



Research paper

The Moderation Management programme in 2004: What type of drinker seeks controlled drinking?

Ana Kosok*

Teachers College, Columbia University, 525 West 120th St., NY 10027, USA

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Abstract

Objective: Moderation Management (MM) is a mutual aid support group that helps problem drinkers reduce drinking to non-harmful levels. This study describes member characteristics as part of an organisational evaluation. The results are compared to those of an earlier survey.

Methods: An anonymous survey was distributed to all members in the online and face-to-face MM groups. Respondents ($N=272$) reported demographic characteristics, drinking history, frequency/amount of drinking, alcohol dependence, life problems six months prior to MM, drinking goals upon programme entry, and pre-MM help sought. Data were analysed for the entire group and by programme delivery format: online-only (OL), face-to-face only (F2F), and both (Both).

Results: Members had a mean age of 44 years, and were 66% female, 98% White, 90% US residents, 80% employed, 54% married, 94% college educated; 77% had an annual income over \$50,000; 54% had not sought prior help. The pre-MM mean number of drinks per week was 34 (S.D. 20, range 0–105), dependence score was 11 of a possible 39 (S.D. 5, range 0–24), and number of life problems was 1.9 (S.D. 1.4, range 0–6) of a possible 6. The OL group was younger than the other two groups. The F2F group had sought more prior help than the OL group and drank less than the Both group. Those using Both formats sought to move from abstinence to moderation more frequently than the OL group.

Conclusions: People participating in MM are largely White and upper middle class. Participation by women has increased since 1999; MM may be attracting members with a higher level of dependence than previously. As over 50% have not previously sought help, MM is an important addition to other treatment choices. It is an option problem drinkers want.

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Introduction

An estimated two-thirds of the United States population consumes at least some alcohol (Greenfield & Rogers, 1999; Midanik & Room, 1992). Of those who drink, about 1 in 10 have drinking-associated problems, but only about 10% of that number seek help (Roper-Miller & Winecker, 2003). Help may not be sought early in problem drinking in part because of the stigma of the label ‘alcoholic’ and because of the extreme remedy of never drinking again.

Traditional treatment has required the acceptance of alcoholism as a progressive disease and abstinence as the only

acceptable treatment goal. Contrasted with the abstinence-only approach is the model of harm reduction, which offers individual choice of outcome goal and a menu of change techniques in a stepped care approach. Though there is evidence that choice of treatment goal offers improved outcomes (Rotgers, 1996) and that cognitive/behavioural techniques are efficacious (Miller, Wilbourne, & Hettema, 2003), change in treatment practice is slow to arrive (Miller et al., 2003; Volpicelli & Szalavitz, 2000). As common ground between harm reduction and traditional treatment is sought (Rotgers, Little, & Denning, 2005), and individual practitioners embrace and extend the harm reduction approach (Tatarsky, 2003), this expanded perspective is slowly working its way into the treatment mainstream. Controlled drinking embodies the harm reduction approach.

* Tel.: +1 212 781 3939.

E-mail address: AnaKosok@aol.com.

Alcohol programmes which offer the option of controlled drinking in a non-judgmental setting may appeal to many drinkers and provide early access to help. Though still controversial (Glatt, 1995; Humphreys, 2003; Trimpey & Gates, 1998), controlled drinking has been shown to be a viable treatment goal for some problem drinkers (Rosenberg, 1993; Sanchez-Craig, Wilkinson, & Davila, 1995).

Moderation Management (MM) is a mutual aid support group for self-identified problem drinkers (Kishline, 1994). It is the only US programme to support the goal of moderate drinking and harm reduction. The programme treats problem drinking as a learned habit amenable to cognitive and behavioural change in a group setting. The MM programme was originally intended to be delivered via face-to-face (F2F) support groups; however, an Internet listserv begun in 1996 (the online group, OL) became an unplanned form of programme delivery. Support groups in the new paradigm were slow to start and are frequently short-lived. The Internet format now has more members than the support group format, though about 25% of the members use both (Both).

A number of studies have examined different aspects of this relatively new programme, including three descriptive studies of the MM group. These included an analysis of listserv messages (Finfgeld, 2000), interviews with members (Klaw & Humphreys, 2000), and a survey of 177 members in 1999 (Humphreys & Klaw, 2001). The latter study found that MM members were 'equally divided by gender, were White, employed, college educated, and of early middle age'. The authors concluded that members were largely non-dependent problem drinkers, though they acknowledged that their measure of dependence was not direct.

In 2000, MM reincorporated with a new board of directors. Since then, membership has grown, and new programme components have been added. The present study was undertaken to replicate the earlier work, to determine whether the group served had changed, and to extend the earlier survey by determining whether the programme components were being used and whether there was any change in self-reported outcomes. This report describes the socio-demographic characteristics of the members active in MM in July 2004, the size of the MM group, and their drinking prior to joining. These data are reported for the entire group and for members in each programme format.

Methods

Study questionnaire

The survey used in this study included eight content areas and was divided into three sections. Section I included questions about demographic characteristics, history/development of problem drinking, pre-programme drinking goals, and prior help sought. The demographic information collected in this study included gender, age, ethnicity, country of residence, early religious background, marital sta-

tus, educational status, current employment status, and combined family income. The drinking history items included age at first drink, age at regular drinking, and age at the onset of perceived problem drinking. Section II, the pre-MM section, addressed the frequency/amount of subjects' drinking, alcohol dependence, and life problems related to alcohol, all during the 6 months prior to joining MM. Section III, the post-MM section, repeated the questions contained in Section II, but with respect to the immediate past month. It also addressed the use and perceived value of programme components (e.g., periods of planned short-term abstinence, cognitive-behavioural techniques, support of moderation as a goal). All subjects in the study were to complete Sections I and II of the survey; Section III was intended only for those who had been participating in MM for one month or more.

Test-retest reliabilities were calculated for all items in a sample of 23 subjects who completed the questionnaire on two separate occasions two weeks apart. All items but one included in the final survey were found to have reliabilities between .86 and 1.0. The lowest reliability for an item in the survey, one of the life problems, was .73.

The quantity and frequency of drinking in the period six months prior to participation in MM was assessed by three slightly modified questions from the Alcohol Use Disorders Test (Babor et al., 1994; Saunders, Aasland, Babor, de la Fuente, & Grant, 1993). In these multiple choice items, respondents reported their typical number of drinks per drinking day, the usual number of drinking days per week, and the number of days when five drinks or more were consumed. Drink size was specified as it is in MM: 1 glass of wine = 5 oz., 1 beer = 12 oz., 1 drink of spirits = 1.5 oz. Test-retest reliabilities for frequency/quantity items ranged from .86 to .92. To the question, 'How often do you have a drink containing alcohol?' the choice 'every day' was substituted for the choice '4 times a week'. For the question, 'How often do you have six or more drinks on one occasion?' '5 drinks' was substituted.

The Short-form Alcohol Dependence Data (SADD) Questionnaire (Raistrick, Dunbar, & Davidson, 1983) was used to measure dependence. This instrument has been validated in three studies (Davidson & Raistrick, 1986) and was developed to be sensitive to drinkers who are moderately alcohol-dependent. Although this measure was designed to be answered in present time, responses in Part II were retrospective; test-retest reliability of the retrospective responses was .93. The SADD assesses subjective and behavioural aspects of drinking, acquired alcohol tolerance, inability to control drinking, thinking about or experiencing the desire to drink, and alcohol withdrawal symptoms. It has 15 items, which are answered by 'never', 'sometimes', 'often', or 'nearly always'. The total score indicates a high, medium, or low degree of alcohol dependence. The present study utilised thirteen items of the SADD and prorated the score. The prorated score remains valid (D. Raistrick, personal communication, September 2004).

The SADD has been used in the Moderation Management programme since MM's inception. Its use is recommended in

books *Moderate Drinking* (Kishline, 1994) and *Responsible Drinking* (Rotgers, Kern, & Hoeltzel, 2002) and on the MM website (www.moderation.org). Some MM members retake the questionnaire to track their progress over time.

The question on drinking goals asked subjects to indicate which of five responses best described their goal at the time they joined MM: reduce drinking, shift from total abstinence to moderate drinking, achieve total abstinence, decide between abstinence and moderation, or drink about the same. The response categories 'keep drinking the same' and 'achieve total abstinence' were chosen by only two and four respondents, respectively. The analysis for this question therefore included only responses to the other three choices.

Life problems associated with alcohol were assessed by items from the Health and Daily Living Form (Moos, Cronkite, & Finney, 1990). Three of the items on the original scale (assault, neighbourhood trouble, trouble with the police) had test-retest reliability coefficients below .50 for the MM group, so these were omitted. The remaining items (problems with health, job, money, family arguments, and friends) were repeated in the current study with the addition of one other item, driving under the influence (DUI) of alcohol. Responses were yes/no. The reliability coefficients for these items ranged from .72 to 1.0. The total score for six life problems was used in analysis and had a reliability of 1.0.

The survey was pilot tested using 10 volunteers and took 20–25 min to complete. Consent to participate in the survey was affirmed by response to the statement, 'I am willing to complete this anonymous survey'. The study was IRB approved.

Recruitment and size of sample

Requests to complete the survey were submitted to all members known to be active in MM at the time of the survey. Identifying these members was accomplished with the help of the listserv owner and the facilitators of the support groups. On July 8, 2004, a computer-generated advance notice of the survey was sent to the email addresses of all members subscribed to receive MM listserv email ($n = 633$): 30% of these messages were undeliverable, and those email addresses were identified as no longer valid. A survey invitation with the Web address of the survey and an individual password was then sent to the remaining 447 addresses. Requests to respond were repeated on five separate occasions from July to mid-September to capture non-responders. Of the 447 invitations that were received, 17 went to participants who had also received a printed copy of the survey in their F2F group. This reduced the number of discrete OL participants to 430.

Twelve F2F groups were active at the time of the survey. Packets of numbered, printed surveys were sent to each group's facilitator, and any undistributed surveys were returned to the researcher. Each person attending an MM group meeting between May and July 2004 ($n = 102$) received a survey and return envelope. Thus, 430 members in the OL group and 102 in support groups were identified as active

members and were invited to complete the survey. Seventy-three percent of those in the F2F support groups and 50% of those in the Internet group responded to the survey, for an overall rate of response of 54% (286 of 532).

Survey participants were designated as "new" at the time of the survey if they had been participating on the listserv for less than one month, or if they had attended only 1 F2F meeting. New members completed only the pre-MM portion of the survey. One month after the survey was administered, all new survey participants who had subsequently withdrawn from the listserv or who had stopped attending F2F group were identified by computer comparison of email addresses and by facilitator report. This provided the dropout rate. Respondents were considered eligible to participate in the study if they were 18 years or older, were participating in MM to address their own drinking, and agreed to complete the survey. Four respondents were excluded because they were not problem-drinkers; they were either addiction professionals or had participated out of concern for a family member who drank.

The final sample on which the data analysis is based consisted of 272 people who were participating in MM at the time of the survey, met the other requirements, and submitted fully completed surveys. There were 172 participants in the online-only format, 45 in the support group format, and 55 in the Both format. Of this number, 44 (16%) were 'new' members.

Data analysis

The overall test of significance was conducted using analysis of variance (ANOVA) when the assumption of equality of variance was met and by Welch's Test when it was not. If either of these tests was significant at the .05 level (this implied that at least one group was different) multiple (pairwise) comparisons were made. The Scheffé Test was used when the variances were homogeneous, and Dunnett's T3 was used when the variances were not. Chi-square analysis or Fisher's Exact Test was used for categorical variables. Most of the data analyses were performed using SPSS, Version 11.0. The SAS programme, Version 9.0, was used to compute Fisher's Exact Test.

Results

Table 1 shows the members' demographic characteristics, drinking goal at MM entry, and types of help sought prior to MM participation. The mean age of the sample was 44 years; they were 66% female, 98% White, 90% in US residence, 54% married, 87% of Christian background, 80% employed, and 94% had attended college for a period of at least one year. Seventy-six percent of the sample had a yearly household income of \$50,000 (USD) or more. Of these variables, only age was associated with choice of programme format ($F = 6.0$, 2/84 d.f., $p < .001$). Members who participated via

Table 1
Characteristics of members by programme types^a

	Entire	OL	F2F	Both	<i>p</i> value ^b
<i>N</i>	272	172	45	55	
Age (mean, S.D.)	44.3 (9.5)	42.4 (8.3)	48.5 (12.1)	46.9 (8.8)	.000 ^{c,d}
Female (%)	66	69	62	58	.279
White race (%)	98	99	93	98	.061
Reside in US (%)	90	87	100	91	
Marital status (%)					.338
Married	54	57	57	42	
Never married	24	23	20	28	
Previously married	23	20	24	30	
Religion of family of origin (%)					.444
Protestant	53	55	44	55	
Catholic	34	34	42	27	
Other or none	13	12	13	18	
Employed (%)	80	82	78	76	.602
Education (%)					.062
High school or less	6	9	0	2	
1–4 years college	54	55	51	51	
Graduate school	40	36	49	47	
Household income (%)					.368
<\$30,000	8	10	9	9	
\$30,000–49,000	13	17	5	11	
\$50,000–100,000	41	41	39	44	
>\$100,000	35	32	48	35	
Drinking goal ^c pre-MM (%)					.021 ^{c,d}
Reduce drinking	74	77	67	69	.305
Abstinence to moderation	8	5	5	19	.011 ^d
Decide between abstinence and moderation	19	18	28	13	.172
Sought help pre-MM (%)					
All sources	44	37	62	53	.003 ^c
AA	32	30	33	35	.802
Counselling	25	20	36	30	.040 ^c
Rehab	9	9	9	11	.899
Psychiatric	7	6	7	13	.241
SMART, SOS	6	4	9	9	.266
Detox	4	4	0	9	.062
MD	4	3	7	6	.455
Hospital	3	2	2	6	.478

^a Programme types = Online Only (OL), Face-to-Face Group Only (F2F), and Both Internet and F2F group (Both).

^b *p* values calculated based on Chi Square, *F*, or Fisher's Exact Test.

^c Significant (*p* < .05) contrast effects found for OL vs. F2F.

^d Significant (*p* < .05) contrast effects found for OL vs. Both.

^e Response categories abstinence (<1%) and drinking the same (~1.5%) were omitted from the analysis because their frequencies were too small.

F2F-only and those in the Both group were significantly older than those in the OL group.

About three-quarters of the members reported that their goal in coming to MM was to reduce their level of drinking. Only 8% of the sample as a whole wished to shift from abstinence to drinking in moderation; 19% sought to decide whether one or the other goal was best. There was a significant association between goal and programme format ($\chi^2 = 10.4$, 2 d.f., *p* = .021), with Both members choosing to move from abstinence to moderation more frequently than members of the OL group (*p* = .011).

For 56% of the group, MM was the first help sought. Forty-four percent of the sample had sought help prior to MM,

particularly from Alcoholics Anonymous (AA) (32%) and from counselling (25%). There was a significant association between prior help-seeking and choice of programme format ($\chi^2 = 11.4$, 2 d.f., *p* = .003) and specifically between format and outpatient counselling ($\chi^2 = 6.4$, 2 d.f., *p* = .04). The F2F group had sought more help in general and more outpatient counselling than had the OL group.

Table 2 shows the data on problem-drinking variables, drinking history, life problems, and dependence. In the six-month period prior to participating in MM, 61% of the members drank daily. The average consumption per drinking day was six drinks per day. There was a significant association between programme format and mean number of drinks

Table 2
Pre-MM drinking, history of drinking, and dependence: comparisons by programme type

	Entire	OL	F2F	Both	<i>p</i> value ^a
<i>N</i>	272	172	45	55	
Drinking history, age (mean, S.D.)					
Age at first drink	17.0 (2.9)	16.9 (2.8)	17.4 (3.5)	17.1 (2.4)	.483
Age at regular drinking	22.0 (6.3)	21.8 (6.3)	23.6 (7.8)	21.7 (4.7)	.304
Age at problem onset	32.8 (9.7)	31.8 (8.7)	35.9 (12.5)	33.6 (9.4)	.086
Years to develop problem drinking	10.7 (7.7)	9.93 (6.8)	12.2 (9.4)	11.9 (8.8)	.163
Frequency/amount					
Drinking (days/week)	5.7 (1.9)	5.8 (1.8)	5.2 (2.0)	5.8 (2.0)	.154
Drinks/drinking (day)	5.7 (2.2)	6.0 (2.7)	5.0 (3.0)	6.9 (4.2)	.037 ^b
Drinks (week)	33.9 (19.5)	34.4 (19)	26.3 (16.5)	38.3 (22.0)	.008 ^b
Days/week > 5 drinks	3.4 (2.0)	3.5 (2.0)	2.4 (2.1)	3.8 (2.1)	.004 ^{c, b}
>50 (drinks/week, %)	20	20	11	29	.081
Life problems (Mean, S.D.) ^d	1.9 (1.4)	1.8 (1.4)	1.8 (1.2)	2.3 (1.5)	.052
Dependence					
SADD score (mean, S.D.) ^e	11.4 (4.6)	11.5 (4.4)	10.7 (3.9)	11.5 (5.8)	.497
Dependence category (%)					.200
Low	27	27	25	31	
Medium	64	63	69	53	
High	9	10	4	16	

^a *p* values calculated based on *F* or Chi Square.

^b Significant (*p* < .05) contrast effects found for F2F vs. Both.

^c Significant (*p* < .05) contrast effects found for OL vs. F2F.

^d Maximum possible score = 6.

^e Maximum possible score = 39.

per day ($F = 5.1$, 2/82 d.f., $p < .04$) and between programme format and number of drinks per week ($F = 6.0$, 2/269 d.f., $p < .01$). The F2F group drank significantly less than the Both group. Number of days on which more than five drinks were consumed also differed by group ($F = 3.4$, 2/82 d.f., $p < .01$). The F2F group had fewer such days than did either of the other groups prior to joining MM.

The mean number of six life problems related to alcohol (problems with health, job, money, friends, family, and DUI) was 1.9 in the sample as a whole. MM members who participated in Both formats, however, tended to have more problems than either of the other groups ($F = 3.0$, 2/269 d.f., $p = .052$). Seven percent of the entire sample reported pre-MM DUI.

The sum of scores on the SADD alcohol dependence instrument was used to assess level of alcohol dependence. The mean of the summed scores for the entire sample was 11, which falls in the Medium range of dependence: 28% of the sample scored in the Low range, 62% in the Medium, and 10% in the High range. There were no associations between dependence score or category and use of programme format.

There were no significant differences between men and women on the variables drinking history, amount/frequency consumed, dependence, or life problems.

Of the 44 survey participants who were new to MM at the time they took the survey, 27 (61%) left within one month. There were no significant differences between dropout and ongoing members except for the variable age ($p = .005$). The average age of drop-outs was 39.5 (± 8.1) years, compared

with the average age of 44.3 (± 9.5) years for the remainder of the sample.

Summary

The MM group of this survey was strikingly homogeneous with respect to ethnicity and religious background. Participants were particularly notable for their high levels of education and income.

Members differed by programme format in several ways. The OL group was significantly younger than either of the other groups. The F2F group had sought more help than the OL group prior to MM membership and drank less than the Both group. Those in the Both group tended to have more life problems relating to alcohol than the other two groups, and they sought to move from abstinence to moderation significantly more frequently than the OL group.

Discussion

The option of Moderation Management is not widely known. It is not publicised, clients are rarely referred to it by physicians or psychotherapists, and, in fact, many therapists will not support a client with a drinking problem who is exploring controlled drinking. Nevertheless, people are finding MM. This is an option that people want.

There were more than twice as many MM members who participated online in 2004 than the number estimated in

1999. Since the number of active F2F groups in 2004 was the same number reported for 1999 (12 active groups), it is clear that the growth that occurred in MM from 1999 to 2004 was largely or wholly limited to members participating online. This is not surprising, since it is easier to participate online, and there are relatively few F2F groups available.

MM F2F groups do not start up easily and may be short-lived when they do. Since groups are member-run, the person who starts one is tasked with finding a meeting space, attracting other members, facilitating the group, and answering questions about an unfamiliar programme, as well as working on his or her own drinking problem. The loss of anonymity in being identified with a programme for problem drinkers is also a major concern.

Given these constraints, there are relatively few meetings available and this naturally limits the number of F2F meeting participants. Each meeting provides facilitator contact information, which is listed on the MM website. At the time of the survey, 24 meetings were listed, but when meeting facilitators were contacted, only 12 of these were still active. The meetings whose members contributed to the survey were in New York City (two meetings); California (Los Angeles, Oakland, Orange County, and San Francisco); Minneapolis (two meetings); Chicago; Houston; Morristown, New Jersey; Seattle; and Washington, DC. In post-MM programme participation data (to be reported separately), ongoing OL members with no near-by meetings were asked if they would attend a F2F meeting if one were available. Forty-two percent said that they would. Clearly, the desire for meetings exceeds their availability.

Nine years after its inception, MM remains small in absolute numbers. The scarcity of F2F meetings is a limiting factor for membership. At least two other factors contribute to MM's small size: MM is not a programme that is court-mandated for DUI infractions; and the programme was not designed for long-term, continuous member participation. Therefore, meetings will never swell with the ranks of successful long-term members or those whose attendance is required by an outside agency. Finally, there has been little recent publicity about MM. Few professionals and even fewer of the lay public know of its existence.

The dropout rate for new members was 61%. However, in the post-MM programme participation data (not treated in this paper), 49% of those in the OL and Both groups reported that they had left the listserv but had subsequently returned, indicating that this leave-and-return behaviour may represent a common pattern of programme use. The dropout rate for AA members within one month of joining has been reported as 81% (Alcoholics Anonymous 1989 Membership Survey, internal document, as cited in Fox, 1993).

It can be hypothesised that some of the MM dropouts come only for initial information, some may not be ready for change, and some may simply not like the programme. The only variable that distinguished early dropouts from those who continued in MM in the present investigation was that the dropouts were significantly younger. Younger people

may have difficulty identifying with members who are older because of the different social context of their alcohol use.

The results were generally in agreement with those of the previous survey (Humphreys & Klaw, 2001). Both surveys found that the average MM member is White, over age 35, college educated, and wants to learn to control his or her drinking rather than abstain altogether. Both surveys found that the programme attracted women as much or more than men. In addition, the present study and the previous one agree that most MM members are heavy and regular drinkers at the time they join MM, but as yet have not developed severe alcohol dependence or many life problems related to alcohol abuse. Both surveys indicate that programme format is associated with the frequency/amount of members' drinking prior to joining MM. While the Humphreys and Klaw survey and the present survey employed somewhat different measures of drinking, both surveys indicate that members in the F2F format drank less heavily than those with OL experience.

The results of the present survey differed in some ways from the results of the earlier survey. The differences suggest several trends. The proportion of women attracted to MM is increasing (49% versus 66%). Fewer MM members have prior experience with AA than before. Though figures for the overall 1999 group were not provided in the Humphreys and Klaw study (2001), more members in each programme format had previously attended AA than was the case for the 2004 group. For example, 57% of the 1999 Both group had prior AA exposure, while only 35% of those in that format had a similar background in the sample of the present study. This is significant as those who have had less contact with Alcoholics Anonymous have been found to be more successful with the controlled drinking option (Heather & Robinson, 1983)

MM may be attracting members with a somewhat higher level of dependence than before. Humphreys and Klaw stated that the mean for their sample on 11 of 25 items from the Alcohol Dependence Scale suggested low dependence, while the mean for the present sample on the SADD was in the medium dependence range. This is a potentially important finding, but it might have been an artefact of differences between the measures. If in fact people who are attracted to MM today are, on the average, more alcohol-dependent than before, MM may need to give them additional help, support, or direction.

Critics of controlled drinking have feared that previously abstinent problem drinkers would be tempted to drink again if they had access to a programme offering controlled drinking as a goal. In fact, just 8% of the drinkers in this study (but 19% of those in the Both group) indicated that they wished to shift their drinking goal from abstinence to moderation. However, 19% of the sample had come to MM hoping to receive help in deciding between these goals. This implies a recognition in the undecided group that not every problem drinker can learn to drink moderately.

Though more men than women are problem drinkers (Fleming, 2003; Greenfield & Rogers, 1999), the rate of women seeking treatment has been increasing since 1980 (Institute of Medicine, 1990). Women seek help more readily

Table 3
Characteristics of AA members and MM members

	AA members	MM members, 2004
Age in years, mean	42.5 ^a	44.3
Women (%)	12 ^a , 33 ^b	66
White (%)	88 ^b	98
Married (%)	37 ^b	55
Education	Average 11 years school ^b	94% at least 1 year college
Previous help sought (%)	61 ^b	44

^a Tonigan, Toscova & Miller (1996).

^b Alcoholics Anonymous General Service (1999).

than men in general (Beckman, 1993), and women seek help more quickly after recognition of problem drinking (Simpson & Tucker, 2002). Thus, women would more readily tend to seek help at the point of alcohol abuse, rather than dependence, which would mean that MM might be a more attractive option than an abstinence programme.

As shown in Table 3, members of both programmes have little diversity in ethnicity, but MM attracts more women, members who are slightly older, and those with a higher education level than AA. In addition, MM attracts a higher proportion of people who have not previously sought help.

There is a striking difference between the proportion of women in MM and in AA. Sixty-six percent of the MM members are women, while AA's female membership is approximately 33% (Alcoholics Anonymous General Service, 1999). Several factors may contribute to this. Fear of stigma is a particular barrier to women's help-seeking (Beckman, 1993), and the MM online format combined with a pseudonym offers complete anonymity. Women may also have needs unmet by AA, which focuses primarily on alcohol cessation and emphasises ego deflation. MM emphasises balance in all areas of life and encourages discussion of other life problems and emotional issues. Women have expressed a need for help with social and psychological problems in addition to help with problem drinking (Thom, 1987). Their special issues include low self-esteem, greater parental responsibilities, and lack of family support for help-seeking (Thom, 1986). Thus, MM may be particularly attractive to women because they need not leave home or disclose their help-seeking to family and friends, and because MM may offer more opportunities for attention to personal issues. A Canadian programme with features similar to those of MM ('brief, individual, outpatient, strictly confidential . . . designed for persons who have not previously been treated for alcohol problems and who wish to quit or reduce their alcohol consumption'; Sanchez-Craig, 1990, p. 172) also recruited as many female as male problem drinkers from the general community.

The MM and AA programmes differ in the degree of literacy needed, and this may account in part for the difference in members' educational levels. Though there are now AA chatrooms and online meetings, the F2F support group is the

usual format in which the AA programme is delivered, and an oral format requires a lower level of literacy. While it was not possible to compare the average income of members of MM versus AA, it is likely that MM members have a higher average income because of the correlation between income level and education. Better educated people are more likely to have the skills both to use the computer and to express themselves in writing. The important role that reading and reference to current research play in MM might also serve to discourage less-educated people from participating.

MM and AA differ in their theoretical orientation, and this may account for part of the difference in socio-economic status between the two groups. AA, which takes the position that alcoholism is a disease, operates along the lines of the medical model of care, while MM, viewing drinking as a habit disorder for many, reflects the compensatory (or cooperative) model. Attribution theory (Brickman et al., 1982) indicates that programmes using the medical model place the helper in the diagnostic and directive role and the help-seeker in the position of accepting the diagnosis and following the prescribed treatment. As Bartlett and Windsor (1985) noted, 'Authority inherently exacts dependence from the person who seeks advice or assistance, and the acceptance of authority (medical or otherwise) implies a surrender of private judgment' (p. 223). The compensatory model that underlies Moderation Management asks, 'How can I help you?' and acts to supply missing resources, such as information or problem-solving techniques. In this model of helping, the help-seeker is free to define his or her own problem, to specify the goal, and to choose which, if any, offered resources will be used.

Higher education prepares individuals to analyse problems, evaluate information, make choices, and employ their own critical judgment. It may be hypothesised that those with less education, fewer advantages in life, and fewer life choices are less comfortable making the choices required in MM and may welcome the more directive approach of AA.

Study limitations

The 50% response rate for the OL group exceeds the response rates of 37% for Internet surveys conducted from 1986 to 2000 (Sheehan, 2001) and 43% for those conducted in 2002 (Fraze, Hardin, Brashears, Smith, & Lockaby, 2004). The 74% response rate for the F2F members who received paper copies is comparable to the 73% response rate of a similar survey administered to Women for Sobriety members (Kaskutas, 1996). However, the overall survey response rate of 54% means that the characteristics of about half of the members were not known; therefore, the findings of this study may not be true of the group as a whole.

As an evaluation of one programme at one point in time, the present study has obvious and important limitations, including reliance on self-report and, for the pre-MM portion of the survey, retrospective responses. The researcher served as the programme director of MM from 2000 to 2005

and is therefore not free of bias. The MM group does not represent all problem drinkers or all those who attempt moderation.

Conclusions

MM continues to attract largely White, middle-class, well-educated people who for the most part are mildly to moderately alcohol-dependent, though the degree of dependence may be increasing. Trends suggest that MM continues to be particularly attractive to female problem-drinkers and those who have a preference for participating online. It is an important option for individuals who have not previously sought help and for those seeking guidance as to whether to choose moderation or abstinence. Indications are that a controlled drinking option would be a choice for many if it were more widely available.

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