

Characteristics and Motives of Problem Drinkers Seeking Help From Moderation Management Self-Help Groups

Elena Klaw, *Center for Health Care Evaluation, Veterans Affairs, and Stanford University Medical Centers, Palo Alto, and San Jose State University*

Shira Luft and Keith Humphreys, *Center for Health Care Evaluation, Veterans Affairs, and Stanford University Medical Centers, Palo Alto*

Moderation Management (MM) is a relatively new self-help/mutual aid organization that adopts a cognitive-behavioral conceptualization of alcohol abuse. Specifically, MM construes problem drinking as a habit that can be brought under control through the application of cognitive-behavioral principles in the context of a network of supportive peers. MM therefore serves as an alternative to the spiritually oriented disease model of Alcoholics Anonymous (AA), as well as to the abstinence goal orientation of AA and other self-help organizations (e.g., Women for Sobriety and SMART Recovery). To provide cognitive-behavioral therapists and researchers more information about MM, this paper describes the MM organization and presents survey data on the characteristics and help-seeking motives of 467 individuals who contacted the organization by telephone over a 1-year period. Callers to MM's national telephone number had significantly less severe drinking problems and greater educational and economic resources than typical help-seeking populations of alcohol-dependent persons (e.g., AA members). Study participants, particularly women, typically experienced MM as a better "fit" with their drinking problem, life experiences, and valuation of personal mastery than disease-model, abstinence-based approaches. Although the organization has never been subjected to a controlled outcome study, cross-sectional data indicate that MM members appear to reduce their level of alcohol-related harm over time. Cognitive-behavioral treatment professionals working with nondependent problem drinkers may thus wish to consider referring clients to MM.

ALCOHOL DEPENDENCE has long been recognized as a prevalent and serious disorder (American Psychiatric Association, 1994), but the large majority of alcohol-related problems in the U.S. (e.g., auto accidents) actually result from maladaptive drinking patterns among nondependent individuals (Sobell, Cunningham, & Sobell, 1996). Such "problem drinkers" outnumber alcohol-dependent persons by about 4 to 1, and typically do not experience the extensive consumption, physical symptoms, and functional impairment commonly associated with alcohol dependence (Babor, 1994; Institute of Medicine, 1990). In the professional health care system and within the grassroots self-help group movement, attention to the needs of problem drinkers has been uncommon (Humphreys & Tucker, 2002). Perhaps as a result, problem drinkers are less likely to access such sources of help (Cahalan, 1987). However, in 1994 the first self-help group resource for such individuals was founded and, drawing heavily upon the work of cognitive-behavioral research and theory (e.g., Sanchez-Craig, Wilkinson, & Davila, 1995), has been attracting problem drinkers. The purpose of this paper is to familiarize cognitive-behavioral therapists

with this new organization—Moderation Management—and provide data on the characteristics of individuals who seek help from it.

Moderation Management (MM) was founded by people with alcohol problems as the first alcohol mutual-help organization to specifically focus on nondependent problem drinkers. MM's program assumes that many problem drinkers may be able to return to moderate, nonproblem drinking. MM rejects the disease model and holds that spiritual change is not necessary in the recovery process. In place of a spiritual approach, the organization attempts to help problem drinkers manage their drinking as a habit disorder using social support and cognitive-behavioral principles. It includes a nine-step professionally reviewed program, which provides information about alcohol, moderate drinking guidelines and limits, drink-monitoring exercises, goal-setting techniques, and self-management strategies. Furthermore, MM encourages individuals to accept personal responsibility for choosing and maintaining their own approach to recovery, whether moderation or abstinence is their ultimate goal. In this vein, the MM approach stresses that self-esteem and self-management are essential to recovering from learned problems regarding alcohol use. These characteristics make MM quite different from Alcoholics Anonymous (AA) and many professional treatment programs and therefore controversial in some quarters.

Cognitive and Behavioral Practice 10, 384–389, 2003

1077-7229/03/384-389\$1.00/0

Copyright © 2003 by Association for Advancement of Behavior Therapy. All rights of reproduction in any form reserved.

MM's literature does not oppose spiritually based or abstinence-based self-help organizations and treatments, per se, but does argue that such interventions are not appropriate for many problem drinkers. At the same time, like the founders of AA, MM's founders recognize that severely dependent drinkers should not attempt to become moderate drinkers (Rotgers & Kishline, 2000). This strategy is consistent with evidence that more alcohol dependent individuals are less likely to return to moderate drinking (Rosenberg, 1993). To help screen out individuals for whom MM is inappropriate, MM advocates a 30-day trial period of abstinence before determining whether one can drink within the moderate limits provided. For those who successfully complete 30 days of abstinence, MM provides the following guidelines for moderate drinking: Abstain from drinking at least 3 or 4 days a week, consume no more than 3 drinks in a day and 9 per week if female, and no more than 4 drinks in a day and 14 per week if male. Although no systematic data are available, MM's board of directors estimates that approximately a third of its participants use the 30-day "trial period" of abstaining as a stepping stone to accessing an abstinence-based program. Thus, MM attempts to serve a secondary preventive function for individuals who are becoming alcohol dependent as well as to provide ongoing support for individuals with less severe problem drinking.

The MM organization comprises about 20 face-to-face groups across the United States and Canada as well as multiple Internet-based forums, including an international electronic discussion group with approximately 250 members. MM also operates a national information and referral telephone line. MM groups are founded and led by volunteers, some of whom are mental health professionals. All MM participants are encouraged to read Audrey Kishline's¹ (1994) book *Moderate Drinking* as a first step in addressing their substance use. As with other mutual-help organizations, participation in meetings and on-line discussions is considered voluntary, and there is no charge for any form of participation, save small "pass the hat" contributions.

Group meetings usually occur weekly or biweekly and follow the suggested meeting guidelines delineated on MM's Web site (www.moderation.org). In general, meetings are open to all who wish to attend and a tradition of confidentiality is observed. On average, meetings contain between 3 and 15 participants. During the meeting, specific time is allotted to congratulate individuals who have successfully completed a 30-day period of abstinence. Un-

like in AA, "cross talk" is allowed and is integral to the meeting format. Throughout the meeting, individuals provide each other with strategies for moderating alcohol consumption (e.g., alternating alcoholic drinks with nonalcoholic drinks). Individuals also discuss arenas of their lives outside of drinking in which they would like to adopt more moderate and healthy behavioral decisions (e.g., eating, smoking, exercise, coffee drinking).

MM is similar in philosophy to Self-Management and Recovery Training (SMART), an abstinence-based, non-profit organization that provides self-help for people having problems with drinking. SMART views excessive drinking as a self-destructive behavior and uses the principles of rational emotive behavior therapy (REBT) to help individuals cope with the beliefs and emotions that undergird alcohol abuse. SMART offers support group meetings designed to provide education focused on changing drinking behavior. Rational Recovery (RR), another abstinence-based self-help program, shares a similar cognitive-behavioral approach to SMART in the management of drinking as a learned behavior. According to RR, thoughts and feelings that support continued alcohol use can be seen as one's "addictive voice." In contrast, thoughts and feelings that support abstinence are understood as the true self. RR claims that if one recognizes one's addictive voice, one can "defeat" this voice and gain mastery over drinking. Through their Web site, RR provides an electronic "crash course" on the Addictive Voice Recovery Training (AVRT) Technique. According to RR, the crash course on AVRT that is offered through their Web site provides sufficient training for some individuals to fully recover from addiction to alcohol or drugs.

Women for Sobriety (WFS), another abstinence-based self-help program, differs from such groups as MM, RR, and SMART in that, like AA, it uses the designation "alcoholic" and employs a step-based approach to recovery. WFS is distinct from AA and the alternatives discussed in that it focuses solely on the unique needs of women drinkers. Their 13-step "New Life" program emphasizes positive beliefs about the self, emotional and spiritual growth, and women's inherent power to learn to adopt a nondrinking lifestyle. WFS offers self-help groups throughout the world.

In the context of these AA alternatives, MM appears to occupy a unique niche. Even though there are other alcohol self-help organizations that try to serve as an alternative to AA (see Horvath, 2000, on SMART; Galanter, Egelko, & Edwards, 1993, on RR; and Kaskutas, 1994, on WFS). MM may be able to attract a unique population interested in moderation as a goal. Support for moderation as a viable option is unique to the MM program.

Research suggests that individuals with greater socioeconomic status, educational attainment, and social and personal resources are more likely to address drinking problems before they experience severe functional impair-

¹ Kishline, MM's primary founder, eventually left MM and began pursuing an abstinence goal in AA. She relapsed 8 months later and killed two individuals in an auto accident while intoxicated. This tragedy led to a storm of controversy in the United States about MM, AA, and alcohol problems that, in many respects, paralleled the controlled drinking debates of the 1970s (Humphreys, 2003).

ment (Humphreys, Moos, & Finney, 1995). This early recognition, combined with intact economic and social resources, seems to enable such individuals to taper their alcohol use down to a moderate, safe level without the aid of abstinence-oriented interventions. MM hopes to appeal to such individuals, namely problem drinkers who experience negative consequences as a result of drinking but do not exhibit severe functional impairment or physical dependence.

Although research has examined such AA alternatives as RR and WFS (Galanter et al., 1993; Kaskutas, 1994), the present study is part of the first research program focused on MM. Prior studies from this project have presented qualitative analyses of the life stories of MM members (Klaw & Humphreys, 2000), analyzed the content and nature of communication in MM's on-line self-help group (Klaw, Huebsch, & Humphreys, 2000), and contrasted members of on-line versus face-to-face MM groups (Humphreys & Klaw, 2001). In this paper, we describe the characteristics of those who telephone the MM information and referral line, examining the drinking problems, help-seeking motives, demographics, and belief systems of individuals who choose MM to cope with alcohol use problems.

Method

Sample

Participants were 445 problem drinkers (52.6% female, 95% Caucasian) who telephoned MM's national information and referral line. Callers to the MM information line possessed significantly higher levels of employment and education compared to the majority of individuals in addiction self-help groups (Kessler, Mickelson, & Zhao, 1997). Eighty-seven percent of the 443 participants who provided responses were currently employed (full-time students, homemakers, and retired persons were coded as unemployed). Eighty-two percent of the current sample had received a college degree, and 52% had received graduate or professional school training. In light of their high level of education, it is not surprising that most callers learned about MM through the MM World Wide Web site (30.8%), the MM Guidebook (27%), or a newspaper or magazine article describing MM (23.4%).

Procedures

Surveys of callers to MM's information and referral line. Over the course of 1 year, surveys were administered by the first author to individuals telephoning the MM information and referral line. The survey measured *alcohol dependence symptoms* using 5 items from the Alcohol Dependence Scale (response range from 0 = *never* to 4 = *often*; alpha = .84; Skinner & Allen, 1982). *Alcohol-related problems* (response range from 0 = *never* to 4 = *often*; alpha = .79) were assessed using a 9-item scale from the Health and

Daily Living Form (Moos, Cronkite, Billings, & Finney, 1990) in which participants rated how often they had experienced drinking-related problems within various life domains such as health, work, and family. Respondents also reported how many *days per month they were drunk or intoxicated*, and rated the *perceived severity of their drinking problem* on a scale ranging from 1 (*no problem*) to 5 (*serious problem*).

Frequency and typical amount of alcohol consumption was assessed using two items from the Alcohol Use Disorders Identification Test (Babor, de la Fuente, Saunders, & Grant, 1992). In addition, supplemental questions assessed participants' demographic characteristics, how they learned about MM, their use of psychiatric medications and illicit drugs, and whether they had participated in alcohol-related treatment or AA.

Participants also were asked an open-ended question: "How do you think MM will help you to moderate your drinking?" If the participant had difficulty responding to this question, she or he was provided with the prompt, "Most people who have called have already tried to stop/reduce their drinking. What do you hope to get out of MM that you haven't gotten already?" All individuals calling out of personal interest in MM were asked to complete the survey (i.e., significant others of problem drinkers and students and treatment professionals interested in learning more about MM were not surveyed). Over a 1-year period, 531 problem drinkers telephoned the information and referral line at least once, 467 (88%) of whom consented to the survey. Twenty-two of the individuals completing the survey declined to answer the open-ended question (hence, $n = 445$ for this question), typically because they were calling from their workplace and lacked the privacy to answer. Employing a grounded theory approach to qualitative data, content analysis was used to code the responses to the open-ended questions and derive thematic categories that summarized the responses.

Results

Alcohol Problems and Help-Seeking History

With regard to frequency of alcohol consumption, 55% of respondents reported drinking 4 or more times a week, 24% reported drinking 2 to 3 times a week, 9% reported drinking 2 to 4 times a month, 1% noted drinking monthly or less, and 11% of the sample was currently abstaining. On typical drinking days, 44% consumed 5 or more drinks, and 14% reported drinking 7 or more. Only 14% of respondents reported that they had had a craving for a drink when they first woke up in the morning.

The average caller reported only 1.2 alcohol dependence symptoms, 2.1 alcohol-related problems, 4.8 days intoxicated per month, and perceived severity of drinking score of 3.1. In comparison, Timko and colleagues (1993) found that new AA members averaged 11.3 alcohol

dependence symptoms, 10.4 alcohol-related problems, 12.8 days intoxicated in the past month, and 4.3 on perceived severity of drinking.

In terms of specific alcohol dependence symptoms, 48.3% of MM callers had experienced blackouts in the last 6 months, 37.8% had gotten physically sick, and 22.5% had experienced "shakes." In contrast, only 13.9% of callers had craved a morning drink, and only 1.8% of people experienced hallucinations.

Notably, 62% of the callers had attended at least one AA meeting prior to telephoning MM. Twenty-seven percent had received professional treatment for alcohol problems and 31% were currently taking psychiatric medication for either depression or anxiety. A small percentage (5.6%) had experienced health, family, work, or legal problems in the past 6 months as a result of using drugs such as marijuana or cocaine.

Reasons Provided for Interest in MM

Five basic themes were identified in the reasons callers provided for pursuing involvement with MM. These themes encompassed all but six of the responses to the open-ended question included in the telephone survey (excluding individuals who answered "I don't know" or "I want to check it out").

Representing the most common response, approximately 40% of callers expressed the hope that participation in MM would enable them to drink moderately. Both callers who had experienced periods of abstinence (13%) and those who had never successfully limited their drinking noted that MM provided a unique set of guidelines for handling alcohol use. An example of this type of response was:

"I'm hoping it's going to give me the tools to control the drinking without complete abstinence . . . physical or psychological tools to not give in to temptation." (female)

Twenty-eight percent of callers noted their interest in MM was based on a desire for support in the quest to cease abusing alcohol. Interestingly, 33% of women expressed a need for support compared with only 23% of men ($\chi^2 = 5.56, p < .05$). This was the only gender difference found in the types of responses provided. An example of this type of response was:

"I think going to a mental health professional is good, but a support group of peers is more supportive; where we are all rooting for each other and you don't need to make an appointment. As a semiprofessional in the field, I believe self-help groups are valuable. I'm best with others." (female)

Similarly, a full quarter of respondents expressed the hope that participation in MM would enable them to

address health and coping difficulties linked to their alcohol use. For example, a male respondent indicated the following:

"My drinking is a problem when I'm alone. . . . I think I'm medicating myself to deal with the pain and uncertainty about the future and lack of close relationships."

Framing their interest in more positive terms, 23% of callers noted that they gained an increased sense of personal control by choosing to pursue involvement in MM. An example of this type of response was:

"I believe there is power in the mind, attitude, practice, and discipline that I have been careless about. Assuming responsibility is important. I have two options—practice responsibility or choose abstinence." (male)

The smallest group of respondents, constituting 20% of callers, mentioned that their interest in MM was based on their view of MM as different from other treatment approaches. These callers tended to contrast MM with AA and note features that they disliked about AA. Two examples of this type of response were:

"I've been involved in the AA movement and I find that it has been hard to relate to the members and the philosophy and how things are run. The continuous message is very negative and degrading." (male)

"I have tried AA but didn't want that label and didn't identify with people who have severe, chronic problems." (female)

Discussion

MM is a self-help organization that is primarily accessed by individuals whose heavy alcohol consumption has not caused physical dependence symptoms or severe life disruption. Like other alternatives to AA (e.g., see Galanter et al., 1993, on RR), the population drawn to MM is well educated and has significant economic and social resources. A plurality (40%) of individuals contacting MM hoped that participation would enable them to drink moderately. Interestingly, 14% of callers had engaged in periods of abstinence prior to calling MM, and over 60% had gone to at least one AA meeting. These individuals, in particular, hoped that MM could help them have a more normative relationship to alcohol. The other reasons cited for pursuing involvement with MM (endorsed by 20% to 28% of callers) included desires for interpersonal support, help with psychological and interpersonal problems, greater personal control, and an alternative to AA.

Consistent with MM's stated purpose, the results of this study suggest that the MM approach may be especially

appealing to individuals who do not experience physical dependence symptoms, and to individuals who have recognized their drinking as problematic early and wish to prevent progression of the problem. MM's program may also be useful in self-diagnosis to alcohol abusers in that those who are unable to complete its 30-day abstinence period and adhere to its subsequent drinking guidelines may realize that their problems are more severe than initially thought. Because MM, like AA, accepts that there is a genuine difference between problem drinking and alcohol dependence, members would see no contradiction in encouraging such an individual to seek help from SMART, RR, or AA.

The high proportion of women among callers to MM's telephone line (52.6%) provides further evidence of its unique appeal to female drinkers. Women also compose the vast majority of individuals who post messages to MM's on-line support group (Klaw et al., 2000). As women tend to have less severe alcohol problems than do men, MM's approach may represent a particularly attractive source of help to them.

In sum, both clinical experience and research findings reveal significant diversity within individuals who abuse alcohol (e.g., Institute of Medicine, 1990; Tucker, Donovan & Marlatt, 1999). MM represents a cost-free alternative for nondependent persons seeking a cognitive-behavioral approach to managing alcohol use. Further research is needed to determine what types of interventions best serve the distinct types of alcohol abusers and how to provide the most appropriate resources to individuals at different stages in the process of alcohol abuse and recovery. Clinicians can expand the range of patients that they assist by increasing their familiarity with the myriad of options that exist for addressing substance-related concerns. In addition to books and continuing education programs, the Internet can be a useful resource in this regard. Programs such as MM (www.moderation.org), AA (<http://www.alcoholics-anonymous.org/>), SMART (<http://www.smartrecovery.org/smart.htm>), Rational Recovery (<http://www.rational.org>), and WFS (<http://www.womenforsobriety.org/>) provide extensive information about their organizations on their Web sites. In addition, MM, SMART, RR, WFS, and AA all provide Internet discussion forums for individuals who wish to learn more about their approach and/or apply its principles.

Of course, the current study only reveals MM's nature and who it attracts, not whether it is effective. Further research is needed to assess substance-use-related outcomes associated with MM participation. Longitudinal investigations that compare the outcomes of MM members to those of members of other self-help organizations such as AA and WFS will be particularly valuable in identifying the distinct effects of each program over time.

Although the organization has never been subjected

to a controlled outcome study, cross-sectional data indicate that MM members appear to reduce their level of alcohol-related harm over time (Klaw, Stewart, Horst, & Humphreys, 2002). Cognitive-behavioral treatment professionals working with nondependent problem drinkers may thus wish to consider referring patients to MM. Clinicians who refer patients for concurrent MM involvement at this time should monitor its impact closely and will, we hope, disseminate their observations to the treatment community.

References

- American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders*. Washington, DC: Author.
- Babor, T. F. (1994). Avoiding the horrid and beastly sin of drunkenness: Does dissuasion make a difference? *Journal of Consulting and Clinical Psychology*, *62*, 1127-1140.
- Babor, T. F., de la Fuente, J. R., Saunders, J., & Grant, M. (1992). *AUDIT: The Alcohol Use Disorders Identification Test: Guidelines for use in primary health care*. Geneva: World Health Organization.
- Babor, T. F., de la Fuente, J. R., Saunders, J., & Grant, M. (1995). The Alcohol Use Disorders Identification Test (AUDIT): Validation of a screening instrument for use in medical settings. *Journal of Studies on Alcohol*, *56*, 423-432.
- Cahalan, D. (1987). Studying drinking problems rather than alcoholism. In M. Galanter (Ed.), *Recent developments in alcoholism*. New York: Plenum.
- Galanter, M., Egelko, S., & Edwards, H. (1993). Rational Recovery: Alternative to AA for addiction? *American Journal of Drug and Alcohol Abuse*, *19*, 499-510.
- Horvath, A. (2000). SMART Recovery. *International Journal of Self Help and Self-Care*, *2*, 163-169.
- Humphreys, K. (2003). *Circles of recovery: Self-help organizations for addictions*. Cambridge: Cambridge University Press.
- Humphreys, K., & Klaw, E. (2001). Can targeting non-dependent problem drinkers and providing internet-based services expand access to assistance for alcohol problems? A study of the Moderation Management self-help/mutual aid organization. *Journal of Studies on Alcohol*, *62*, 528-532.
- Humphreys, K., Moos, R. H., & Finney, J. W. (1995). Two pathways out of drinking problems without professional treatment. *Addictive Behaviors*, *20*, 427-441.
- Humphreys, K., & Tucker, J. (2002). Towards more responsive and effective intervention systems for alcohol-related problems. *Addiction*, *97*, 126-132.
- Institute of Medicine. (1990). *Broadening the base of treatment for alcohol problems*. Washington, DC: National Academy Press.
- Kaskutas, L. A. (1994). What do women get out of self help? Their reasons for attending Women for Sobriety and Alcoholics Anonymous. *Journal of Substance Abuse Treatment*, *11*, 185-195.
- Kessler, R. C., Mickelson, K. D., & Zhao, S. (1997). Patterns and correlates of self-help group membership in the United States. *Social Policy*, *27*, 27-46.
- Kishline, A. (1994). *Moderate drinking: The Moderation Management guide for people who want to reduce their drinking*. New York: Three Rivers Press.
- Klaw, E., Huebsch, P. D., & Humphreys, K. (2000). Communication patterns in an on-line mutual help group for problem drinkers. *Journal of Community Psychology*, *28*, 535-546.
- Klaw, E., & Humphreys, K. (2000). Life stories of Moderation Management mutual help group members. *Contemporary Drug Problems*, *27*, 779-803.
- Klaw, E., Stewart, E., Horst, D., & Humphreys, K. (2002). *Expectations and experience in Moderation Management: Established and potential members perceptions of an alternative self-help setting for problem drinkers*. Manuscript submitted for publication.
- Moos, R. H., Cronkite, R. C., Billings, A. G., & Finney, J. W. (1986).

- Health and Daily Living Form Manual* (Rev. ed.). Palo Alto, CA: Social Ecology Laboratory, Stanford University.
- Rosenberg, H. (1993). Prediction of controlled drinking by alcoholics and problem drinkers. *Psychological Bulletin*, *113*, 129-139.
- Rotgers, F., & Kishline, A. (2000). Moderation Management: A support group for persons who want to reduce their drinking, but not necessarily abstain. *International Journal of Self-Help and Self Care*, *1*, 145-158.
- Sanchez-Craig, M., Wilkinson, D. A., & Davila, R. (1995). Empirically based guidelines for moderate drinking: 1-year results from three studies with problem drinkers. *American Journal of Public Health*, *85*, 823-828.
- Skinner, H. A., & Allen, B. A. (1982). Alcohol dependence syndrome: Measurement and validation. *Journal of Abnormal Psychology*, *91*, 199-209.
- Sobell, L. C., Cunningham, J. A., & Sobell, M. B. (1996). Recovery from alcohol problems with and without treatment: Prevalence in two population surveys. *American Journal of Public Health*, *86*, 966-972.
- Timko, C., Finney, J. W., Moos, R. H., Moos, B. S., & Steinbaum, D. P. (1993). The process of treatment selection among previously untreated help-seeking problem drinkers. *Journal of Substance Abuse*, *5*, 203-220.
- Tucker, J. A., Donovan, D. M., & Marlatt, G. A. (1999). *Changing addictive behavior: Bridging clinical and public health strategies*. New York: The Guilford Press.

Preparation of this paper was supported by NIAAA grant AA11700-01 and by The Department of Veterans Affairs Health Services Research and Development Service and Mental Health Strategic Healthcare Group.

Address correspondence to Elena Klaw, Ph.D., San Jose State University, Psychology Dept., One Washington Square, San Jose, CA 95192-0120; e-mail: eklaw@email.sjsu.edu.

Received: November 4, 2001

Accepted: December 16, 2002

♦ ♦ ♦