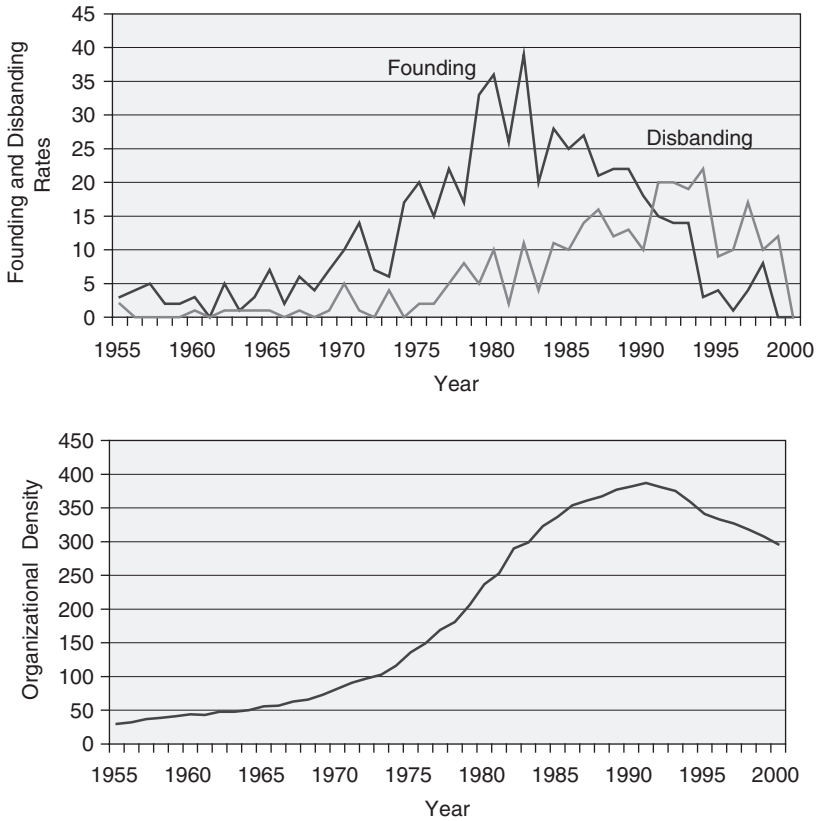
## ANALYSES

### SELF-HELP/MUTUAL-AID GROWTH, DECLINE, AND PERSISTENCE

Figure 1 presents founding, disbanding, and density rates for the population of self-help/mutual-aid organizations in this study. The first graph in Figure 1 depicts the founding and disbanding rates for self-help/mutual-aid organizations during the 45-year observation period. The second graph depicts the density function.

*Founding rates.* Like other populations of organizations, both commercial and noncommercial, the founding rate of self-help/mutual aid is initially low, rises dramatically, and then falls just as quickly. During the early period of the population, from the 1950s throughout the 1960s, the founding rate remained about 3.5 organizations a year. After 1969, the average number of self-help/mutual-aid foundings jumped to 10 organizations founded per year. Then in 1971, nearly 15 self-help/mutual-aid organizations formed. A year later, there was a large drop in the founding rate, which not only recovered but exceeded the highest previous rate. This pattern of large jumps followed by a year at a lower rate occurs throughout the middle period. In 1982, the founding rate peaked at 39 organizations. The 39 organizations founded that year include a wide array of subpopulations, such as Children of Alcoholic Parents (alcohol), Chronic Granulomatosis Disease Association (genetic disorder) and Deaf/Blind (disabled). After 1982, the founding rate begins an equally precipitous decline until the end of the century. The year following 1982 witnessed only 20 organizational foundings. This number rose to 28 the next year, before slowly dropping off. The greatest decline occurred between 1993 and 1994, when the self-help/mutual-aid founding rate dropped from 14 per year to 3 per year.

*Disbanding rates.* In the meantime, the rate at which self-help/mutual-aid organizations disbanded shows a slow but steady increase during the observation



**Figure 1. Trends in Organizational Founding and Disbanding Rates and Organizational Density, National Self-Help/Mutual-Aid Organizations, 1955 to 2000**

Note: N = 589.

period. During the early period of the population, from the 1950s throughout the 1970s, the disbanding rate, like the founding rate, remained low. Until 1976, the average number of self-help/mutual-aid disbandings was less than 1.5 per year. This translates to about half as many disbandings as foundings. After 1976, the population began to experience much higher disbanding rates. These elevated disbanding rates peaked in the early 1990s at around 20 organizations a year. The rate of disbandings during the 1990s is higher than foundings. However, because of the accumulated mass of organizations founded prior to the 1990s, the overall rate of decline in the self-help/mutual-aid population is slow. The overall rate of change in this population is depicted by the shape of the density curve in the second graph in the figure.

*Density.* The second graph in Figure 1 depicts the long, slow, upward curve of the density of self-help/mutual-aid organizations during the 45-year period. The density of organizations in the population at each period is a cumulative function of the number of organizations at each period, taking into account the difference between foundings and disbandings. As already noted, although the self-help/mutual-aid literature provides historical accounts regarding the general formation of the population, there is little research on population dynamics.

The shape of the density curve in the second graph in Figure 1 is relatively  $\cap$  shaped. The figure shows a long left-hand tail from the origins of the population through the mid-1970s. There is sustained but slow growth during the first 20 years of development of the population (1955-1975). Consistent with the significant rise in founding rates, the population of self-help/mutual-aid organizations experiences more accelerated growth in the late 1970s and early 1980s. Inspection of the first two graphs shows that the pattern of continual, then accelerated, growth in self-help/mutual aid is due to a considerable increase in the ratio of foundings to disbandings around the 1970s. The steady acceleration of the density curve bears this out.

The founding rate, however, peaks in 1982 and begins to decline, whereas the rate of disbanding accelerates starting in the late 1970s. This pattern of declining founding rates and heightened disbandings causes the density curve to slow, finally reaching a saturation point in 1991. During that year, 382 self-help/mutual-aid organizations were active in the population. This is the largest number of self-help/mutual-aid organizations active at one time during the 45-year observation period. From the early 1990s through the end of the century, the number of active self-help/mutual-aid organizations begins to decline at about the same rate that it grew. Technically, the number of organizational disbandings outnumbers foundings during the last decade of the 20th century. The reversal of births to deaths of self-help/mutual-aid organizations reflects the positioning (or concentration or dominance) of larger, more durable organizations in the population, a common pattern in long-lived organizational populations (Barron, 1999). I examine this possibility in the final section.

Overall, the shape of these distributions is remarkably similar to those found in commercial, bureaucratic, and other social movement and nonprofit organizational populations. A comparison of the structure of this population to other empirical distributions (e.g., Figure 7.3 in Carroll & Hannan, 2000, p. 156; Figure 2 in Minkoff, 1994, p. 954) demonstrates the consistency of the ecological framework for diverse populations including self-help/mutual aid.

#### SELF-HELP/MUTUAL-AID DIVERSIFICATION

The previous discussion of individual-founding organizations in the self-help/mutual-aid population described a range of enterprises from addiction organizations to those addressing heart disease or mental illness. Diversification

is important in understanding how self-help/mutual-aid organizations fill a variety of functional niches in the population. Prior studies of self-help/mutual aid have been limited to historical accounts of the growth of self-help/mutual aid or case studies focusing on single organizations. Therefore, no systematic research on the distribution of these components of the alternative health and human service sector exists, although the information is readily available. To get a better understanding of how different self-help/mutual-aid subpopulations emerge, I examine the distribution of specialty niches in detail.

During the earliest periods of the history of self-help/mutual aid, there should only be a few founding organizations represented by alcohol or drug addiction groups and groups dealing with families of children who were physically or emotionally ill or handicapped (Katz, 1993). Next, in later periods, the population should diversify to include organizations addressing a wide range of problems and conditions because of continuing gaps in services and because it will be easier to use a form that is already legitimated and increasingly available (Carroll & Hannan, 2000).

Table 1 shows changes in the distribution of self-help/mutual-aid organizations by functional categories during the 45-year observation period. As might be expected, there was extensive growth in the number of different conditions covered by these organizations. The percentages represent the number of active organizations in each category during the selected year. I have sorted the data by prevalence in 1955 and present data for each decade only (rather than year to year) to show the way that niche specialization in self-help/mutual aid blossomed.

In the early years of the population's history, the majority of groups occupied two niches among the 18 different subpopulations: relationship support (23.3%) and alcohol and drug addictions (16.7%). Relationship organizations include those composed of the recently widowed or divorced and 12-step groups serving as support for friends, relatives, family, spouses, and partners of alcoholics, substance abusers, gamblers, and other addicts. Addicts themselves constituted the second most prevalent functional area. Groups addressing functional areas that include mental illness (e.g., Schizophrenics Anonymous, Autism Network International) and those devoted to eye, ear, nose, or throat (e.g., National Retinitis Pigmentosa Foundation) were the third most prevalent functional area, along with groups focusing on problems associated with neurology and paraplegia.

Ten years later, the same rankings in prevalence are observed. At this time, though, self-help/mutual-aid organizations designed to address areas such as status and other addictions have grown. Niches in several new functional areas arose in the 1970s and persist throughout subsequent decades. By the mid-1970s, one surprising pattern has emerged: Alcohol and drug addictions cease to be the second most prevalent functional area. Contrary to popular claims that all areas of social life were being organized under the auspices of addictions from substance abuse to codependency (Kaminer,

**Table 1. Percentage Yearly Active National Self-Help/Mutual-Aid Organizations in Each Subpopulation, 1955 to 2000**

<i>Organizational Subpopulations</i>	1955	1965	1975	1985	1995	2000
Social welfare						
Relationship	23.3	28.0	20.7	15.2	12.3	11.8
Alcohol, drug addiction	16.7	12.0	7.8	6.2	6.4	6.4
Mental illness	13.3	12.0	7.8	5.0	5.8	5.7
Status	3.3	4.0	10.3	11.1	9.7	9.1
Other addictions	3.3	8.0	4.3	4.0	3.3	3.4
Reproduction, children	3.3	2.0	2.6	5.3	4.7	5.5
Physical disability, autism, retardation	3.3	6.0	5.2	6.2	4.7	4.1
Legal	3.3	4.0	1.7	2.8	3.1	3.0
Abuse, violence	0.0	2.0	3.4	4.6	3.3	3.7
Grief	0.0	0.0	5.2	6.8	6.4	6.4
Medical						
Eye, ears, nose throat	13.3	10.0	9.5	6.8	5.6	6.4
Neurology, paraplegia	6.7	6.0	8.6	8.7	9.7	9.8
Respiratory, circulatory, pulmonary	6.7	2.0	1.7	1.5	2.2	1.4
Cancer	3.3	2.0	2.6	2.5	1.4	1.4
Gastroenterology	0.0	2.0	1.7	2.2	3.6	3.0
Disease, infections	0.0	2.0	3.4	3.1	4.5	4.7
Genetics, metabolic growth	0.0	0.0	0.9	4.3	8.6	9.8
Skin, burns, reconstructive surgery	0.0	0.0	2.6	3.7	4.5	4.4
Number of organizations	30	50	116	323	359	296
Organizations (%)	100	100	100	100	100	100

1992), the proportion of organizations devoted to these areas declined from 17% of the total in 1955 to 8% of the total in 1975.<sup>6</sup> Instead, status or identity issues (e.g., gays and lesbians, men in nursing, gender dysphoria, ethnicity) became the second-largest organizing functional area and remained so throughout the next 25 years. Over time, other functional areas emerged as well. Self-help/mutual-aid organizations for disease and infections (e.g., American Hepatitis B Association, HIV Info Exchange, and Support Group) have been around only since the 1980s. Yet by the end of the century, these types of organizations were prevalent.

One way to think about the distribution of organizations in functional areas is to imagine that equilibrium across niche areas would be observed if no functional area represented more than 5.5% of the total self-help/mutual-aid population (100 of 18 areas = 5.5%). Given the actual distribution, we conclude that there are about three or four broad areas (i.e., relationships; status; eye, ears, nose, and throat; disease and infections) that dominate the distribution, whereas the remainder are evenly represented. Some areas, though, have only a few organizations representing them (i.e., mental illness, and skin and burns).

With respect to diversification, an interesting pattern emerges. Initially, 12 of 18 functional areas were covered by self-help/mutual-aid organizations

(not just 1 or 2). Several large fields dominate (i.e., relationship; alcohol and drug addictions; mental illness; eye, ears, nose, and throat). In the next 20 years, all 18 areas were organized. Except for one surprising shift, from alcohol and drug addiction groups to status groups, changes in the distribution of self-help/mutual-aid functional areas were small but consistent in the direction of increasing diversification and equilibrium.

#### SPECIALISTS AND GENERALISTS

The previous discussion of diversification is one way of understanding how organizations take advantage of openings in resource space to exploit a niche. Resource-based frameworks detail the relationship between organizational strategies and organizational viability. In these models, organizations attempt to manage crowding in markets by targeting unique resource segments in an effort to reduce competition when different organizations converge on a single resource or production space (Carroll & Hannan, 2000). By differentiating themselves from potential competitors along a number of formal dimensions, organizations that do not enjoy scale advantages (e.g., usually newer or smaller organizations) can exploit variations in available resource space, even when a market has attained a high degree of concentration. Concentration occurs when a few large (sometimes older), usually generalist, organizations monopolize a market. Consequently, environmental constraints induce organizational heterogeneity rather than homogeneity. Heterogeneity promotes organizational viability because market differentiation reduces competition through development of structures, routines, and practices that allow organizations to cultivate specialty niches.

In the self-help/mutual-aid population, specialists and generalists are evenly distributed overall (48.2% and 51.8%, respectively). But the main interest is how the dynamics of the population unfold over time. Table 2 details the shifting ratio of specialist and generalist self-help/mutual aid within and between subpopulations. I begin by sorting the organizations by prevalence of specialists and generalists in 1955. If resource partitioning takes place, then the generalist populations will contract, whereas specialists will grow. This has implications for who controls self-help/mutual aid because generalist organizations can be driven by interests other than those of members with the focal condition. In fact, self-help/mutual aid displays a marked reversal of resource-partitioning expectations. For self-help/mutual aid, the proportion of specialists dominates generalists until the late 1970s, at which point rising generalists overtake specialists.

What accounts for this reversal? First, social welfare specialists decline markedly from a high of 50% in 1955 to a low of about 35% in 2000. Second, two interesting events parallel this decline in social welfare specialists: The proportion of medical specialist self-help/mutual aid is stable from 1955 to 2000 (at about 10%), but the proportion of medical generalists grows from 20% to about 30%. Not surprisingly, 60% of social welfare self-help/mutual-aid

**Table 2. Percentage Yearly Active National Self-Help/Mutual-Aid Organizations Using Specialist or Generalist Strategy in Each Subpopulation, 1955 to 2000**

<i>Organizational Subpopulations</i>	1955	1965	1975	1985	1995	2000
Social welfare						
Specialist	50.0	54.0	45.7	41.2	34.3	34.5
Generalist	20.0	22.0	23.3	26.0	25.6	24.7
					Variance between years ( <i>F</i> )	41.34***
					Variance between groups ( <i>F</i> )	22.41**
Alcohol and drug addiction	16.7	12.0	5.2	4.3	3.6	4.1
	0.0	0.0	2.6	1.9	2.8	2.4
Relationship	13.3	20.0	12.9	9.3	7.5	6.8
	10.0	8.0	7.8	5.9	4.7	5.1
Mental illness	10.0	8.0	7.8	3.7	2.8	3.0
	3.3	4.0	0.0	1.2	3.1	2.7
Status	3.3	2.0	7.8	6.5	5.6	5.1
	0.0	2.0	2.6	4.6	4.2	4.1
Other addictions	3.3	8.0	3.4	2.5	2.2	2.7
	0.0	0.0	0.9	1.5	1.1	0.7
Reproduction, children	0.0	0.0	0.0	2.5	2.2	3.0
	3.3	2.0	2.6	2.8	2.5	2.4
Abuse, violence	0.0	0.0	0.9	2.2	1.4	1.7
	0.0	0.0	2.6	2.5	1.9	2.0
Grief	0.0	0.0	4.3	4.6	4.2	4.1
	0.0	0.0	0.9	2.2	2.2	2.4
Physical disability, autism, retardation	3.3	2.0	2.6	3.1	2.2	1.7
	0.0	4.0	2.6	3.1	2.5	2.4
Legal	0.0	2.0	0.9	2.5	2.5	2.4
	3.3	2.0	0.9	0.3	0.6	0.7
Medical						
Specialist	10.0	10.0	10.3	7.1	12.0	11.1
Generalist	20.0	14.0	20.7	25.7	28.1	29.7
	4.26 <sup>†</sup>					
	7.30*					
Eye, ears, nose, throat	6.7	6.0	5.2	3.1	3.1	3.0
	6.7	4.0	4.3	3.7	2.5	3.4
Cancer	3.3	2.0	0.9	0.3	0.3	0.3
	0.0	0.0	1.7	2.2	1.1	1.0
Neurology, paraplegia	0.0	0.0	0.9	0.9	0.6	0.3
	6.7	6.0	7.8	7.7	9.2	9.5
Respiratory, circulatory, pulmonary	0.0	0.0	0.0	0.0	0.6	0.0
	6.7	2.0	1.7	1.5	1.7	1.4
Gastroenterology	0.0	2.0	0.9	0.9	1.4	1.7
	0.0	0.0	0.9	1.2	2.2	1.4
Disease, infections	0.0	0.0	0.9	0.3	2.2	2.0
	0.0	2.0	2.6	2.8	2.2	2.7
Genetics, metabolic growth	0.0	0.0	0.0	0.6	2.2	2.4
	0.0	0.0	0.9	3.7	6.4	7.4
Skin, burns, reconstructive surgery	0.0	0.0	1.7	0.9	1.7	1.4
	0.0	0.0	0.9	2.8	2.8	3.0
Number of organizations	30	50	116	323	359	296
Organizations (%)	100	100	100	100	100	100

<sup>†</sup>*p* < .10. \**p* < .05. \*\**p* < .01. \*\*\**p* < .001.

organizations are specialists, and 72% of medical self-help/mutual aid are generalists. Analysis of variance provides further support for these trends. Differences between declining specialist organizations and rising generalists are significant. Analyses of variance in longitudinal trends show that specialists significantly decline, whereas the proportion of generalists grows, except for medical specialists, the proportion of which remains small and unchanging from 1955 through 2000.

Changes within subpopulations underlie these trends. Social welfare specialists in the areas of relationships, alcohol, and drug addiction and mental illness experienced precipitous declines during the history of the population, from double-digit to single-digit proportions. At the same time, medical generalists in neurology or paraplegia, genetics, and skin, burns, or reconstructive surgery experienced gains that contribute to the slow but steady growth of medical generalist organizations.

Although only more case-relevant analysis can uncover factors responsible for this reversal, it is likely that specialists and generalists in this population enjoy different economies of scale that do not correspond to the putative expectations that generalist organizations are necessarily "large generalists" and specialists are small. Pfeffer (1997) notes that in environments with uneven resource distributions, specialists might become larger than generalists, in which case expectations for concentration of large generalist organizations and growth of specialties would be reversed. Analyses to this effect (not shown) indicate that, at least throughout the first three decades of this population's history, self-help/mutual-aid specialists were large relative to generalists. Future analyses will show whether specialist size motivates these anomalous results. Finally, it may be that 45 years is too short a time for generalist competition to yield a high degree of consolidation. I address the possibility in the discussion below.

#### SELF-HELP/MUTUAL AID RESOURCE PARTITIONING

As we have seen, the question of resource partitioning in the self-help/mutual-aid population is not a matter of the dominance of a few large generalists but of how resources (i.e., members) are distributed and concentrated among both specialists and generalists.

Table 3 provides a clearer picture of the extent to which concentration of resources occurs in self-help/mutual-aid populations across several subtypes: specialists and generalists, and social welfare and medical self-help/mutual-aid. Column proportions at selected periods represent market share of membership held by the four largest organizations in each of the indicated categories.<sup>7</sup> For example, the four largest self-help/mutual-aid specialist organizations (i.e., National Amputee Foundation, Taking Off Pounds Sensibly, Alcoholics Anonymous, and Narcotics Anonymous) controlled 85.8% of all population resources in 1955.<sup>8</sup> In contrast, large generalists (i.e., Al-Anon, Mended Hearts, Spinal Cord Injury Foundation, and the International

**Table 3. Specialist and Generalist Concentration: Proportion of Estimated Membership Held by Four Largest Active National Self-Help/Mutual-Aid Organizations in Each Classification, 1955 to 2000**

<i>Organizational Subpopulations</i>	1955	1965	1975	1985	1995	2000
Population shares						
Specialist <sup>a</sup>	85.8	79.2	67.7	59.0	43.4	50.8
Generalist <sup>a</sup>	11.9	9.2	9.2	10.7	19.2	16.4
Total membership	862,628	1,025,003	1,284,390	3,119,058	4,446,574	4,978,553
					Variance between years ( <i>F</i> )	5.77*
					Variance between groups ( <i>F</i> )	33.61**
Social welfare shares						
Specialist <sup>a</sup>	91.8	87.1	80.4	71.3	53.4	61.5
Generalist <sup>a</sup>	6.4	7.7	8.4	10.8	21.9	15.6
Social welfare membership	806,200	931,855	1,050,127	2,580,754	3,613,468	4,112,290
Variance between years ( <i>F</i> )	4.35 <sup>†</sup>					
Variance between groups ( <i>F</i> )	30.64**					
Medical shares						
Specialist <sup>a</sup>	0.2	62.5	53.6	24.6	10.7	8.5
Generalist <sup>a</sup>	99.2	36.5	33.3	31.6	44.4	45.1
Medical membership	56,428	93,148	234,263	538,304	833,106	866,263
Variance between years ( <i>F</i> )	1.27					
Variance between groups ( <i>F</i> )	2.60					
Number of organizations	30	50	116	323	359	296

Note: Market share based on estimates of membership size.

a.  $n = 4$ .

<sup>†</sup> $p < .10$ . \* $p < .05$ . \*\* $p < .01$ .

Association of Larynectomees) held only 11.9% of member resources. Over time, trends reveal an interesting pattern: Market share for specialists declines from 86% to 50% and grows slightly for generalists, from 12% to 16%. The latter is consistent with predictions of a resource-partitioning argument. Large generalists should dominate the sector through market capture. Were we to accidentally sample only medical generalists (last row), we might mistakenly adduce support for resource partitioning: The four largest medical generalists controlled 45% of the market. Yet overall (row 2), the largest self-help/mutual-aid generalists controlled only 16% of the total market. The remainder was distributed mostly among specialists and a few other generalists. This pattern holds among social welfare generalists as well. The largest social welfare generalists captured only 16% of membership resources. As shown in the previous table, social welfare specialists dominate the self-help/mutual-aid sector. Nevertheless, their influence declines over time from 92% of market share to 62%. Because partitioning theory focuses on explaining growth in the specialist population as a consequence of generalist consolidation, it is unclear what kind of competition occurs among specialists and whether specialist concentration follows from it. Specialization by definition seems to preclude concentration because each organization cultivates its own niche. Still, empirical findings in this population

indicate that there are large specialists and that these dominate the market in general and among social welfare organizations. The final section explores reasons why this is so.

## CONCLUSIONS

This study investigated the organizational dynamics underlying the institutionalization of self-help/mutual aid by examining founding and disbanding rates, diversification, and resource partitioning. Although the analyses in this article are exploratory, we learn that organizational ecological models of organizational dynamics are useful for understanding a variety of different kinds of organizational populations, including self-help/mutual aid. Specifically, the shape of growth and decline in self-help/mutual aid is comparable to that of both commercial and other noncommercial populations ranging from newspapers, breweries, and insurance companies to social service agencies and feminist organizations. In addition, by extending the basic tenets of resource partitioning to population-level analyses, we were able to explore the anomaly that arises in most mature industries: How do specialist segments coexist in sectors dominated by a few large (generalist) enterprises? This is important because once we know that the dynamics of diverse industries are comparable (or not), we can test explanatory mechanisms underlying any number of features of a particular system. In this case, although self-help/mutual-aid population dynamics are comparable with commercial, bureaucratic, and social movement organizations, the processes of resource partitioning are considerably dissimilar. Consequently, patterns underlying the latter need to be understood using a framework that distinguishes the nuances of resource use in nonprofit sectors from that in commercial and bureaucratic ones. Some of this work has begun by looking at the organizational-level effects of market differentiation on viability (Archibald, 2004).

Concerning market partitioning in the self-help/mutual-aid population, we found that diversification occurs during the long run, with striking effects on the distribution of organizations throughout the population and subtle, but important, effects on resource partitioning. Analyses of individual firms in studies of the beer industry (Carroll & Swaminathan, 2000) and Dutch newspapers (Boone et al., 2002) show how market share becomes concentrated in the hands of a few of the largest firms (e.g., four enduring breweries end up with 80% market share, rising from just 10%). In contrast, the distribution across self-help/mutual-aid subpopulations and within social welfare and medical self-help/mutual aid suggests that the domains most prominent at the beginning of population's history, relationship, substance abuse, mental illness, and eye, ears, nose, and throat remained so even as other specialty organizations and organizational subpopulations sprang up to form groups addressing additional problems and concerns.

If resource partitioning were to take place in this population in the fashion suggested by most ecological work, then the generalist subpopulations within these functional niches would contract, whereas specialists would grow. In fact, self-help/mutual aid displays a marked reversal in that the proportion of specialists dominates generalists until the late 1970s, at which point rising generalist organizations overtake specialists (as shown in Table 2). Unlike other industries, self-help/mutual-aid generalists begin only later to exercise economies of scale, dominate their competitors (whose failure rate increases), and eventually control large swaths of self-help/mutual aid. One consequence is that organizational membership and ownership of self-help/mutual aid become diluted by broader definitions of who can belong late in the game. What accounts for this finding? As noted previously, it may be that 45 years is too short a time for specialist resurgence, which will come only after self-help/mutual-aid generalists begin to consolidate in the coming decades. It is more likely, though, that the distribution of resources in the environment has important effects (Carroll & Hannan, 2000; Pfeffer, 1997) and that their use is contingent on whether professionals control access. For example, niche-width theory focuses on environmental conditions. Depending on variability of environmental change and the degree of instability in the environment, either specialist or generalist organizations will prevail. The key prediction is that in stable environments (and in unstable, frequently changing, ones) specialists will dominate generalists. This contrasts sharply with organizational contingency theories, which argue that unstable environments always favor generalist organizations. Characterizing the degree of instability (i.e., uncertainty) in self-help/mutual-aid environments and mapping it across subpopulations should help clarify why there is a reversal in the ratio of self-help/mutual-aid specialists to generalists. In addition, the large discrepancy in market share between specialists and generalists and the pattern of generalist dominance in medical subpopulations suggest that environmental variability is critical in structuring these populations. This is an important extension of resource-partitioning theory in that it explores how subpopulations of organizations emerge and control the field as a result of the processes of partitioning in markets.

The next step is to describe the particular socioeconomic, political, and organizational features of these population environments to answer the question of why the distribution shifts in this particular way (e.g., perhaps legitimacy). Because resource partitioning is likely to be an endogenous process, another important question concerns the effects of partitioning on disbanding rates across subpopulations. In all, use of this framework can and does provide valuable insight into the organizational processes affecting the expansion and decline of not just commercial and bureaucratic organizational sectors but those in civil society as well, where a good deal of organizational resources are aimed at and promote social and cultural change.

## Notes

1. In the interest of brevity, for further information about case definition and selection, please contact the author.

2. The issue of organizational control remains complex, even with the extensive criteria used to select the cases from a source such as the *Encyclopedia of Associations*. (Gale Research Company, 1955-2000) As one reviewer points out, Reach for Recovery, for example, began as a member-controlled self-help/mutual-aid group but was later co-opted by medical professionals. The cross-listing in White and Madara (2002) includes Reach for Recovery under breast cancer support, which is consistent with the encyclopedia. However, in White and Madara, there is a note that individual groups only are member owned.

3. For example, organizations include Acoustic Neuroma Association (acoustic neuroma), Adoptee Birthparent Support Network, Adoptees in Search (adoption), Adult Children Anonymous World Service Organization (family and friends of alcoholics), Agoraphobics in Motion (agoraphobia), Aid to Incarcerated Mothers (incarceration), National Depressive and Manic Depressive Association (depression), National Graves Disease Foundation (Graves disease), Sjogren's Syndrome Foundation (Sjogren's syndrome), Voices in Action (incest), We Can Do! (cancer), Wegener's Granulomatosis Support Group (genetic), Women for Sobriety (alcoholism), and Women Helping Women (divorce).

4. I also created a measure that examined service use across membership levels. The idea was to test whether a limited constituency and few service offerings could be used to define specialist self-help/mutual aid, whereas a broad-based constituency with many types of members and many services defined generalist self-help/mutual aid. This measure simply confirmed trends shown with the simpler tool, using membership only, so I retained the latter.

5. Please note that membership figures for voluntary associations are often biased. Trying to capture annual changes is challenging at best. Unfortunately, these are the only data currently available for self-help/mutual aid. I therefore omit cases with questionable and missing data from analyses of market share. In addition, I pick 4 organizations because 4 of 30 organizations is about 10% of the population.

6. This may represent a decline, or it may represent consolidation of the dominance of a few powerful organizations such as Alcoholics Anonymous (AA) and Narcotics Anonymous (NA).

7. These are the largest organizations because they have the most members.

8. Note that AA and Taking Off Pounds Sensibly had the largest share, with about 730,000 members, compared to NA and National Amputee Foundation, with approximately 5,000 members each. In contrast, Al-Anon had 50,000 members, Mended Hearts 24,000, International Association of Larynectomees 24,000, and Spinal Cord Foundation 5,000.

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