Life stories of Moderation Management mutual help group members

BY ELENA KLAW
AND KEITH HUMPHREYS

This study analyzed life story themes of 30 Moderation Management (MM) members. MM is the only mutual-help organization in the U.S. that supports problem drinkers who wish to moderate their alcohol consumption. Qualitative interview data indicated that MM involvement was often precipitated by a conscious rejection of the 12-step philosophy espoused in Alcoholics Anonymous and in many professional treatment programs. In particular, MM members did not believe that their problem drinking was a disease manageable only through abstinence or that they needed to surrender control to a spiritual "higher power" for recovery. In contrast, the MM world view, which emphasizes self-control and choice, seemed to better match the experience, values and preferred self-narratives of this high-functioning sample of white, middle-class, well-educated Americans.

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In the United States the formal and informal care systems for people with alcohol problems have been uniquely influenced by the concept that alcoholism is a disease that can be arrested only through abstinence (Mäkelä et al., 1996). Almost all health professionals and mutual-help group members* view abstinence as the only legitimate goal for problem drinkers, despite evidence that many recoveries culminate in moderate, non-problem drinking (Dawson, 1996; Humphreys, Moos & Finney, 1995; Sobell, Cunningham & Sobell, 1996; Vaillant, 1983). As a result, problem drinkers in the U.S. who wish to become moderate consumers of alcohol have difficulty finding supportive resources and legitimation. In 1994 a problem drinker named Audrey Kishline attempted to rectify this situation by founding the mutual-help organization Moderation Management (MM). To better understand MM, as well as the experience of problem-drinking individuals who attempt recovery in a culturally disapproved fashion, the present study examines the life stories of 30 members of this new and controversial organization.

A brief review of the formal and informal care system for problem drinkers in the U.S. provides needed context for understanding MM's role in the culture and in the lives of its members. Most professional alcohol treatment agencies in the U.S. (12-step-based or not) endorse the goal of abstinence for all patients and refer them to abstinence-oriented self-help groups for aftercare (Humphreys, 1997). In the voluntary sector, the 12-step mutual-help organization Alcoholics Anonymous (AA) has a dominant position, with approximately one million members (Kurtz, 1997). A handful of mutual-help organizations serve as alternatives to AA, although none of them has even a tenth of AA's membership. Secular Organization for Sobriety (Connors & Dermen, 1996) rejects the spiritual emphasis of AA and replaces it with a secular world view. Women for Sobriety (WFS; Kaskutas, 1992, 1994) is an explicitly feminist alternative to AA. Rational Recovery (Galanter, Egelko & Edwards, 1993) and SMART Recovery (Horvath, in press) reject the disease model and the 12 steps and

offer instead scientifically rationalized, cognitive-behavioral change principles. Despite these differences from AA, all of these mutual-help organizations endorse abstinence as the only viable drinking goal. This may help explain why some of their members see no contradiction in attending AA concurrently (Connors & Dermen, 1996; Kaskutas, 1992, 1994; Galanter, Egelko & Edwards, 1993).

Like SMART Recovery and Rational Recovery, MM differs from AA in conceptualizing alcohol abuse as a learned behavior and drawing concepts and techniques from the scientific literature on cognitive-behavioral interventions (Kishline, 1994). However, MM is unique among alcohol-related mutual-help organizations in allowing members to attempt moderate drinking. Although abstinence is certainly allowed in MM, members rarely select this as their goal. Interestingly, MM's philosophy explicitly acknowledges that some alcohol-dependent individuals will not be able to achieve moderation and therefore may be better off in an abstinence-oriented self-help organization such as SMART Recovery or even AA (Kishline, 1994). In this sense, MM does not question the existence of "alcoholics" as typically defined in AA and in American culture generally. Rather, the organization asserts that the alcoholic label and the prescription of abstinence are applied far too broadly, and that moderation is a legitimate goal for a larger proportion of problem drinkers than is commonly recognized.

In order to help its members exert greater control over their drinking behavior, MM offers a program of support and education guided by principles of moderation, self-management, and personal responsibility. MM has approximately 30 face-to-face mutual-help groups across the United States and Canada as well as a number of electronic mail discussion groups (or "listservs") with over 300 members worldwide. In addition to the asynchronous electronic mail discussion groups, MM members regularly hold impromptu internet chat

meetings in real time (i.e., with essentially no delay between when a message is typed and when it is transmitted and read).

Both face-to-face and internet-based MM meetings give members the opportunity to share their progress and discuss their concerns. In face-to-face meetings, members typically conduct an initial "go round" followed by about an hour of open discussion. Throughout the meeting, individuals provide each other with coping techniques to avoid abusing alcohol. Unlike AA, exchanges of advice during meetings are common and accepted in MM. Although MM meetings focus on achieving moderate drinking, members self-disclose any experiences or concerns perceived as relevant to their progress. Because the majority of participants have had professional counseling, for example, experiences in psychotherapy may be discussed. As ongoing and free-flowing discussions, the internet-based MM "groups" are less structured than are face-to-face meetings. However, a systematic analysis of messages posted to the MM listserv indicated that, as in face-to-face meetings, the most common types of communication were self-disclosure, information and advice, and emotional support (Klaw, Huebsch & Humphreys, 2000).

In addition to supportive meetings, MM offers its members a program of change based on health education and cognitive-behavioral change strategies. This program is described in Audrey Kishline's (1994) book *Moderate Drinking: The Moderation Management Guide for People Who Want to Reduce Their Drinking*, with which almost all MM members are familiar. In addition to providing an autobiographical account of Ms. Kishline's drinking problems, negative treatment experiences, and founding of MM, the book also reviews the scientific literature on controlled drinking and cognitive-behavioral treatment strategies. The book encourages members to carefully monitor their alcohol consumption, provides information on how to determine the amount of ethanol in different drinks, and offers guidelines for moderate consumption. Specifically, the book suggests that members

consume alcohol no more than three to four days a week and not exceed three drinks per drinking day if female or four drinks per drinking day if male.

As detailed in the handbook, the suggested first task for all MM members, regardless of their ultimate drinking goals, is a 30-day period of abstinence. This exercise is intended to lessen individuals' physical tolerance of alcohol and psychological reliance on it (Kishline, 1994). In keeping with MM's view that not all problem drinkers can return to moderate consumption, inability to complete the initial 30-day abstinence period is considered an indicator that the member may be better suited to an abstinence-based approach. Those who complete the abstinence period successfully are considered good candidates for subsequent moderate drinking within MM's guidelines.

The tone of Kishline's book, as well as that of the meetings the authors have observed, is remarkably flexible and undogmatic. Final decisions about the meaning of inability to abstain for 30 days, for example, are left entirely up to the individual concerned. Similarly, unlike in AA, no standard or pressure for lifetime attendance is in evidence. Rather, members assume each individual will choose to attend MM as frequently and as long as necessary (N.B.: At this writing, to the authors' knowledge no one has ever been court-mandated to MM). Further, although the experience and wisdom of experienced members are valued during meetings, there is no AA-style formal sponsorship of newcomers by "old timers." In summary, MM's program consistently reflects values of self-control, individual responsibility and rationality, and personal freedom.

MM has attracted extensive media attention in the U.S., but, as a new organization, it has not been subjected to formal scientific analysis. The present study is one of an interrelated set of research projects (Klaw, Huebsch & Humphreys, 2000; Klaw, Luft & Humphreys, 2000) intended to better under-

stand MM and its members. The chief purpose of the present study was to illuminate the life experiences of problem drinkers for whom MM provided (1) an alternative world view and narrative reflective of their personal experience and values and (2) the only organized assistance for their culturally disapproved approach to recovery from alcohol problems.

Method

Participants

Participants were 15 men and 15 women ranging in age from 28 to 59, with a mean age of 41.9 (SD = 8.1). Twenty-nine of the participants resided in disparate parts of the United States, and one participant resided in Sweden. All participants were Caucasian and had had at least some college education. Half were currently married. Twenty-seven members of the sample were currently employed. In sum, this was a highly educated, economically well-off sample relative both to problem drinkers and to the U.S. population as a whole.

The sample was evenly divided between individuals participating in face-to-face MM meetings only, electronic mail discussion group meetings only, and both types of meetings. Duration of involvement with MM ranged from one month to four years, with a mean involvement of approximately 12 months (SD = 9.9). Electronic mail discussion group users typically read the discussion at least once a day. Those who belonged to a face-to-face MM group typically attended at least two meetings a month. All participants reported that their drinking goal in MM was moderate alcohol consumption rather than abstinence. None of the 30 members was concurrently attending AA.

Recruitment

The research team recruited participants in three ways: By visiting two West Coast and one East Coast MM group meetings and asking members to participate; by mailing fliers describing the study to MM group leaders, who distributed

fliers to their groups and in some cases volunteered to participate; and by posting the flier to the MM electronic mail discussion group. Audrey Kishline, MM's founder, assisted recruitment by sending a letter to all MM groups that endorsed the study.

Interviews The first author conducted all interviews by telephone (n=23) or in person (n=7). To elicit life story narratives, participants were instructed as follows: "Begin with your personal story about your alcohol problems and your involvement in MM. Pick some point in your life to begin that makes sense to you and go forward in time from there. Cover whatever you think is important to understanding the problems that brought you to MM, how you got involved in the organization, and how it has affected you." Participants were encouraged to speak at whatever length necessary to tell their stories in their own words. After each story, the interviewer asked specific questions about a number of areas (e.g., age of onset of problem drinking, treatment experiences, perceptions of MM, etc.) only if the participant did not spontaneously mention them in the story. Interviews were audiotaped and transcribed (n=26) except in those cases of mechanical failure (n=2) or participant refusal (n=2). For these four participants, field notes were completed and summarized by the interviewer. The interviewer also administered the Alcohol Use Disorders Identification Test (AUDIT) to all participants, using the year prior to joining MM as the reference period. The AUDIT is a 10-item quantitative screen for alcohol problems with demonstrated reliability and validity (Babor, de la Fuente, Saunders & Grant, 1992).

Analyses The software package NUD*IST (Non-numerical Unstructured Data Indexing Searching and Theorizing) was employed to facilitate an analytic process based on immersion in the interview data and the grounded theory approach (Creswell, 1998; Strauss & Corbin, 1990). Initial themes were independently generated by the two authors and by a third coder who had not previously participated in the study. Next,

using NUD*IST, the first author coded each distinct unit of qualitative data. Through multiple systematic readings of the text, negative case analysis (Lincoln & Guba, 1986), and ongoing negotiation between the authors, the codes assigned to each unit of text were iteratively generated, revised, and consolidated until both authors agreed on two overarching themes that tied together the coded units of qualitative data. Theoretical memos were generated that tied together these themes across data units and cases.

Results

Description of course and severity of drinking problems

In the portions of their personal narratives dealing with the beginning of their drinking problems, 6 participants reported pre-adult onset, 10 reported college-age onset, and the remaining 14 reported developing their drinking problems in their mid-20s. AUDIT scores in the year prior to MM involvement ranged from 2 to 28 (Mean = 17.9, SD = 7.3). Utilizing the AUDIT cutoff point of 10, about two-thirds of the sample would meet *DSM-III-R* criteria for an alcohol use disorder (Bohn, Babor & Kranzler, 1995), which in all but three or four cases would probably be alcohol abuse rather than alcohol dependence (based on responses to particular items). On the AUDIT item concerning frequency of consuming six or more drinks on one occasion, 7 members responded "daily or almost daily," 12 responded "weekly," 5 responded "monthly," 1 responded "less than monthly," and 5 responded "never." These data suggest that MM attracts the non-dependent problem drinkers for whom it was originally conceived.

Qualitative themes

Participants' life stories tended to reflect two overarching themes. First, most participants described feeling alienated by the 12-step approaches to recovery employed in professional treatment and in AA. Second, in contrast, most participants described feeling empowered by MM's emphasis on personal responsibility, self-control and choice.

Dissatisfaction with 12-step-based professional treatment programs

Eight participants had received inpatient alcohol treatment; in all cases these interventions were based in part on 12-step principles and approaches. The most negative perceptions of treatment were expressed by the three participants whose inpatient treatment was sought under pressure from a health professional/insurer:

> And, um, [after an intervention conducted by a group of concerned members of my profession] I agreed at that time to go down, um, for an evaluation to W Psychiatric hospital. And there, after an evaluation, they said that they definitely thought I had a problem and suggested rather, rather coercively that I needed to stay. I say coercively because what they alluded to is the fact that their best medical advice is that I should stay and do a rehab treatment. And if I left it would go on my record as leaving, as they called it, AMA, against medical advice. And so if any problems occurred it would show that I was unwilling to seek help for my problem. So, um, I stayed for 47 days—35 days I believe after my insurance ran out and I ran up a fairly large, substantial bill. When I left W Psychiatric, I was fairly indoctrinated into the AA approach of alcohol treatment. (#20, 45-year-old male)

In contrast, the five participants who voluntarily sought inpatient treatment tended to mention positive qualities of the experience, even though they later came to resent the tenets of the 12-step approach:

> I checked into [the hospital unit] for a 30-day period in 1997. I found it to be incredibly safe, nurturing and supportive. I was vulnerable and desperate for an answer, a way to make everything better. I was willing to do whatever everyone said. Now I look back at 12-steps stuff as brainwashing. I was vulnerable at the time and was told that I was sick and had a disease that was incredibly negative. Women who grew up in the 70s and 80s and had careers don't like being told they are powerless. I had been an atheist; I even began questioning that. (#11, 40-year-old female)

Turning to outpatient treatment, most participants (n=21) had utilized outpatient psychotherapeutic services to cope with relationship discord and/or pervasive feelings of unhappiness and anxiety. Many of these participants reported that they explicitly chose not to use psychotherapy to address their

problems with drinking. In fact, several participants asserted that they deliberately did not share their drinking problems with psychotherapists in light of previous experiences where such professionals had insisted that they attend AA. In a few cases, such "contracts" were made explicit:

> I sought professional help for my other problems and also told [my counselor] in this case . . . about drinking, and she was not an endorser of the MM approach. She definitely came from the AA school. But we agreed, over time we agreed for me to take care of my drinking problems elsewhere and she and I could work together on the other issues. Which we did, and it worked out fine. (#4, 37-year-old male)

Alienation from Alcoholics Anonymous

Most of the 19 participants who had attended AA expressed significant resentment about the experience. For the majority of these participants, contact with AA was brief (i.e., fewer than six meetings). With remarkable consistency, these participants attributed their decisions to attend only a few AA meetings to four broad areas of mismatch. First, these educated, economically well-off MM members expressed class-based prejudice and social discomfort with those AA members who were unemployed, uneducated and homeless. Second, these MM members tended to describe themselves as atheist or agnostic and therefore averse to AA's spiritual focus. Third, participants stressed that a sense of personal control over their lives was paramount to their identity and thus conflicted with AA's concepts of surrender and powerlessness. Finally, because their drinking problems were less severe than those of most AA members, they felt out of place at AA meetings.

Although almost all participants with AA experience mentioned at least one of these four objections to AA, gender influenced which was most prominent. Women tended to tie their objections to AA to feelings of isolation and low self-esteem engendered by their participation:

> I never felt at home in AA, I felt alienated. It [drinking] had not affected anyone or my life. My family said, "You don't have a

problem." I couldn't relate, I never lost family or days off from work. I just didn't want to have the habit of drinking every day. (#14, 59-year-old female)

I was uncomfortable with the being around a lot of really sick people. And I think that happened in just about any program, but huh, I don't, huh. It tended to depress me on one hand and on another hand, um, it made me feel more flawed . . . myself. As a member kind of thing. And I had been doing a lot of reading also about cognitive therapy. I thought, boy, here I am, every day saying to myself My name is __ and I'm an alcoholic. And that's about the most detrimental kind of affirmation I think you can make for yourself every day. It didn't seem positive for me once I had been doing a little more research. (#18, 44-year-old female)

In contrast, while mentioning the same general four objections to AA, male MM members were more likely to tie them to disdain, anger, and class prejudice toward AA members:

I'll just tell real quick about [a certain meeting]; it was a classic horror story about AA where it's just these people, everybody there is just so down and out. And they're just reveling in the horror of their previous lives. It's like some kind of weird Christian penitence where they smear themselves with blood. It's self-flagellation kind of. "Oh I'm such a degraded creature, only God can lift me up." There's like 24-year-olds with blown-out teeth [saying] "When I was in the army I was drinking a lot and the sergeant made us drink more and then when I woke up in the gutter in Atlanta I came to the AA meeting." It was real bad. Everybody at this meeting, probably 90% of the people who spoke could barely speak . . . like either they were brain damaged or born stupid or in some way their mouths had been injured or they had no education whatsoever past the basic 20 words that are required to get some food. (#16, 39-year-old male)

The big ones are about God and powerlessness. That, you know, I don't, oh boy, I'm atheist, I'm not very religious, and their concept of a higher power and powerlessness, and giving over your life to a higher power, with control of your life, and to me it's what they're advocating. That's just flat-out wrong. I couldn't do it. I'd be dead. So there was no way. Then got into details, like apologizing to everyone for all the harm you've done. It's like no, no . . . (#4, 37-year-old male)

In contrast to those who left AA almost immediately, seven participants attended AA for a year or more. Unsurprisingly, those who had stayed in AA longer were usually more positive about the organization than were those who attended only a few meetings. For example, the only two participants with more than a decade of AA involvement both viewed AA's support for their abstinence as helpful, even though they ultimately decided to leave the organization and pursue moderate drinking.

I found AA very good at the start and I liked it very much. And I never drank during these 11 years. But after some years, I think it was good for me to be sober these 11 years, no question about that. Maybe seven, eight had been enough, but I mean that's a question in retrospect. I liked it very much at that time. And I did lots of other things at the same time too, I went to about two AA meetings a week. I also was on the board of AA. . . . (#22, 54-year-old male)

Another long-time AA member who decided to try MM meetings in place of AA noted that he continues to benefit from the spiritual principles he learned in AA:

. . . just from being . . . kind of hooked on the spiritual thing and that has become an important part of my life whether I'm using or not. . . . (#9, 39-year-old male)

Those who had extensive involvement in AA prior to MM tended to mention that despite some positive AA experiences, they eventually became bored with the simplicity of the 12-step model or lost faith that certain AA tenets applied to them:

After 80 days abstaining, I ended up going out with a client and discussing wine. When he ordered a bottle, I felt it would draw too much attention for me to refuse. I had one glass of wine and *nothing happened.* AA makes you believe you would be a drunk on the street if you start to drink. Not true—I was proof. Like people who take cold medicines, not realizing they have alcohol, AA would lead you to think they'd be drunk for the rest of their lives. So I began to test. I wanted to see what would happen if I binge drank one night—would I not be able to stop? I binged one day and was still able to stop the next. Proved I could do it. (#11, 40-year-old female)

I went to AA for about a year and a half, didn't drink. I developed some good friendships, um, some close people, who I still have friendships with today. This is back around 1985 or so. I never really believed in the philosophy though, and I never really believed in the labeling, like to me you throw that label on your forehead, you become the label, meaning the alcoholic label. And if you screw up, and everybody does or the most part once in a while, it's a self-fulfilling prophecy. (#6, 39-year-old male)

A few MM members who left AA after extended involvement saw their AA experience in retrospect in an extremely negative light—for example, agreeing with anti-AA books (e.g, Bufé, 1998; Ragge, 1998) that AA is a form of "brainwashing." For these members, MM participation seemed as much about recovering from AA (which they described with considerable acerbity) as about recovering from problem drinking:

AA will make you feel guilty about reading alternative solutions. [When I first saw the MM handbook], yeah, I'm buying the AA line all the way. This is just denial, there is no way a person can change his drinking behavior. You either is or you isn't, and you is . . . Well. That's what they tell you in AA. . . . I thought This is scary, because now it's a real conflict with everything I've been doing for the previous 2¼ years. Which is getting brainwashed by AA. (#17, 49-year-old male)

Interestingly, the 11 participants who had never been to AA nevertheless tended to express criticism of AA, at times based on what the authors judged as significant misunderstandings of what actually occurs in AA meetings. This appeared to stem from exposure to anti-AA stories told by others (both MM members and non-members), reactions to printed AA literature, and a desire to show commitment to the MM organization.

Finding person–enviroment fit in MM

Most participants found MM during a broader search for non-12-step-based assistance. For example, one described a positive experience of attending WFS for five months, several had positive reactions to literature published by SMART Recovery, and three had been to Rational Recovery meetings

(which were described either as "lacking members" or emotionally "cold"). Many participants learned about MM on the World Wide Web (http://www.moderation.org) or through the MM handbook (Kishline, 1994). Several participants reported strongly identifying with the autobiographical aspects of Kishline's book:

> . . . And here was another person writing it in a book, saying yeah, this happened to her and she felt the same way about it. You know, you were told something that you didn't believe, you were forced into going through a treatment that you felt that you didn't need, you know, and so I could really relate to that. (#19, 33-year-old female)

Consistent with Kennedy and Humphreys' (1994) findings that mutual-help group members tend to incorporate aspects of the organization's world view into their personal narrative, participants portrayed themselves in ways that mirrored their perception of the unique strengths of MM. Specifically, MM participants described themselves as individuals who asserted control over their own lives. In this vein, they emphasized that MM works for people who assume such responsibility. Differentiating MM's philosophy from their perceptions of the 12-step approach, they noted that MM stresses self-control, choice, and rationality as opposed to powerlessness, spiritual factors, and acceptance of being an alcoholic:

> I think MM is effective for people with the self-determination to take control over their lives. It works for atheists and non-religious people who aren't comfortable with AA. Most of us are very contrary types: You tell us to do one thing, we do another. (#28, 38-year-old female)

Participants opined that rebellious, cognitively complex individuals who dislike simple solutions are best helped by MM. Participants usually recognized (with occasional relish) that by choosing MM they were, in fact, challenging the hegemonic discourse in the United States regarding problem drinking. Putatively, this belief has some truth value, but more importantly it serves the organizational maintenance function of constructing MM as a haven for free-thinking,

intelligent individualists. Thus MM members can defend themselves against the charge that they are alcoholics in denial by believing that in actual fact they are part of an elite group that can see through their culture's simplistic notions:

Well it clearly, I feel it needs to be somebody who's mature enough to take responsibility for their own behavior. And it has to be somebody who doesn't need absolutes. And somebody who is more thoughtful and is willing to sort of kind of combat the system that at least, unfortunately, is in America, in the United States. But for those same reasons it attracts those type of people. And those type of people, at least for me, are much more supportive than the kind of people that are much more black and white, religious or not. (#21, 52-year-old female)

Not surprisingly, MM participants described themselves as individuals who value personal insight and authority over one's life. They noted that they benefited from MM because they were able to relate to the other participants' educational, intellectual and economic backgrounds and because they shared a disdain for AA, which they perceived as dominated by less intelligent and more simplistic individuals.

This group is, they're such fascinating people, they seem to be, the ones that post, not everyone, there's some clinkers. But they seem to be extremely intelligent and articulate and educated, and they're just like me in so many ways, you know! (#24, 47-year-old female)

To illustrate why he felt comfortable with the MM community, one participant provided a detailed prototypic profile of an MM member:

I'll tell you what the MM personality type is like. We're all the same, in a few ways: we're all independent-minded, we reject absolutes, . . . we tend to be intelligent, we tend to be educated, we tend to have some, we're honest with ourselves, we're honest with other people, we're candid. . . . Uh, so the people tend to be self-assertive, they develop an understanding and understanding of themselves. And they're looking for other people that are similarly self-aware and, you can just, you go to these meetings and everybody's on the same plane . . . it's just people who are able to relate to one another and feel a certain chemistry and shared world views. (#7, 49-year-old male)

Despite the individualistic thrust of MM's ethos, camaraderie was described as a key component of MM. Indeed, MM members saw themselves as part of a group of rebels who were flouting "the 12-step treatment industry" by pursuing individually determined moderation goals. As they attempted to control their drinking, they felt empowered by the emotional support, group cohesion, and guidance that are fundamental to mutual help (Lieberman, 1989; Surgeon General, 1990). For example, participants reported that in both face-to-face and internet-based MM meetings they received helpful feedback on achieving whatever specific moderation goal they had set for themselves. Like members of other self-help groups, participants tended to describe MM as "nonjudgmental," "warm," "safe," and "open," and they felt they benefited both by giving and by receiving aid (Kaskutas, 1992, 1994; Salem & Bogat, in press; Salem, Bogat & Reid, 1997; Winzelberg, 1997). Whereas most participants felt judged by treatment staff, AA members, and some people in the general public, they sensed that MM members accepted their personal experiences of drinking problems:

> I feel like I have friends all over the country. And I get a lot of support and a lot of just really good info. They always remind me Don't beat yourself if you slip up. That's one of my biggest problems. I also feel that, hopefully, that I'm able to give encouragement to other people. (#25, 32-year-old female)

In addition to the emotional support and identification, participants valued the cognitive and educational aspects of the MM program. Most noted that they had become more conscious of their drinking behavior. Further, formerly automatic responses to stress were now recognized as triggers to alcohol abuse:

> . . . it's like, you know, drinking is not nearly as much fun as it used to be. . . . Well, because it's like I'm so conscious now, it's like I am a student of myself, saying "Ok, that's really interesting how at 8:30 the other morning how you learned, when you were thinking to abstain that night, and your boyfriend told you: . . . Oh, by the way, I'm going to this dinner tonight for the corporation . . . , and instantly I decided it's like 'Oh, ok, all right, you know

I'm drinking.' " (laugh) I mean it's that kind of observation. And I think it has kind of its pros and its cons. I mean the pros are obviously I am gaining insight and more power in my life. (#1, 34-year-old female)

Participants also asserted that they benefited from MM's concept that their problem drinking is a controllable "bad habit" rather than a disease:

I see a parallel with something like Weight Watchers, it's some people who have a problem armed with a little knowledge and some helpful hints and some feedback mechanisms are able to solve their problem and control their weight, and I think MM's kind of like that. Armed with some more knowledge and some helpful hints and a little support and a lot of people can control their drinking. (#27, 49-year-old male)

[What I like best about MM is] the MM philosophy of choices, it's a bad habit, not sick or disease. You can do it. You are not powerless. (#11, 40-year-old female)

Participants tended to report that framing problem drinking as a learned, malleable behavior increased their self-understanding, self-confidence and hope, which they contrasted with what they perceived as the "doom and gloom" philosophy of the disease model:

. . . through school, 'cause you know we studied a lot about alcoholism and things too, and it was always taught it was a disease and it was genetic. So I just figured heck, I'm doomed, my dad is an alcoholic, I'm doomed. And, um, it was, it was nice, 'cause she really shot a lot of holes in the disease theory of alcoholism. And one thing I appreciated about, and one thing that we talk to our kids about all the time, you know, I mean, you can have bad experiences, you can have, you know, whatever, but you just have to get on with your life and get over it. And I really liked her, I, you know, forget about the disease theory, and that you're doomed; what you do with your life is up to you and I've always believed that. (#3, 36-year-old female)

Finally, participants reported that MM helped them understand the need to modify their drinking behavior in the context of their ongoing quest to make healthier life choices. For

some, a pivotal insight included realizing that their alcohol abuse was a maladaptive coping response to an underlying stressor or personal problem:

> [Once] you remove the fog of alcohol, what you notice, and I've seen so many people on the list do this, is that they go, all of a sudden they go you know what, I've got this anxiety now, I've got this thing and I can't face it, and you want to go Hey, really, that's the whole crux, and I've seen it so many times. This is what you have to solve. You've got to solve that and my, my thing is that you've got to solve that before you go back to moderation. I, that's what I firmly believe, is that you define what you are numbing from. And the 30 [days of abstinence] is a great time to do that. You get the fog of alcohol out. You find out what you're numbing from, solve that, find some way to solve that before you return to moderation, before you start moderation. . . . Well, it worked for me and that's why it's my opinion. And I know other people can do it other ways, it worked so clear cutly for me, and I know there's a fellow in New York who, we've talked a lot, and he has about the same thing, the same realization that, you know, you've got to solve these problems. And once you start solving these problems, it really helps. (#20, 45-year-old male)

For some members, MM's emphasis on self-control and self-responsibility was a source of pride, because after an initial period of vigilance and effort, maintaining moderate drinking was now fairly effortless. Indeed, four participants noted feeling that they had successfully internalized drinking limits:

> Then moderation became always. Now I am always in the guidelines. Now I have the internal mechanism to notice when I am starting to not feel good. I don't mean to say that I don't need to be careful. I need to be constantly vigilant and conscious. Now I have new values. I don't keep wine in the house. Not drinking is the routine. (#30, 52-year-old female)

In contrast, these same beliefs had different consequences for those participants (about half) who were currently struggling to become moderate drinkers. Because of their belief in self-control and personal responsibility, these participants experienced guilt over failures to adhere to MM's moderation guidelines:

I do know what the limits are. I do know how much is a glass of wine is a drink, is a drink, I know that. Sometimes I honestly turn my head the other way and say, I don't want to know how many, you know. But I think overall I'm aware of it. You know I am aware of approximately how many, and it bothers me because I don't feel that I'm totally moderate yet. It's depressing because, you know, you feel like am I going to be, is this going to be the big struggle of the lifetime? Is this always something that I'm going to have to keep on a leash? (#13, 44-year-old female)

Despite participants' espoused belief in the power of self-control, however, some feared that moderation was an unattainable goal for most MM members. In fact, a few participants wondered whether MM was actually "one colossal rationalization" for continued drinking:

I didn't believe I was powerless over alcohol so I tried MM. I went to three meetings in a year. In the MM meetings 20% of the people were reaching their goals. Eighty percent were not reaching the goals, maybe 20% were. They all seemed to be struggling, and I, I got a B.A. in social work and I've taken classes, one master's level class on alcohol and drugs . . . so I know quite a bit about it and I've seen guys in AA; these guys [in MM] were drinking twice as much as me and they had big problems. (#9, 39-year-old male)

. . . I would like to get to a point where, oh, I could take it or leave it, but I don't know if I could ever do that, but it is sort of a goal that I have. (#2, 49-year-old female)

Despite the struggles and doubts noted by some participants, none expressed any reservations about their own decisions to become involved in MM. Indeed, all participants in some way or other characterized themselves as the particular kind of person who was best suited to MM: rational, individualistic, able to exercise self-control, and focused on "creating a balanced, healthy lifestyle." Given that the sample was composed almost entirely of white, well-educated Americans, their endorsement of these values and self-perceptions is of course not particularly surprising:

I think people who want to take control of their situation and say You know, this is something that I can control and I'm going to control it; I'm capable of controlling this. I think those are the peo-

ple who are going to have positive outcomes with the group. (#23, 29-year-old male)

I think it brings about the change in that you are responsible yourself for your things and also that it's a way to be more mature, to find moderate ways of doing things in life. It's not rushing from one extreme, to another extreme, from one addiction to another addiction. It's more of starting to handle your problems and facing up to "Who am I?" (#22, 54-year-old male)

Conclusion

This study elucidates the ways in which problem drinkers who participate in Moderation Management construct a personal narrative around their drinking and recovery that is distinct from the "disease of alcoholism" narrative dominant in the U.S. In part because of self-selection processes driven by degree of person–environment fit (Maton, 1989), and in part because the world views of mutual-help organizations influence the personal life stories of committed members (e.g., Cain, 1991; Humphreys, 2000; Kennedy & Humphreys, 1994), MM participants highlighted unique themes in describing the stories of their recovery from alcohol problems. Specifically, MM participants emphasized their faith in self-control and personal choice and their skepticism of the disease model, spiritually driven recovery, and the prescription of abstinence.

Participants' confidence in their ability to control their alcohol consumption no doubt stemmed in part from the fact that their alcohol problems were less severe than those of, for example, a typical group of AA members. At the same time, participants' values also obviously reflected their status as white, highly educated individuals living primarily (29 of 30) in the U.S. That is, MM's world view fit seamlessly with the preferred self-narratives (White, 1995) of this population because of its emphasis on personal power and rationality and its secular outlook. MM's philosophy, like AA's, helps pro-

mote cohesion by selecting a more homogeneous subgroup out of the problem-drinking population. In doing so, it creates a supportive setting with which members can identify and in which they feel valued and effective.

In the case of MM, the program targets a population of drinkers with less severe problems. Participants are attracted to the program because of its non-spiritual ideology, flexible drinking goals, and emphasis on personal insight, self-control, and behavioral change. Further, as a new program whose focal materials make extensive reference to peer-reviewed scientific evidence and are located on the internet, in bookstores and in libraries, MM attracts problem drinkers with higher than average economic and educational resources. The majority of the current sample noted that they felt "at home" in MM because they easily identified with other members as highly educated, middle-class professionals with mild to moderate drinking problems.

Further, for problem drinkers attempting a return to moderation, the narrative of MM generated increased options for identity construction, attitude formation, and behavior management regarding alcohol. For example, many individuals expressed discomfort regarding adopting the label "alcoholic." For these individuals, conceptualizing their drinking as a "bad habit" allowed them to re-envision their problem and attempt resolution while preserving cherished values and fundamental identity. Indeed, several participants stated that they "owed it" to themselves to try moderation even though, in their view, moderation was more difficult than abstinence. This resolve again speaks to the primacy of personal control in these individuals' self-definitions.

Limitations of this study include reliance on single interviews involving a small sample of 30 MM participants. Due to the recruitment processes employed, the sample consisted primarily of individuals who were actively engaged in the MM program. Thus the study does not address the narrative con-

structions of those who ceased involvement with MM after some contact or participation. On the other hand, the study included individuals with different types and levels of MM participation. Further, the small size of the sample allowed the researchers to devote many hours to each participant, increasing rapport during interviews and depth during data analysis.

We close by noting that of course person–environment fit and subjective enjoyment of a mutual-help organization are necessary but not sufficient conditions for effectiveness. Some participants described attempting moderate drinking as "a continual struggle"; the prevalence of this experience across the organization is currently unknown. If a significant proportion of MM members attain their drinking goals, this cost-free organization has potential to benefit public health, because most of the harm associated with alcohol is produced by non-dependent problem drinkers (Sobell, Cunningham & Sobell, 1996). The present study demonstrated that for a subgroup of the problem-drinking population in the U.S., MM represents an extremely attractive avenue of assistance preferable to more widely available forms. Definitive, longitudinal assessment of the alcohol-related outcomes of participation in MM (and in similar self-help organizations, should they arise) is a crucial task for future research.

Note

* In the abstract, AA's founders (Miller & Kurtz, 1994), as well as some treatment professionals, acknowledge that not all problem drinkers are alcoholics incapable of moderate drinking. However, in practice this dispensation is virtually never given, because of the self-supporting logical structure of disease-model reasoning: The wish to become a moderate drinker is *in itself* viewed as a sign that the person is an alcoholic in denial who cannot become a moderate drinker (e.g., "That is your disease talking"). Hence problem drinkers pursuing moderate drinking are in an impossible situation—the only way for their goal to be legitimized is for them to abandon it as unattainable!

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