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Group Demographics in the Mental Patient Movement: Group Location, Age, and Size as Structural Factors

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ABSTRACT: This paper presents a descriptive overview of the mental patient self-help movement based on a sample of 104 groups. Groups are classified in terms of group structure, group affiliation, and evaluation of psychiatry and are then described in a demographic profile that includes the factors of location, age and size.

After a review of the literature on functional models of selfhelp groups, the mental patient movement is shown to be composed of groups with widely varying political philosophies–from radical "separatist" groups promoting consciousness-raising, empowerment, and social reform to conservative "partnership" groups that emphasize individual reform through "alternative therapy."

The movement is shown to be increasingly dominated by moderate "supportive" groups and, as such, is characterized as a true client-controlled social or "community" alternative to the professionally-controlled medical programs that dominate the mental health system today.

Despite its nearly 20 year history, and its significant growth during the 1980s, the mental patient selfhelp movement has received little attention from the media or the social sciences and, thus, is largely an unknown entity. Although the movement is composed of hundreds of groups that claim to provide serious "alternatives" to the mental health system for thousands of current and former mental patients, very little systematic research has been done on this progressive social movement *as* a social movement. This is surprising in light of the current general interest in the selfhelp movement nationwide (Borman, Borck, & Hess 1982; Leiberman & Borman 1979).

While some research has been done on individual mental patient selfhelp groups, these studies have concentrated on the more traditional and conservative national organizations–groups, like EMO-

TIONS ANONYMOUS, GROW INC., and RECOVERY INC, that adopt some form of the 12-step "anonymous model" (see for example, Sagarin 1969; Lee 1976; and Rappaport and Seidman 1985). This model of selfhelp often includes a religious element in what is basically a conservative orientation toward promoting *individual reform* by means of some type of ideology under the guise of "alternative therapy" (Antze 1979). Virtually no research has been done on the many radical *social reform* selfhelp groups that emphasize consciousness-raising and the empowerment of former mental patients. These groups promote such activities as political and legal advocacy, providing selfhelp information and referrals, and giving technical assistance to prospective selfhelp groups. Accordingly, there is little systematic information available about the *mental patient selfhelp movement* as a broad-based and politically varied social movement of selfhelp groups.

Given the recent interest being shown in "the selfhelp method" by such professional mental health agencies as the Community Support Program, the National Institute of Mental Health, the American Psychiatric Association, and the new national Mental Health Protection and Advocacy Program, general statistical, demographic, and substantive information about this movement is surprisingly lacking and, thus, timely. Basic demographic information about the mental patient movement should also be of interest to the leaders of the various competing movement organizations that are currently working on developing national affiliations of selfhelp groups.

This paper presents a basic descriptive overview of the mental patient selfhelp movement in the form of a statistical profile which typifies movement groups in terms of the demographic factors of location, age, and size (i.e., size of membership, leadership, and budget). These descriptive statistics are presented in a framework of three variables, developed in two earlier papers (Emerick 1988a and 1988b). The variables of group structure, group affiliation, and evaluation of psychiatry reflect structural, political, and philosophical characteristics of mental patient movement groups. Three measures of central tendency—mean, median, and mode—are used to present the demographic data.

FUNCTIONAL MODELS OF SELFHELP GROUPS

Despite the lack of research on the parameters of the mental patient selfhelp movement, a number of students of the broader selfhelp movement have developed some conceptual outlines or models of types of

selfhelp groups which may be useful in organizing our thinking about mental patient groups. These earlier models tend to be elaborations based on *what groups do,* i.e., their functions, rather than *what groups are,* in structural sense. By contrast, the demographic data presented below emphasize structural aspects of mental patient selfhelp groups. Nonetheless, the functional models do provide some insight–basically the only kind of insight currently in the literature–into the nature of selfhelp groups.

Sagarin's "Management of Deviance" Model

Even before the popularity of so-called "selfhelp" groups, sociologist Edward Sagarin (1969) talked about "societies of deviants" as falling into two categories based on how deviants define the stigma-escaping goal of the organization. Sagarin's "management of deviance" model differentiates between groups that allow members to escape from their stigma by either changing the norms of society to include acceptance of their behavior, or by changing themselves in order to be able to conform to the norms of society. In the first case the goal is to change the rules, the rule-makers, or what Sagarin calls the "rule-making order." These "social reform groups" target the object of change as the society, i.e., the social norms and values that relate to the deviance in question. In the second case the goal is to produce change within individuals in order to allow them to conform to the norms and values of society. These "individual reform groups" see the individual as the problem and the appropriate target of change.

Katz and Bender's "Normative" Model

Katz and Bender (1976) make essentially the same distinction as Sagarin by classifying selfhelp groups in general as either "outer-focused groups" or "inner-focused groups." Outer-focused groups target aspects of society for change, while inner-focused groups see the individual as in need of change. Katz and Bender's model identifies most selfhelp groups as part of a national selfhelp "social movement" which, like all social movements, is characterized by the fact that "it seeks to change the social structure or redistribute the power of control within the society."

Accordingly, Katz and Bender go on to elaborate a more specific three-category model of selfhelp groups based on how they relate to change or stability of social norms and cultural values. The categories

include 1) revolutionary groups, 2) anti-establishment groups, and 3) therapeutic groups.

Outer-focused groups (Sagarin's "social reform groups") either *challenge* or *reject* social norms and values. "Revolutionary" selfhelp groups (category 1) *challenge* social norms and values and engage in radical protest and "revolutionary" activities. In the mental patient selfhelp movement this would include groups in the old INTERNATIONAL CONFERENCE FOR HUMAN RIGHTS AND AGAINST PSYCHIATRIC OPPRESSION (FHRAPO) organization, now sometimes referred to as the NETWORK TO ABOLISH PSYCHIATRY (NAP). "Anti-establishment" selfhelp groups (category 2) *reject* social norms and include a) "social advocacy" groups, like welfare and disabled rights organizations and the radical NATIONAL ALLIANCE OF MENTAL PATIENTS (NAMP) as well as the NATIONAL MENTAL HEALTH CONSUMERS ASSOCIATION (NMHCA); and b) "alternative living" groups ("outcast haven" groups or "rock-bottom" groups) like early SYNANON or the OAKLAND CENTER FOR INDEPENDENT LIVING.

Inner-focused "therapeutic" groups (category 3) are comparable to Sagarin's "individual reform groups." These groups tend to *accept* the norms and values of society and focus on providing "self fulfillment" and "personal growth" opportunities that promote individual change. Examples would include the "anonymous" groups like AA and, in the mental health arena, EMOTIONS ANONYMOUS, NEUROTICS ANONYMOUS, and the RECOVERY INC. and GROW INC. organizations.

Gartner and Riesman's "Individual Reform" Service Model

While the first two models are clearly sociological in their theoretical orientation, the model presented by Gartner and Riesman (1977) takes a decisive individualistic and practical slant and emphasizes groups involved in promoting individual change. While Gartner and Riesman mention two types of groups–1) those that provide *direct services* to members and 2) those that provide *indirect services*–they go on to discuss "selfhelp in the human services" which, from their perspective, means "Type I" direct services groups. This includes individual reform oriented selfhelp groups that provide direct services "to both patients and their relatives." Gartner and Riesman thus gloss over the crucial distinction made by ex-mental patient selfhelpers between what are

called "primary" (ex-patient) and "secondary" (relatives and friends) selfhelp groups.

Gartner and Riesman's typology is a classification of individual reform, inner-focused, "therapeutic" groups only. From this perspective, selfhelp groups are only an extension of, or an auxillary to, professional care–what Antze (1979) calls "peer psychotherapy groups." That is, these groups represent an extension of the ideology and therapeutic methods of professional health care providers–the professions of psychiatry, clinical psychology, and psychiatric social work.

Grassroots selfhelpers disdainfully refer to these kinds of groups as "alternative therapy" groups. They argue that these kinds of groups ignore the social, political, and economic implications of the "empowerment" and "consciousness-raising" goals that typify the more socially-oriented grassroots selfhelp groups that are the heart of the mental patient movement.

Zinman's "Social Reform" Service Model

By contrast, Zinman's (1987) model of types of selfhelp groups takes a socio-political orientation in classifying "outer-focused" former mental patient selfhelp groups. This model also presents a practical typology of groups based on the kinds of services provided. Zinman, a long-time activist leader in the mental patient movement, distinguishes between what she calls 1) "political action groups," 2) "independent living groups," 3) "drop-in centers," and 4) "support groups" all of which she considers to be types of social reform groups.

Relating Zinman's scheme to that of Katz and Bender, Zinman's "political action groups" are equivalent to their "revolutionary groups." These groups challenge social norms and values and engage in protest activities directed toward the goal of significant change in the "mental health system" and, sometimes, even avow the Szaszian goal of abolishing psychiatry–at least in institutional and involuntary forms. Zinman's cateogies of independent living groups, drop-in centers, and support groups all fit into Katz and Bender's "anti-establishment groups" category because they tend to reject social norms and values.

The Comprehensive Primary Service (PS) Model

Based on data collected from a sample of mental patient selfhelp groups, we developed a model of types of groups that reflects the entire

range of the conceptual categories in the four models presented above (Emerick 1988c). The comprehensive "primary service" (PS) model includes the whole range of groups, from radical protest and revolutionary advocacy groups on the left to conservative alternative therapy groups on the right. The six categories in the PS model include three types of social reform groups: 1) advocacy-legal groups, 2) information-referral groups, 3) educational-technical assistance groups; and three types of individual reform groups: 4) drop-in centers, 5) support groups, and 6) alternative therapy groups.

In contrast to Zinman's model, we believe that "drop-in centers," and "group support" groups are more organized and directed by the goals of individual reform than social reform. We see these kinds of groups as typically engaged in helping individuals learn to adapt their own values and behavior to be more consistent with the society *as given* rather than promoting social change.

The demographic statistical data on the mental patient selfhelp movement presented below is, to some extent, a descriptive elaboration of the PS model. That is, our quantitative description of the mental patient movement includes the full range of types of groups–from radical social reform groups to conservative individual reform alternative therapy groups.

RESEARCH DESIGN

The Sample: Primary Consumer Ex-Mental Patient Selfhelp Groups

Although the literature indicates that there are thousands of selfhelp groups in this country, the parameters of the population of ex-mental patient selfhelp groups are largely unknown (Gartner & Riesman 1977; Katz & Bender 1976; Borman et al. 1982; Lieberman & Borman 1979). Accordingly, a "snowball sample" of groups was begun by reviewing articles in some forty current newsletters and magazines produced by ex-mental patient groups. By reading through these newsletters and other "movement" literature, a list of ex-mental patient groups located throughout the United States and Canada was developed.

A basic informational questionnaire was mailed out to all groups in the snowball sample. One of the questions asked for the names and addresses of other, comparable or competing mental health selfhelp

groups. Following these leads, the sample of movement groups was further developed with eight separate "waves" of questionnaire mailings.

In analyzing the content of newsletter articles, and after talking with hundreds of members of selfhelp groups, it became apparent that the most important distinction that people in the movement make is between "primary" consumer groups (groups of former mental patients) and "secondary" consumer groups (groups comprised of parents and relatives of mental patients, and sometimes professionals). In general, these two kinds of groups are considered to be antithetical to one another–philosophically, politically, and pragmatically. It was determined that the present research would concentrate on the study of primary consumer mental patient groups, rather than secondary consumer groups.

Another major categorical distinction made by people in the movement is the differentiation between the "grassroots" selfhelp groups, which are considered to be true movement groups, and the "formal" selfhelp organizations. The grassroots groups are seen as developing out of the nearly 20 year history of the movement and from the *bottom up,* although often establishing ties later with other movement groups for mutual support and assistance. The formal groups are seen as organized from the *top down,* emanating as satellite spin-offs from large, well-established, formally-organized and protective national parent organizations that seek to promulgate their "method" of selfhelp. Accordingly, these formal groups are insular in that they remain deliberately somewhat isolated from the larger mental patient selfhelp movement.

Because both the grassroots groups and the formal groups fit the definitional criteria of being primary consumer selfhelp groups, and because representatives of the formal groups do participate, albeit in more tangential ways, in the events and the issue-formation process of the mental patient movement (such as the annual "Alternatives" conferences of mental patient selfhelp groups), it was decided to include both grassroots and formal groups in this study.

The focus of the present research was thus determined to be groups that are: 1) *primary mental health consumer groups* (those composed of ex-mental patients, rather than family members or relatives) and 2) *selfhelp groups* (those claiming to promote mutual peer help, rather than traditional types of psychiatric or psychological therapy groups involving hierarchical therapist-client relationships).

The Questionnaire

The questionnaire is composed of 20 questions designed to elicit basic descriptive and demographic information about the groups. Although the questionnaires were usually filled out by an officer of the group, the strong democratic values promoted in these often anti-psychiatric and always anti-authoritarian groups insured that, in virtually all cases, the questionnaire items and the group's responses to them were issues discussed by a "committee of the whole." In fact, the difficulty of establishing consensus within the group was often cited on the questionnaires as a basis for the group's failure to respond to some of the questionnaire items and for their delay in returning the questionnaire.

A total of 140 groups returned questionnaires. After eliminating 36 questionnaires, because they were incomplete or came from groups that did not meet our criteria for inclusion, the remaining 104 questionnaires constitute the sample of primary consumer mental patient self-help groups for the study.

Obviously, since we have no basis for knowing the extent of the population of such groups, our findings are offered as only suggestive of the nature of the mental patient selfhelp movement.

Data Processing and Analysis

Since this is an exploratory descriptive study of a group whose population parameters are still unknown, the data generated by the questionnaire items are treated as "nonparametric" measures of nominal and ordinal variables. The major statistic used in this study is percentage figures, although the nonparametric "contingency coefficient" measure of correlation (C) and chi square tests of statistical significance are computed for all cross-tabulation tables (see Siegel 1956). In general, the correlations between the variables were found to be not statistically significant. Accordingly, we concentrate on the percentage figures as descriptive data.

THE VARIABLES

The three structural variables in this study are cautiously referred to as "independent" variables in order to indicate that we do not suggest that they literally "come first" in the sense of causal factors which then determine the demographic factors as "dependent" variables. At this

early exploratory stage of the research, we can only say that the "independent" variables are presented "as if" they were independent variables for the purpose of providing a contextual framework for the presentation of demographic information about movement groups.

The Structural Typology of Groups: Group Affiliation and Group Structure

In an earlier paper we briefly traced the history of the mental patient movement and developed a structural typology of groups in the movement today (Emerick 1988a). Mental patient movement groups are characterized in terms of "group affiliation" and "group structure." Both of these variables reflect a radical-to-conservative dimension of group organization.

Group affiliation is the more actor-relevant or subjective category of group classification in that it reflects the popular discourse of people in the movement and the categories they use to identify groups and distinguish between the various political philosophies in the movement. Group affiliation categories include, from most radical to most conservative, two mainline but informal movement affiliations known as 1) the NATIONAL ALLIANCE OF MENTAL PATIENTS (NAMP), and 2) the NATIONAL MENTAL HEALTH CONSUMERS ASSOCIATION (NMHCA). In addition, there are 3) "nonaffiliated" groups, 4) "local" organizations (state- and county-wide affiliations), and 5) formal "national" organizations.

Group structure is a more objective measure of group type in that it is a composite dimension based on the group's type of leadership and type of membership, yielding three categories of group structure. This variable was developed by mental patient activist Judi Chamberlin (1978) although it is not as much a part of the current movement vocabulary as are the categories of group affiliation specified above.

According to Chamberlin's classification, most mental patient self-help groups do not allow professionals to participate in leadership capacities. Those that do are referred to as "partnership groups" and are based on a structural model that theoretically promotes a kind of sharing of leadership responsibilities between professionals and patients-as-partners. Within the client-led groups, there are two different models that reflect type of membership. Groups that reject professionals within the membership—in any capacity—are known as "separatist groups," while those that allow professionals in the membership in auxiliary or advisory roles are called "supportive groups." Thus, the

three categories of group structure are, from most radical to most conservative: 1) separatist, 2) supportive, and 3) partnership.

The Antipsychiatric Orientation: Evaluation of Psychiatry

An additional "independent" variable in this study represents categories of groups based on their general evaluation of psychiatry. Categories of this variable–"evaluation of psychiatry"–are also ordered along a radical-to-conservative continuum, where "radical" means "antipsychiatry" and "conservative" means "pro-psychiatry."

Respondent groups were asked to indicate their evaluation of psychiatry on a five-point Likert-type scale composed of "very positive," "positive," "neutral," "negative" and "very negative" options. "Very positive" and "positive" responses were taken as a basis for classifying a group as "propsychiatry." "Neutral" responses yielded the "neutral" group classification. And "negative" or "very negative" responses led to the classification of a group as "antipsychiatry."

The Demographic Variables and Measures of Central Tendency

These three "independent" variables constitute the framework within which we will sketch a demographic profile of movement groups in terms of their location, age, and size. Three measures of central tendency–mean, median, and mode–will be used to provide the most appropriate interpretation of the demographic data.

THE FINDINGS: LOCATION, AGE, AND SIZE OF THE GROUPS

I. Group Location

The first mental patient selfhelp groups were organized on both coasts, in New York City, Boston, Portland (Oregon), and Vancouver (British Columbia), in 1970 and 1971. Movement groups have since developed across the nation, but they still tend to be concentrated on the two coastlines, particularly along the north Atlantic coast from Boston to Washington, D.C. and in California. Groups also tend to be found in large cities, as opposed to rural areas. Our data speak to the question of group location both in terms of geographical regions and size of the communities in which the groups are located.

1. Mental Health Regions The National Institute of Mental Health divides the nation into ten separate geographical catchment zones or "mental health regions" (see Figure 1a). Figure 1b shows the distribu-

Figure 1a

U.S. Mental Health Regions

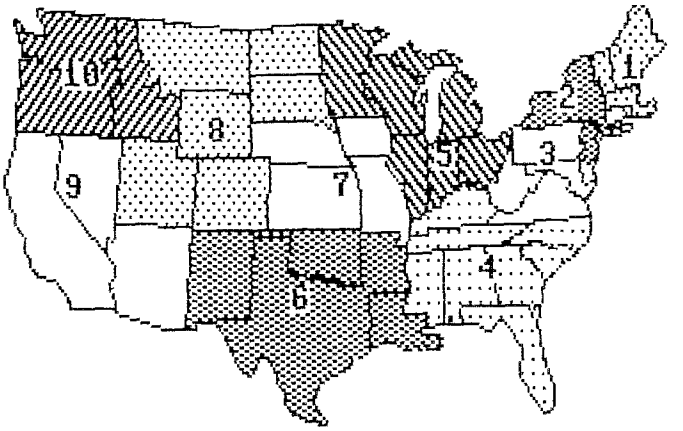
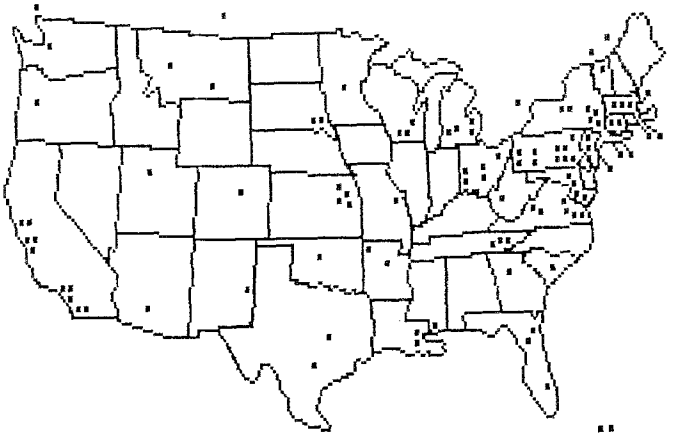


Figure 1b

Distribution of 104 Mental Patient Selfhelp Groups



tion of the 104 mental patient selfhelp groups in the sample throughout these ten regions. Each dot represents one group. There are five groups

located in Canadian cities ranging across the entire U.S.-Canadian border. Also, two groups in the sample are located in Puerto Rico, and are shown by the two dots off the southern tip of Florida. It is apparent in Figure 1b that the largest concentration of groups is in Regions 1, 2, and 3, in the north Atlantic to mid-Atlantic states. There is a secondary concentration of groups in Region 5, the Mid-West, and a third cluster in Region 9, in the southern Pacific zone–particularly in California. There is a comparative absence of movement groups in the central and south central plains states and in the mountain states. Movement groups are clustered on the two coasts and in the upper Mid-West states.

The numerical distribution of groups by region and group structure is presented in Table 1. Clearly the most antipsychiatric separatist groups tend to be concentrated in the more liberal northeastern states (Regions 1, 2, and 3 include 76.4% of the separatist groups) and in California (Region 9 has 17.7% of the separatist groups). In contrast,

Table 1

Group Structure by Region

Region	*Group Structure*							
	Separatist I		*Supportive II*		*Partnership III*		*Total*	
	N	%	N	%	N	%	N	%
1. New England	4	(23.5)	1	(1.5)	4	(18.2)	9	(8.7)
2. N. Atlantic	4	(23.5)	8	(12.3)	3	(13.6)	15	(14.4)
3. Mid-Atlantic	5	(29.4)	12	(18.5)	4	(18.2)	21	(20.2)
4. S. Atlantic	0	(0.0)	8	(12.3)	1	(4.6)	9	(8.7)
5. Mid-West	1	(5.9)	7	(10.8)	5	(22.7)	13	(12.5)
6. S. Central	0	(0.0)	7	(10.8)	1	(4.6)	8	(7.7)
7. Plains	0	(0.0)	4	(6.2)	1	(4.6)	5	(4.8)
8. Mountain	0	(0.0)	5	(7.7)	1	(4.6)	6	(5.8)
9. S. Pacific	3	(17.7)	7	(10.8)	1	(4.6)	11	(10.6)
10. Northwest	0	(0.0)	2	(3.1)	0	(0.0)	2	(1.9)
11. Canada	0	(0.0)	4	(6.2)	1	(4.6)	5	(4.8)
Total	17	(100.0)	65	(100.0)	22	(100.0)	104	(100.0)

Chi square = 26.74; C = .45; $p < .20$.

the distributions of the supportive groups and the partnership groups tend to mirror the overall distribution of the sample, with the exception that the partnership groups are more represented in Region 1 (New England) and Region 5 (Mid-West) than the rest of the sample, while at the same time being under-represented in Region 9 (South Pacific). The supportive groups are very similar, in their regional distribution, to the overall sample distribution. This lends support to our earlier characterization of the politically moderate supportive groups as "the heart of the mental patient movement today" (Emerick 1988b).

When we look at the distribution of groups by region and group affiliation, we find again that the most radical category of group affiliation (NAMP groups) tends to be concentrated in the more liberal areas (Regions 1 and 2 contain 55.5% of the NAMP groups). And once again, the most conservative type of group affiliation, the "national" organizations, generally mirror the sample distribution, except for a lower concentration of groups in Regions 6, 7, and 8, the plains states, and Region 10, the Pacific northwest.

These data lead us to conclude that *the two coastal clusters of movement groups represent the more politically radical groups*–the separatist groups and those in the NATIONAL ALLIANCE OF MENTAL PATIENTS organization. The third cluster of groups in the Mid-West includes a disproportionate number of conservative groups–those structured on the partnership model and those groups that are affiliated with "national" selfhelp organizations.

2. Community Size

The second aspect of group location measured in this study is the size of the communities in which the groups are located. Seven categories of community size were used in the questionnaire. They represent a rural-to-urban continuum from small towns (under 10,000) to large metropolitan areas (one million and over).

Movement groups are generally less frequent in the smaller communities and more frequent in the larger-size communities. Only 3.8% of the sample is located in small towns of under 10,000 population, while almost 30% of the groups are located in the largest metropolitan areas of one million or more populations.

It has often been pointed out that psychiatry is an urban phenomenon, and that the greatest proportion of psychiatrists and psychiatric facilities and activities are located in the five or six largest metropolitan areas in the country. Thus, it is not surprising that mental

patient movement groups, representing an anti-psychiatric movement which began as a reaction against psychiatry, also tend to be concentrated in the largest urban areas.

Our data also show that the most radical separatist groups are most highly concentrated in the largest urban areas. While 56.7% of the sample is located in the three largest community categories representing communities of one-quarter million or more population, 76.5% of the radical separatist groups are located in these larger communities. In contrast, only 40.9% of the most conservative partnership groups are located in these larger cities, while more than one-fourth (27.2%) are found in towns of under 50,000 populations (compared to only 5.9% for separatist groups and 14.4% for the sample).

Looking at community size and the distribution of groups by group affiliation, we see again the general tendency of the more radical groups to be concentrated in the largest communities. Forty-four percent of NAMP groups and 61.6% of NMHCA groups are located in the three largest community size categories (250,000 or more population). In contrast, the most conservative "national" organization groups are disproportionately represented in the smaller and middle-sized communities (50% are in the two smallest categories, under 50,000 and under 10,000 population, compared to 14.4% for the sample).

The largest community size category, Category 7 (1,000,000+), is the modal category for the sample, while Category 5, (250,000–499,999) is the median category. The mean category for the sample is Category 4 (100,000–249,999).

Clearly, the mental patient movement, like psychiatry, is an urban phenomenon. We conclude from our data that *the typical movement group is located in a large metropolitan area of one-quarter million or more population.*

II. Age of Group

The available histories of the mental patient movement are largely insider perspectives written by movement participants (Chamberlin 1978, Lapon 1986, McKinnon 1986, and Zinman *et al.* 1987). These histories promote a common assumption that the oldest movement groups are also the most radical and anti-psychiatric of the groups in the movement and, conversely, that many of the newest groups are significantly more conservative, even pro-psychiatric groups. Data from the present study cause us to question this portrayal of the history of the movement, although there does seem to have been a continuous

movement in the direction of moderation of earlier radical values and goals. The heart of the movement now, in terms of sheer numbers of groups and people, is the moderate supportive groups and the non-affiliated and local affiliation groups (Emerick 1988b).

Groups in the sample were identified in terms of four separate "age of group" categories: 1 to 2 years old, 3 to 5 years, 6 to 10 years, and 11 years and older. While the radical separatist groups are over-represented in Category 4, the 11 + years category (17.6% compared to 13.9% for the sample), they are also over-represented in the two youngest categories of groups (76.4% versus 66.4% for the sample). That is, the most radical separatist groups are not simply the oldest groups in the movement. The most conservative partnership groups are also over-represented in the oldest age of group category (18.2% versus 13.9% for the sample) while only average in representation in the two youngest categories (68.2% versus 66.4% for the sample). The moderate supportive groups are slightly under-represented in the oldest category, Category 4, with only 11.3% compared to 13.9% for the sample, and they are slightly over-represented in Category 3, with 25.8% compared to 19.8%. In general, these moderate supportive groups reflect the age distribution of the total sample. However, the supportive groups, which promote accepting outside or mental health system involvement, including funding of mental patient groups, represent 27 of the 44 youngest groups in the sample (Category 1 groups).

In Table 2 we see that the oldest movement groups are distributed bimodally in terms of group affiliation. That is, 22.2% of the most radical affiliation groups (NAMP) are located in category 4, but also 27.3% of the most conservative "national" organization affiliated groups are found in age Category 4, being 11 or more years old, compared with only 13.9% of the sample.

Thus, it is fair to say that a significant portion of these conservative national groups have been around for as long as have some of the most radical groups. In contrast, the youngest category of affiliations is the NATIONAL MENTAL HEALTH CONSUMERS ASSOCIATION (66.7% in Category 1). This organization is radical, in the sense of being one of the mainline movement affiliations, but is often referred to by activists as the "conservative" organization within the movement. This lends further support to the claim of continuing moderation of the earlier radical abolitionist and anti-psychiatric philosophies of movement groups as time goes by.

Table 2 shows that the modal age category is Category 1 (1 to 2 years),

Table 2

Group Affiliation by Age of Group

Age of Group	*Group Affiliation*											
	NAMP I		*NMHCA II*		*Non-Affil III*		*Local IV*		*National V*		*Total*	
Years	N	%	N	%	N	%	N	%	N	%	N	%
1. 1-2	3	(33.3)	12	(66.7)	16	(45.7)	11	(39.3)	2	(18.2)	44	(43.6)
2. 3-5	2	(22.2)	6	(33.3)	5	(14.3)	7	(25.0)	3	(27.3)	23	(22.8)
3. 6-10	2	(22.2)	0	(0.0)	8	(22.9)	7	(25.0)	3	(27.3)	20	(19.8)
4. 11-	2	(22.2)	0	(0.0)	6	(17.1)	3	(10.7)	3	(27.3)	14	(13.9)
Total	9	(100.0)	18	(100.0)	35	(100.0)	28	(100.0)	11	(100.0)	101	(100.0)

Chi square = 14.58; C = .36; $p < .30$.

with 43.6% of the sample. The median category is the second category (3 to 5 years). The mean category for the sample is near the dividing line between Category 1 and Category 2 (1.98). Thus, our data suggest that *the typical movement group is two or three years old.*

III. Group Size: Budget, Membership, and Leadership Size

The sample of mental patient movement groups is characterized below in terms of three interrelated factors that delineate the size of the groups. These factors are: 1) the size of the group's annual budget, 2) the size of the group's membership, and 3) the size of the group's leadership cohort. These data were initially collected on the questionnaires in "raw" or ungrouped form and later grouped into categories.

1. Raw Data on Budget, Membership, and Leadership Size Table 3 shows the group averages and group totals for movement groups according to group affiliation. *For the total sample of 104 groups, the combined annual budget is $5,454,362, the total number of members is 15,395, and the total number of leaders is 680.* Using only the arithmetic mean as the measure of central tendency, the raw data suggest that *the typical movement group has an annual budget of $52,445.79, an average membership of 148 people, and an average leadership cohort of 6.5 people.*

In Table 3 we see that the most radical groups have small average annual budgets, with the 9 NAMP groups averaging budgets of $26,178 per year. Interestingly, however, the most conservative "national affili-

Table 3a

Group Affiliation by Group Size (Group Averages)

		Group Size		
Group Affiliation	*N*	*Average Annual Budget*	*Average # of Members*	*Average # of Leaders*
NAMP Groups	9	$ 26,177.78	200.89	1.11
NMHCA Groups	18	$ 62,500.00	300.44	5.89
Non-Affiliated	37	$ 57,793.03	67.59	5.62
Local Affiliated	28	$ 66,015.00	90.54	10.43
National Affil.	12	$ 8,916.67	261.92	5.33
Total	104	$ 52,445.79	148.03	6.54

Table 3b

Group Affiliation by Group Size (Group Totals)

		Group Size					
Group Affiliation	*N*	*Combined Annual Budget*	*%*	*Combined # of Members*	*%*	*Combined # of Leaders*	*%*
NAMP Groups	9	$ 235,600.00	(4.3)	1,808	(11.7)	10	(1.5)
NMHCA Groups	18	$ 1,125,000.00	(20.6)	5,408	(35.1)	106	(15.6)
Non-Affiliated	37	$ 2,138,342.00	(39.2)	2,501	(16.3)	208	(30.6)
Local Affiliated	28	$ 1,848,420.00	(33.9)	2,535	(16.5)	292	(42.9)
National Affil.	12	$ 107,000.00	(2.0)	3,143	(20.4)	64	(9.4)
Total	104	$ 5,454,362.00	(100.0)	15,395	(100.0)	680	(100.0)

ate" groups do not have the largest annual budgets, operating on an average of only $8,917 a year with a large average membership of 262 people per group!

The size of these groups, in terms of number of members, reflects a combination of their longevity and their strong national organizational support. The small budgets, relative to the large memberships, may be possible because these satellite groups are dependent upon the national organizations for financial as well as other kinds of assistance.

The largest annual budgets are found in the politically central, moderate NATIONAL MENTAL HEALTH CONSUMERS ASSOCIATION groups ($62,5000), the non-affiliated groups ($57,793), and the local affiliated groups ($66,015).

It is interesting to note that the nonaffiliated groups have annual budgets almost as large as the formally affiliated local groups and the more informal NMHCA affiliation groups. This suggests that something other than the lure of lucrative budgets will have to be used to attract the non-affiliated groups to the idea of organizational affiliation. One might guess that access to information and social support from organizational affiliates may be more appropriate "carrots" to lure the nonaffiliated groups into affiliation within the mental patient movement. On the other hand, our earlier report on this study (Emerick 1988a) points out that 11 of the 37 nonaffiliated groups are also partnership groups, i.e., those conservative and psychiatrically-run groups that are disproportionately well-financed. Leaders of the two major informal affiliations of mental patient groups–NAMP and HMNCA– would be well-advised to ignore these partnership nonaffiliated groups in their organizing efforts.

Looking at the size of groups in terms of the variable of group structure, we find that the budget, membership, and leadership figures are significantly smaller for the most radical category of separatist groups than they are for other types of groups. Here the average annual group budget is only $15,729.41, the average group membership is 83 people, and the average number of leaders per group is 2.7. The next largest annual budget is a major jump up to $31,737.88 for the moderate supportive groups–twice the size of the average budget for separatist groups. This suggests that the acceptance of the "supportive" organizational model opens up the membership and makes for a significant difference in the size and, thus perhaps, the stability and longevity of the group. The supportive groups' average membership size is 147 people, again nearly twice the average membership of the separatist groups.

Not surprisingly, the most conservative and pro-psychiatry "partnership" groups have average annual budgets that are nearly four and one-half times the size of the largest client-run group budgets ($142,000 for partnership groups versus $31,738 for supportive groups) and more than nine times the average budget of the separatist groups ($142,000 versus $15,729).

Factors of group size also vary interestingly in terms of the ways in which groups evaluate psychiatry–pro-psychiatry, neutral, and anti-psychiatry. Contrary to any reasonable prediction, the 23 pro-psychiatry groups have by far the smallest annual budgets ($12,978). The fact that these groups have fairly large memberships (143) and the fewest number of leaders per group (4.74) is not surprising. While they represent nearly one-fourth of the groups in the sample, the pro-psychiatry groups control only 6.4% of the combined annual budget and 18.9% of the leadership!

It is the psychiatrically "neutral" groups that are disproportionately large. These 29 groups, which are neither pro- nor anti-psychiatry, constitute 27.9% of the groups in the sample but control nearly 60% of the budget (with average annual budgets of $91,365) and 42% of the members (average membership is 167). They have 35% of the leadership cohort in the sample. One possible explanation is again the growth of moderation in the movement and the rewards accruing to this moderation in the form of grants, funding, and public relations benefits leading to increased memberships and budgets.

The anti-psychiatry groups represent about 43% of the sample and account for 37.1% of the combined budget, 29.5% of the combined membership, and 45.8% of the combined leadership in the sample–figures which are consistent with their relative size in the sample.

2. Grouped Data on Budget Size We also evaluated the size of annual budgets using grouped data cross-tabulated with categories of group structure. In general, the more radical separatist groups are clustered in the smaller budget categories, while the most conservative partnership groups are over-represented in the largest budget categories.

Using nine categories of budget size, from 0 to $1,000,000+, we found that both the modal and the median group budgets are located in Category 5–$10,000 to $50,000 per year. This suggests that *the typical movement groups has an annual budget of about $30,000*–the centerpoint of the range in Category 5. Although the arithmetic mean for budget size in the sample is $52,446 (Table 3), the mean budget for the

82 client-run (separatist and supportive) groups is only $28,419. The accuracy of the $30,000 figure as an approximation of the typical movement group budget is supported by the modal and median figures and thus, we believe, is a more reasonable estimate of budget size.

Very few groups have budgets greater than $150,000 per year (6 groups, or 5.8% of the groups in the sample) and 3 of these groups are the most conservative partnership groups, including the only group in the one million dollar or more category. Twelve groups (11.5% of the sample) have no budget at all.

3. Grouped Data on Membership Size We grouped the membership size data into six categories, from 1-15 to 2001+ members. Despite the fact that the average (mean) membership size is 148 people (Table 3), most of the groups in the sample (78 groups or 75%) are located in the first three categories of membership size (200 or fewer members), with 64 groups (61.5%) in the first two categories (28.8% are in the 1 to 15 member Category 1 and 32.7% are in the 16 to 50 member Category 2). In fact, the modal membership category is Category 2 (16 to 50 members), and the median category is also Category 2. The unusually large mean membership figure of 148 people per group is unduly influenced by the fact that four groups (3.8% of the sample) have very large memberships (more than 500), with one group having more than 2,000 members. Putting more reliance on the mode and median measures of central tendency, we suggest that *the typical movement group has about 33 members in it*—the centerpoint of the range in Category 2.

4. Grouped Data on Leadership Size We grouped the leadership size data into seven categories, from 0 to 51+ leaders. By looking at the grouped data we see again that a small number of very large groups has unduly influenced the mean estimate of leadership size, shown in Table 3 as 6.5 leaders per group. The grouped data illustrate that most of the sample (91.9%) are located in the first five leadership size categories, with nearly 78% of the sample in the first four categories—10 or fewer leaders per group. The modal leadership category is Category 3 (2 to 5 leaders), with 35 groups (33.7%); and the sample median also falls in Category 3. Accordingly, we conclude that *the typical movement group has 3 or 4 leaders,* (the centerpoint of the range in Category 3) rather than the 6.5 leaders suggested by the mean calculation.

SUMMARY AND DISCUSSION

Data presented in this paper allow us to summarize the mental patient movement by describing a demographic profile for the statistically "typical group" as follows: *The typical movement group is located in a large metropolitan area of one-quarter million or more population. The typical group is two or three years old. It operates on an annual budget of about $30,000, has a membership composed of approximately 33 people, and a leadership cohort of 3 or 4 people.* We also found a concentration of movement groups in three clusters–one on the East coast, one on the West coast, and one in the upper Mid-west.

Speaking more broadly, in terms of types of groups, our data show that the typical movement group is structurally organized on the "supportive" model, which allows professionals in supportive or advisory roles. In this sense, the typical group is relatively moderate in its political philosophy and its structure, although more likely to be engaged in social reform activities than the individual reform functions of the more conservative groups. The typical group is either non-affiliated or, if affiliated, belongs to a moderate "local" organization or the more informal moderate-to-conservative NATIONAL MENTAL HEALTH CONSUMERS ASSOCIATION. Finally, the typical movement group takes a "neutral" position on evaluating psychiatry as a profession–further evidencing the trend of moderation in the mental patient movement today.

The typical mental patient movement group is a primary consumer-run grassroots (and thus social reform oriented) selfhelp group, rather than one of the partnership groups or one of the formal national organization groups which tend to promote individual reform "alternative therapy" activities. The typical group today, although generally "anti-psychiatric" in its political philosophy, nonetheless shys away from the most radical separatist and abolitionist philosophies that were popular during the genesis of the movement in the early 1970s. Groups seem to prefer the "empowering" and "consciousness-raising" social benefits derived from participation in the broad-based informal selfhelp/mental health consumer networks that are developing throughout the nation.

We believe that, with the increasing movement toward moderation in the philosophies of mental patient groups, this movement may well become accepted as a serious alternative or auxillary to the professional mental health system. Certainly, the mental patient movement represents one of the few truly social or "community" approaches to mental and emotional problems in the "transfer of care" aftermath following

the deinstitutionalization of large state mental hospitals over the past two decades (Brown 1985). And the movement has clearly proven itself, at least in terms of its longevity in paralleling the entire history of the community psychiatry movement in this country.

If selfhelp, networking, and the multiple options of consumerism are truly the "megatrends" of the future (Naisbitt 1982), then all that remains to secure the legitimacy of the mental patient selfhelp movement is the verification of the efficacy of the selfhelp method as practiced in these groups. We suspect that, compared with the failure of professionally-controlled "community psychiatry" programs nationwide (Bloom 1973; Kirk and Therrien 1975) and the 120 year old experiment in dealing with madness as a strictly biological disorder, the relative benefits of a truly social and political approach such as selfhelp will not be difficult to substantiate. At that point, the "ultimate civil rights movement" will be able to turn its attention away from fighting the stigma of "mentalism," and "the mental health of the country" will be on the road to significant improvement. We hope that the information provided in this paper contributes to an understanding of these developments.

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