

Can Targeting Nondependent 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*

KEITH HUMPHREYS, PH.D.,[†] AND ELENA KLAW, PH.D.[†]

Veterans Affairs Health Care System and Stanford University School of Medicine, Palo Alto, California

ABSTRACT. *Objective:* Moderation Management (MM) is the only alcohol self-help organization to target nondependent problem drinkers and to allow moderate drinking goals. This study evaluated whether MM drew into assistance an untapped segment of the population with nondependent alcohol problems. It also examined how access to the organization was influenced by the provision of Internet-based resources. *Method:* A survey was distributed to participants in MM face-to-face and Internet-based self-help groups. MM participants ($N = 177$, 50.9% male) reported on their demographic characteristics, alcohol consumption, alcohol problems and utilization of professional and peer-run helping resources. *Results:* MM appears to attract women and young people,

especially those who are nondependent problem drinkers. It was also found that a significant minority of members experienced multiple alcohol dependence symptoms and therefore may have been poorly suited to a moderate drinking program. *Conclusions:* Tailoring services to nondependent drinkers and offering assistance over the Internet are two valuable methods of broadening the base of treatment for alcohol problems. Although interventions like MM are unlikely to benefit all individuals who access them, they do attract problem drinkers who are otherwise unlikely to use existing alcohol-related services. (*J. Stud. Alcohol* 62: 528-532, 2001)

OVER THE LAST DECADE, a number of experts have called for the U.S. health care system to "broaden the base" of interventions for alcohol problems, and thereby serve a larger and more diverse segment of the population with alcohol problems (Institute of Medicine, 1990; Tucker et al., 1999). Two strategies have been undertaken in pursuit of this goal: (1) to develop forms of assistance specifically targeted toward nondependent problem drinkers (e.g., Sanchez-Craig et al., 1996; Sitharthan et al., 1996), because this population contributes to morbidity and mortality but rarely accesses traditional treatment services (Cahalan, 1987; Institute of Medicine, 1990), and (2) to use electronic communication technologies to expand the reach and accessibility of services (e.g., Cunningham et al., 2000; Heather et al., 1990). The present study is the first to evaluate these strategies in the context of self-help groups (also known as "mutual help" organizations).

Mutual help organizations are a critical arena for access expansion because they are a significant component of the system of care for alcohol problems in the U.S. (Room and Greenfield, 1993). The largest and most commonly accessed self-help organization is Alcoholics Anonymous (AA; McCrady and Miller, 1993), a group that targets alcohol-dependent individuals (Emrick et al., 1993), advocating abstinence as the goal and using face-to-face group meetings as its primary way of serving members. Even alcohol self-help groups that have significant philosophical differences with AA (e.g., SMART Recovery, Women for Sobriety) share these characteristics. In contrast, another self-help organization, Moderation Management (MM), presents alternative goals for nondependent individuals (Kishline, 1994). This group is not intended for chronic drinkers who are dependent on alcohol, and therefore allows members a choice of abstinence or moderate drinking. MM is also the first alcohol-related mutual help venue to serve more of its members via Internet-based groups than through face-to-face groups (Klaw et al., 2000).

Other alcohol self-help organizations have successfully created "niche markets" by targeting particular populations. For example, Secular Organization for Sobriety (Connors and Dermen, 1996) and Rational Recovery (Galanter et al., 1993) appear to attract individuals who are uncomfortable with interventions that emphasize the role of God, or a "higher power," in the recovery process. MM may also

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[†]Elena Klaw is now with the Department of Psychology at San Jose State University, San Jose, California. Address correspondence to Keith Humphreys, Ph.D., Center for Health Care Evaluation, VA Palo Alto Health Care System (152-MPD), 795 Willow Road, Menlo Park, CA 94025, or via email at: KNH@stanford.edu.

attract a unique population because it facilitates access for people who are more likely to participate through electronically mediated forums than face-to-face self-help groups (Alemi et al., 1996). Such Internet-based groups may be especially important for hard-to-reach populations (e.g., individuals who live in areas where services are not physically available, have poor access to transportation or are severely disabled) (Kurtz, 1997). They might also be particularly attractive to groups (e.g., women) who might feel stigmatized for having alcohol problems (Lex, 1994).

The present study evaluates how MM's features relate to its accessibility to nondependent problem drinkers. We also evaluate whether MM attracts severely dependent individuals, for whom moderate drinking is very difficult or impossible to maintain. In addition, we compare the characteristics of members who participate in the organization over the Internet versus those who participate face-to-face.

Method

The subjects were 177 individuals attending MM meetings for alcohol problems. About one third of respondents ($n = 62$) attended face-to-face MM meetings only, and about one fourth ($n = 42$) attended both face-to-face and on-line meetings. The remainder ($n = 73$) were involved in MM only over the Internet.

In August 1999, all current MM meeting participants received a survey, with a cover letter cosigned by the investigators and MM's president, requesting voluntary participation for an anonymous survey. MM received a \$20 donation for each survey returned to the investigators.

All 12 active face-to-face MM groups were mailed a packet of surveys and accompanying letters, along with a personal note to the group leaders asking them to distribute surveys to all attendees at the next two meetings and return them to the project team. As a result, 99 surveys were distributed and 89.9% were completed and returned (two were marked as refusals and eight were not returned). For the Internet version, the cover letter was posted electronically to MM Internet groups with a hyperlink to a web page on which members could complete the survey on-line. A reminder message was posted 2 weeks later and 88 surveys were completed on-line. The participation rate for the electronic version is difficult to assess; approximately 200 individuals were enrolled in the MM on-line group during the survey period, and 160 of these had not already completed the survey at a face-to-face group meeting.

The survey recorded demographic information (e.g., gender, age, race), and beliefs about God using an item from the Religious Background and Behavior Questionnaire (Connors et al., 1996) and a report on the frequency of religious service attendance. Also included were 11 items from the Alcohol Dependence Scale (ADS; Skinner and Allen, 1982) relating to alcohol use and problems in the 6

months prior to MM involvement (response range: 0 = "never" to 4 = "often"; $\alpha = 0.84$), along with a similar scale taken from the Health and Daily Living Form (Moos et al., 1992) regarding a series of difficulties with health, work and family ($\alpha = 0.79$). Respondents reported how many days per month they were drunk or intoxicated (self-defined) and rated the perceived severity of their drinking problem on a scale ranging from 1 = "none" to 5 = "serious". The typical frequency and amount of alcohol consumption was assessed using two items from the Alcohol Use Disorders Identification Test (AUDIT; Babor et al., 1992), and respondents were asked whether their current drinking goal was abstinence or moderation.

The length and intensity of involvement and the form of participation (face-to-face groups only, Internet-based groups only, or both) in MM were recorded. Those who used Internet-based groups were asked their reasons for using on-line resources. Respondents also reported their lifetime use of helping resources (e.g., professional alcohol treatment, AA and other self-help groups, individual psychotherapy and psychotropic medication). Finally, participants were asked a general question about the presence of any drug-related problems in the 6 months prior to MM participation, and another about any use of heroin, cocaine and amphetamines in the prior 30 days.

Results

As shown in Table 1, the 177 MM participants in general were equally divided by gender, were white, employed, college-educated and of early middle age. Almost one third described their religious beliefs as "atheist, agnostic or unsure," and only one sixth attended religious services on a weekly or more-frequent basis.

At the same time, there were some notable differences between participants in different MM groups. Significantly more on-line-only (OL-only) members were female; those with any OL contact had higher levels of education and were more likely to be atheists or agnostics. Those in the OL-only group also demonstrated the most days per month intoxicated, the greatest percent of days with heavy consumption, and had the highest score on alcohol dependence; both groups with OL experience reported more days per week of drinking. These data indicate that ADS and alcohol problem scores were notable for all groups. No direct evaluation of alcohol dependence as defined by any major diagnostic manual was carried out. As an important point of comparison, however, the full sample's scores for the ADS, alcohol problem measure and perceived severity of drinking were about one standard deviation lower than those reported by AA members completing the same instruments in other research (Timko et al., 1993).

Table 1 also offers information regarding the intensity of MM involvement and experience with other forms of



TABLE 1. Comparison of 177 Moderation Management members divided by face-to-face (FTF-only), on-line (OL-only) and combined forms of participation (Both)

	Comparisons by participation type			χ^2 or <i>F</i>
	FTF-only (<i>n</i> = 62)	OL-only (<i>n</i> = 73)	Both (<i>n</i> = 42)	
Demography (%)				
White race	95.2	93.2	100.0	2.92
Female	40.0	63.0	38.1	9.68*
Employed	82.3	78.1	85.7	1.08
Married	55.7	63.9	52.4	1.69
Education				9.30*
< Baccalaureate	32.8	31.5	16.7	
Baccalaureate	31.1	19.2	19.0	
Postgraduate	36.1	49.3	64.3	
Age (years)				9.84*
<35	20.3	33.8	11.9	
35-50	50.8	47.9	50.0	
>50	28.8	18.3	38.1	
Belief in God				12.14*
Atheist/agnostic	21.0	31.9	50.0	
Spiritual	53.2	44.4	42.9	
Religious	25.8	23.6	7.1	
Religious service attendance				7.35
Never	19.4	35.6	38.1	
Less than weekly	58.1	50.7	52.4	
1/week or more	22.6	13.7	9.5	
Drinking items (%)				
Freq. of drinking days				14.25*
≤2-4/month	18.3	8.1	9.8	
2-3/week	20.0	4.8	4.9	
≥4/week	61.7	87.1	85.4	
≥5 drinks per drinking day	49.1	70.6	53.8	6.51*
Current drinking goal of moderation	100.0	93.0	97.5	4.86
Drinking items, mean (SD)				
Alcohol dependence	3.6 (4.0)	5.9 (7.1)	4.3 (2.8)	3.19*
Alcohol-related probs	5.4 (4.2)	6.0 (6.3)	5.1 (3.4)	0.42
Days intoxic./month	7.5 (8.6)	12.3 (9.9)	7.5 (8.2)	5.43 [§]
Perceived severity of drinking problem	3.0 (1.0)	3.5 (0.9)	3.4 (0.9)	5.08*
Use of help, mean (SD)				
Months of MM	9.1 (11.9)	7.6 (8.8)	18.8 (13.6)	14.03 [§]
Personal meetings/month	3.4 (1.2)	—	2.2 (1.5)	19.61 [§]
Hrs/month on Internet-based MM groups	—	18.6 (14.4)	13.2 (13.2)	3.46
Received formal treatment	24.2	23.3	19.0	0.41
Attended AA	53.2	45.2	57.1	1.73
Attended other self-help groups	9.7	13.7	9.5	0.71
Involved in psychotherapy	69.4	61.6	73.8	1.98
Prescribed medication for depression/anxiety	33.9	21.1	34.1	3.39

Note: Measures of alcohol consumption, problems and dependence were completed with reference to the 6 months prior to MM involvement.

**p* < .05; [§]*p* < .005.

intervention. Those with combined types of MM participation (Both) had the longest contact with the group, but were less likely than the face-to-face-only (FTF-only) group to attend personal meetings. The three groups did not differ in experience with additional forms of treatment.

Only six participants reported problems with illicit substances (not shown in the table). In the 6 months prior to participation in MM, only two had attended Cocaine Anonymous or Narcotics Anonymous in the prior year, and only four reported any use of heroin, cocaine or methamphetamines.

Individuals participating in on-line MM activities ($n = 115$) were asked to endorse up to three items, from a list of nine reasons, that described why they decided to access MM in this fashion. In descending order, the most frequent reasons cited were "I have easy access to a computer" (68.7%); "It is important to me to be able to access MM at any time of day" (38.3%); "I like the privacy" (38.3%); "There are no face-to-face MM groups in my area" (30.4%); "It is easier for me to write about my feelings and experiences than to speak about them in front of a group" (25.2%); and "On-line participation is easier than attending meetings, due to my busy work schedule" (23.5%). Given the finding that on-line MM groups might be especially appealing to women, we compared the responses to these items by gender. The results were that 35.5% of the women versus 13.2% of men chose on-line activities because they found writing about their feelings and experiences easier than speaking in front of a group ($\chi^2 = 7.51$, 1 df, $p = .006$), and 50.0% of women versus 24.5% of men wanted access to MM at any time of day ($\chi^2 = 7.85$, 1 df, $p = .005$).

Discussion

The population that accesses MM appears to be distinctive. The proportion of women (49%) in MM is substantially higher than that reported for Rational Recovery (28%; Galanter et al., 1993), Secular Organization for Sobriety (27%; Connors and Dermen, 1996) and AA (33%; AA, 1997). This finding may reflect a "person-environment fit" (Maton, 1989), in which men with drinking problems are more likely to experience physical dependence symptoms than are women (Lex, 1994), and therefore may be more strongly drawn to abstinence-oriented self-help organizations that focus on more severe alcohol problems. The findings here also indicate that MM's Internet presence might increase its appeal to women; this is perhaps related to its 24-hour access and women's discomfort with face-to-face self-disclosure in self-help group meetings where most attendees are men. The gender differences are consistent with the findings of Cunningham et al. (2000), in which more women than men accessed a world-wide web-site that assessed problem drinking.

MM participants have a secular outlook and behavior, a characteristic they share with members of Rational Recovery (Galanter et al., 1993) and Secular Organization for Sobriety (Connors and Dermen, 1996). In qualitative interviews (Klaw and Humphreys, 2000), some atheistic and agnostic MM members asserted that the nonspiritual approach of MM made the program particularly attractive. In this way, these MM members differed from the many non-religious affiliates of AA, who usually do not see a pronounced conflict between their own spiritual outlook and that of the organization (Nealon-Woods et al., 1995; Winzelberg and Humphreys, 1999).

Regarding drinking behavior and problems, the modal individual with MM involvement appears to be a heavy and regular consumer of alcohol, who is experiencing a modest level of alcohol-related physical, social and psychological consequences. Therefore, in general, MM appears to succeed in its goal of attracting nondependent problem drinkers. For both alcohol consumption and problems, MM members appear to have entered the organization with less severe impairment than new members of AA and incoming patients in professional programs (Timko et al., 1993), and were not likely to report concurrent drug problems. Individuals who used MM's on-line resources had more severe problems than those accessing only face-to-face groups, which might reflect the easier accessibility of on-line resources to those for whom problems are relatively more severe and daily life more disordered (Alemi et al., 1996).

Fears that MM was primarily serving severely dependent individuals were not supported by the data, although a significant minority of members had experienced multiple symptoms of dependence on alcohol. The outcomes of these individuals are unknown; however, most research indicates that those with higher dependence levels are less likely to succeed at moderate drinking programs (Rosenberg, 1993). Although MM explicitly attempts to steer alcohol-dependent individuals into abstinence-oriented programs, as a voluntary organization it has no power to enforce this principle. The current data indicate that only 23% of MM members had ever used professional alcohol treatment services and, thus, the approach used by MM might have been the only one acceptable to these participants.

The study's findings must be interpreted in light of the methodological limitations. First, all data were self-reported and some (e.g., reports of pre-MM drinking) were retrospective. Second, not all members completed the survey, and the characteristics of nonrespondents are unknown. These concerns are somewhat minimized by our other studies of MM, which used different methodologies yet also found evidence that MM members are disproportionately female, white and well-educated, and have low levels of physical dependence symptoms and alcohol-related problems (Klaw et al., 2000; Klaw and Humphreys, 2000).

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