Occupational Meanings and Spirituality: The Quest for Sobriety

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This article compares two differing models of intervention for persons with alcohol dependence—the Moyers Model for occupational therapy and Alcoholics Anonymous (AA). Both models were found to share practice strategies but to differ in their emphasis on spirituality and self-control. Additionally, the Moyers Model was basically procedural in its description of the clinical reasoning process, whereas AA places great emphasis on the spiritual aspects of recovery. Because this disparity may lead to confusion when the person with alcohol dependence is involved in both an occupational therapy program (using Moyers Model) and an AA program, the Moyers Model was revised to include a conditional reasoning structure (i.e., a process for therapists to help clients find meaning in actions). By providing opportunities to explore meaning through action during occupations, the revised Moyers Model is both more consistent with the AA principles of spiritual recovery and in keeping with the occupational therapy philosophy of addressing the needs of the whole person.

Alcoholics Anonymous (AA) is a spiritually oriented self-help program for persons with alcohol-related problems, although persons with addictions to other chemicals may also find the program relevant. As a result of approximately 2 million members worldwide and 95,166 groups in 150 countries, AA has become a major influence on the contemporary view of drinking problems and treatment (Alcoholics Anonymous World Services [AAWS], 1996). When occupational therapists encourage their clients with alcohol addiction to also become actively involved in AA, they indirectly give credence to the AA core belief that a spiritual awakening is the cornerstone of recovery (AAWS, 1976). Therapists make this suggestion without knowing whether their approaches are different from or harmonious with the spiritual tenets of AA. If approaches are inconsistent, the person with alcohol dependence may have to choose between the AA program and the occupational therapy program or discount both.

Previously, I proposed the Moyers Model in which persons with alcohol dependence were viewed at three levels, each with different treatment issues, and I proposed possible frames of reference, methods, and expected outcomes (Moyers, 1988, 1992). Because my model has not stimulated any research and because research has suggested the AA approach to be effective and cost-effective when included as a part of a treatment program (Emrick, Tonigan, Montgomery, & Little, 1993; Humphreys & Moos, 1996; McCrady & Miller, 1993), this article reviews, compares, and determines the basic practice similarities and differences between the AA model and the Moyers Model (see Figure 1).

Theoretical Foundations of AA

Theory Base

AA uses the term alcoholism to describe a physical, mental, and spiritual disease (AAWS, 1976). According to AA, the disease is progressive and can be arrested but not cured. The main symptom of the disease is a craving or a compulsion to drink increasing amounts with a resulting loss of control over alcohol. AA sees the most pervasive problem of alcoholism as the spiritual decay that results from the distorted perception that the self, rather than a higher power, is at the center of life (AAWS, 1976).

Being overly reliant on the self and refusing to turn one's life over to the higher power is the AA definition of insanity and is the antithesis of spirituality (AAWS, 1990). This self-focus is a character defect displayed as selfishness, self-obsession, and inability to forgive others. Spirituality involves the organization of one's life around a
### Table: Contrasts and Similarities Between AA and Moyers Model

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### Figure 1. Comparisons between the Moyers Model and the Alcoholic Anonymous model. Note. AA = Alcoholic Anonymous; ADL = activities of daily living; DSM-IV = Diagnostic and Statistical Manual of Mental Disorders (4th ed.) (American Psychiatric Association, 1994); PDS = preferred defense structure.

### Postulates Regarding Change

Committing to abstinence, decreasing preoccupation with the self, and living a lifelong program of spirituality are the essential elements of sobriety according to AA (AAWS, 1970). Thus, sobriety is more than abstinence because it involves progressive changes in character that occur as the result of "working the program" (i.e., following the 12 steps of recovery) (AAWS, 1976, p. 15). After accepting the logic of being powerless over alcohol and arriving at the knowledge that a power greater than the self exists, one must ultimately turn his or her life over to the care of the higher power (Steps 1–3). Spirituality is further developed by examining one’s character assets and defects (Steps 4 & 5), being open to and asking for the help of the higher power to remove the character defects (Steps 6 & 7), and making amends to those harmed by the character defects (Steps 8 & 9). Steps 10 through 12 require an ongoing program of removing character defects and making amends, maintaining a close spiritual connection with the higher power, and acting on the direction of the higher power to help other persons with alcohol dependence.

### Methods of Change

Change occurs when the person with alcohol dependence follows the specific practices of AA, which involve regular attendance at meetings and AA-sponsored activities (AAWS, 1970). These practices, or "tools of the program" (AAWS, 1976, p. 95), also include selecting an AA sponsor (AAWS, 1958) and using slogans, such as "Let Go and Let God" (AAWS, 1990, p. 320), to trigger behaviors that help maintain abstinence. Other tools include avoiding drinking environments and persons who drink, contacting AA members between meetings when in need of support, reading the AA literature, and staying busy when desiring a drink by helping other persons with alcohol dependence (AAWS, 1975).

### Outcomes of Change

Active participation in AA leads to the main behavioral changes of abstinence and the development of sober behaviors, described as using the tools (AAWS, 1970). Cognitive change results when one believes that he or she is an alcoholic without power to control alcohol consumption. There is an emerging ability to identify and modify negative thoughts that would ordinarily lead to a relapse or a "slip," such as changing the thought of "I can drink just one drink" to "I must never take that first drink." Spiritual change is manifested by maintaining a conscious contact with the higher power through daily meditation (AAWS, 1990). Affective change occurs when one recognizes that negative feeling states contribute to the desire to drink; thus, members of AA avoid being hungry, angry, lonely, and tired (AAWS, 1975). Interpersonal change is noted by the AA member entering into and sustaining intimate relationships with a sponsor or other members of the social network.

### Theoretical Foundations of the Moyers Model

#### Theory Base

The Moyers Model used in occupational therapy is based on the view that alcohol dependence results from a complex interaction of causal factors that may include a genetic predisposition or family history, negative character development or experiences within the family structure that lead to impaired interpersonal and coping skills, peer group affiliation that promotes the use of alcohol, social norms accepting the use of alcohol, and the general availability of alcohol (Moyers, 1992). All these causal factors, particularly deficits in interpersonal and coping skills, contribute to the person’s overreliance on a preferred de-
fense structure (PDS) (Moyers, 1988, 1992). Active drinking further modifies this PDS, leading to its rigid use in most situations, regardless of actual effectiveness. The main purposes of the PDS are avoidance of strong emotion, denial of the need for change, and protection of the use of alcohol as an acceptable coping strategy, even when evidence suggests that drinking is problematic. The main components of the PDS include denial, projection, rationalization, obsessions, and attendance to information that is pertinent only to the self.

Postulates Regarding Change

The model proposes three treatment levels that correspond with improving the ability of the person with alcohol dependence to remain abstinent (Moyers, 1988, 1992). At the essence of these treatment levels is a respect for the PDS. Premature confrontation of the PDS results in a therapeutic disaster because the person with alcohol dependence has not yet learned and integrated alternative ways of thinking and acting. Therefore, in treatment level one, the PDS is mobilized or used to achieve sobriety (Moyers, 1992) (see Figure 2). Denial prevents focusing prematurely on interpersonal problems, rationalizations provide reasons to stay sober, projected feelings promote the belief that other persons with alcohol dependence have the same problems, obsessions redirect attention from alcohol to sobriety and healthy coping strategies, high levels of emotionality create excitement about a sober future, and selective, self-relevant attention makes sobriety a highly individual matter that is important to one’s self-image (Moyers, 1988, 1992).

The PDS is weakened in the second treatment level by teaching alternative coping strategies that are consistent with a more open and honest way of relating to others. During the third treatment level, the PDS is confronted, thereby stimulating insight into the need for in-depth personality restructuring, which leads to eventual abandonment of the PDS as a legitimate method of coping.

Methods of Change

The three treatment levels help the occupational therapist identify the treatment issues that match specific frames of reference and treatment methods in order to produce the desired outcomes (Moyers, 1992) (see Figure 2). The treatment issues are different for each treatment level and include loss of control at level one, lack of coping at level two, and poor insight at level three. The treatment issues are operationally defined at each treatment level in terms of strengths and weaknesses in occupational performance areas and in the components of function required by relevant occupational roles.

At treatment level one, the occupational therapist uses directive treatment methods to mobilize the PDS on behalf of recovery (Moyers, 1992). For instance, the behavioral frame of reference describes the manner in which the therapist reinforces the behaviors consistent with abstinence. To weaken reliance on the PDS, treatment level two uses supportive methods that teach coping strategies, such as those described by the cognitive–behavioral frame of reference. Treatment level three uses confrontative techniques to help the client relate maturely to others and to prevent continued use of the PDS. Insight-oriented and confrontative techniques may be best guided by the object relations frame of reference.

Outcomes of Change

Outcomes specified for each treatment level result from the interaction of the treatment issues with the treatment methods and selected frame of reference (Moyers, 1992). Abstinence is the main outcome for treatment level one, along with PDS mobilization. At the completion of treatment level one, the client has fewer problems in activities of daily living and in basic sensorimotor, cognitive, and psychosocial components of function.

The outcome for treatment level two is internal control through the use of newly developed and more adaptive coping strategies to modify work and leisure performances (Moyers, 1992). Relapse is prevented when the client is in more control of his or her behavior during family and other familiar role responsibilities.

During treatment level three, the personality is restructured through enhancement of self-esteem and promotion of self-actualization (Moyers, 1992). Creation of a set of values that supports sobriety and decision making is
crucial (e.g., equating fun with experiencing life as a sober person vs. viewing fun as being “the life of the party”). A belief that enjoyment is only associated with drinking will eventually lead to relapse. Organizing performance behaviors into new roles is another important treatment outcome. For example, the client may have avoided taking risks, such as staying in an unsatisfactory job situation rather than obtaining alternative employment, when he or she was actively drinking.

Theoretical and Practice Comparisons

Unlike the Moyers Model, AA makes no commitment to a particular causal explanation of alcoholism other than simply describing the process as a physical, mental, and spiritual disease (AAWS, 1976). The Moyers Model neither adopts nor disputes the disease theory of alcohol dependence. However, the Moyers Model holds that intervention by professionals is necessary, and involvement in AA is supplemental to therapy (Moyers, 1992). In contrast, AA views therapists and treatment centers as optional tools of recovery (AAWS, 1976) and appealing to the higher power as vital for recovery from alcoholism. The Moyers Model does not address the spiritual aspects of recovery from alcohol dependence.

AA believes that the disease of alcoholism is manifested in the same way and that all persons with alcohol dependence have comparable experiences, making the principles of the fellowship universally applicable (AAWS, 1976). The Moyers Model is multifactorial, leading to the need for a matching approach that selects the best treatment intervention for each person with alcohol dependence (Moyers, 1992). In fact, the model suggests that not all persons respond to the interventions of AA. Research indicates that persons who are most successful in their affiliation with AA have a history of proficiency in the use of external supports to solve problems, have indicators of more severe alcohol dependence, and have more anxiety about their drinking (Emrick et al., 1993). In contrast, the person who drops out of the recovery program to begin consuming alcohol is viewed by AA as not truly possessing the desire to quit drinking (AAWS, 1976). According to the Moyers Model, the person who resumes drinking is thought to possess treatment issues that were not appropriately matched to corresponding frames of reference and treatment methods (Moyers, 1992).

Theoretical conceptions regarding the methods of change also differ between the two models. The most marked contrast is in the area of personal control. Treatment level one of the Moyers Model is similar to the AA belief that external control of alcohol by others is necessary to obtain abstinence (Moyers, 1988, 1992). The difference is that the Moyers Model views the treatment professionals, long-time AA members, family members, and employers as the locus for this external control. AA advocates that external control be achieved by turning one’s will over to the higher power and that one needs to continuously work toward this “letting go” (AAWS, 1990, p. 320). In fact, the second treatment level of the Moyers Model, which develops internal control through successful coping, is actually an anathema to successful recovery as AA outlines. AA articulates that the attempts of members to control their lives and their drinking paradoxically leads to a loss of control: “I cannot afford to believe that I have gained control of my drinking... Such a feeling of control is fatal to my recovery” (AAWS, 1990, p. 26).

As a result of these various contrasts, it would seem that the theoretical orientations of the two models are incongruous. If the Moyers Model were to incorporate some of the AA techniques for developing spirituality, would that incorporation be of concern because of the differing epistemologies of the models? At this point, it is worthwhile to explore the existing practice similarities between the two models. There are at least five main practices that are similar between the models (see Figure 1). Both use comparable intervention strategies that eliminate behaviors that positively reinforce drinking (Moyers, 1992). Additionally, both outline courses of action that are incompatible with drinking and view negative affect as high risk for drinking. The importance of remembering the consequences of drinking and contrasting those experiences with the positive outcomes associated with sobriety is stressed, along with recognizing that dysfunctional thoughts may inhibit abstinence.

Missing Elements

The fact that the Moyers Model and AA share practice strategies still does not resolve the disparities in their divergent emphases on spirituality. The Moyers Model may create confusion when enhancing self-control in treatment level two while encouraging attendance at AA meetings where the person will be exposed to the concepts of powerlessness and of turning his or her will over to a higher power.

The Moyers Model is essentially an explanation of the procedural and the interactive reasoning that occupational therapists use in the treatment of persons with alcohol dependence. Descriptions of the therapist’s conditional reasoning and its impact on the client’s search for spirituality are missing from the model. Conditional reasoning, as defined by Mattingly and Fleming (1994), is “meaning-making relative to action” (p. 213) and is composed of intentionality, or the creation of reasons for doing; habits, or the structure for the daily expression of meaning; and symbolic meanings inherent within the occupations of a given social context.

The contention is that the therapist’s conditional rea-
soning facilitates the use of occupations for enhancing health. With the conditional reasoning process, the therapist and client mutually select occupations that create rationales for being sober, develop habits of sobriety, and produce peak experiences when sober. Peak experiences are moments of ecstasy or spirituality that signal the occurrence of self-actualization (Moyers, 1992). Moyer (1986) defined self-actualization as “the need to be oneself, to do something that is of particular importance to oneself” (p. 342). The importance of meaning is also highlighted by the concept of volition from the Model of Human Occupation (Kielhofner, 1995). Volition is important in choosing occupational behavior and “represents the meaning that we make of ourselves acting in the world” (Kielhofner, 1995, p. 59). According to Frankl (1969), finding meaning is influential in preventing relapse, which may come about when ordinary daily activities do not compete with the seductive memories of a positive affect associated with drinking (i.e., “the good old days”). Finding meaning is a spiritual process because the person attempts to discover his or her purpose or reasons for being in the world and clarifies within their scheme the importance of interpersonal relationships, daily events, and goals.

Model Revisions

Considering that about 13 million Americans are heavy drinkers (Substance Abuse and Mental Health Services Administration, 1996), and that recidivism has been reported to be as high as 90% at 12-month follow-up to treatment (McLellan et al., 1994), it is important to examine the effectiveness of current treatment approaches. Involvement of clients in self-help programs is particularly important given the push by managed care programs to drastically reduce both inpatient and outpatient treatment days (Pollock, 1996). Consequently, treatment programs will be increasingly reliant on AA to support the client’s behavioral changes begun in therapy, thus creating the necessity to determine the compatibility of the approaches advocated by AA and the treatment professionals.

To improve compatibility of the Moyer Model with the AA model, it is important to resolve the self-control controversy and explore the way in which facilitating meaning through occupations is supportive of recovery and return to functional performance. On the basis of an extensive review of the AA literature, interviews with AA members and sponsors, and theory development sessions with groups of occupational therapists, Moyers and Beitzman (1996) generated the following preliminary ideas for the model’s revision (see Figure 2).

Each treatment level could be viewed as successively creating opportunities for the person with alcohol dependence to progressively reinvent the way in which the self is understood. Price-Lackey and Cashman (1996) similarly discovered in their case study of Jenny that she engaged in self-devised graduated occupations to create a new identity and capacities after a head injury.

Treatment Level One

At treatment level one, the focus is on replacing the occupations of drinking with occupations of abstinence. Drinking can be thought of as an occupation because of its many associated tasks and activities, including obtaining the supply, protecting the supply, removing barriers to drinking, creating reasons and situations for drinking, seeking persons with whom to drink, spending time in drinking, recovering from the effects of drinking, and resuming the drinking process. The entire day becomes organized by habits associated with drinking, such as stopping at the same liquor store on the way home from work. In fact, alcohol is the object to which the person gives over control of his or her life. Eventually, freedom to live differently or to engage in occupations other than drinking becomes severely restricted. In the language of conditional reasoning, the person has lost intentionality (Mattingly & Fleming, 1994).

As performance in occupations other than drinking progressively deteriorates, self-concept is insidiously replaced with a negative view. Further engagement in non-drinking occupations is gradually avoided as a method of protecting the ego from future failures. Additionally, non-drinking occupations become devoid of usual meanings and are only meaningful to the extent that they serve as barriers or facilitators to drinking. The “Big Book” (the nickname given by AA members to the main text entitled Alcoholics Anonymous, [AAWS, 1976]) is replete with many stories that describe this distorted view of the self and this loss of freedom to select how one acts in the world. For example:

Long since I had come to believe I was insane because I did so many things I didn’t want to do. I didn’t want to neglect my children. I loved them, I think, as much as any parent. But I did neglect them. I didn’t want to get into fights, but I did get into fights. I didn’t want to get arrested, but I did get arrested. I didn’t want to jeopardize the lives of innocent people by driving an automobile while intoxicated, but I did. I quite naturally came to the conclusion that I must be insane. (p. 199)

Price-Lackey and Cashman (1996) advocated for obtaining clues about the way in which identity and character are fashioned over time through occupations. Therefore, during treatment level one, an occupational history is used to highlight for the client this loss of intentionality and the progressive abdication of control over one’s life to alcohol. The client discovers through this occupational review that he or she has inadvertently become increasingly dependent on others for earning the family income.
paying bills, parenting the children, and so forth. He or she is thereby confronted with the gradual loss of meaning and degradation of the spirit associated with the functional decline of a person who depends on alcohol.

Therefore, the key to treatment level one is to help the person with alcohol dependence relinquish past futile attempts to control alcohol and give the control of alcohol over to others, an objective consistent with the AA goal of admitting powerlessness. In the Moyers Model, giving control to the higher power may be suggested but is not pushed. AA acknowledges that surrendering control to the higher power takes time and first depends on coming to an understanding of what the concept of the higher power entails as well as resolving any past negative religious views of the higher power as being punishing and critical (AAWS, 1976). If the person is comfortable with the concept of the higher power, the occupational therapist can promote the inclusion of prayer in the daily schedule to ask for guidance in decision making.

External control over alcohol means, for example, that the person has someone remove all the alcohol from the home and agrees to stay away from drinking environments and from persons who are actively drinking, essentially giving up access to the first drink. The person surrounds himself or herself with a support system of family and AA members that provides strict consequences if drinking is continued. This is especially important when the person has not fully integrated the concept of the higher power. As a result, the support system is used as the “collective” higher power (AAWS, 1990, p. 226).

In the Moyers Model, the occupational therapist helps the person with alcohol dependence select occupations that reinvent the self as abstinent. For instance, instead of spending time drinking, it is spent on attending therapy sessions and AA meetings and on implementing the suggested strategies for behavioral change. Occupational engagement is organized into basic habits of abstinence, such as getting rest, eating balanced meals, keeping the body neat and clean, and following the therapy regimen. As Kielhofner (1995) stated, “through our habits…we inhabit and belong to our physical, temporal, and social environments” (p. 75).

In addition to basic habits, exploring a variety of activities helps the person determine which occupations of abstinence are meaningful, with whom engagement is enjoyed, and how the typical strategies of engagement are most successfully used. For example, a person newly recovering from alcohol dependence might discover that an exercise program is symbolic of the need to care for the self after years of neglect, thus reinventing a physical body that is more consistent with his or her meanings ascribed to abstinence (being healthy). The activity serves as a metaphor for health or for healing. In treatment level one, occupations are used to explore the loss of intentionality, develop habits supportive of abstinence, and examine symbolic meanings associated with abstinence.

Treatment Level Two

At the second treatment level, the process of reinvention continues with a change in focus from external control to internal control. Because this concept in the original model was the most deviant from the AA philosophy, it was slightly altered to that of internalizing the control provided by others or the higher power. Internalization occurs when coping skills, or the AA tools of recovery, are used during role performance. The person learns to intentionally select how to act within a variety of situations and to develop habits of coping, such as assertively expressing concerns to others. Meaning is derived from occupations that allow exploration of the recovering self, thereby shifting occupational engagement from abstinence to that associated with recovery. Recovery involves reinventing the self from one who abstains from alcohol to one who lives free from the control of alcohol.

For instance, a person might learn that recovery includes daily meditation before beginning a potentially stressful day at work and find that, consequently, his or her reinvention of the self as a more calm and peaceful worker is noticed and appreciated by others. With the assistance of the therapist during treatment level two, the client reestablishes intentionality through the selection of coping techniques, organizes these coping skills into habits, and symbolically redefines the self through application of coping skills during occupations necessary for performance in familiar roles.

Treatment Level Three

Treatment level three is perhaps the most dramatic in terms of reinventing the self. Under the therapist’s direction, the client evaluates his or her personality structure and makes major changes that will be supportive of long-term sobriety. The goals of this treatment level are consistent with the AA goals of conducting a “fearless” moral inventory (AAWS, 1976, p. 59), making amends, and removing defects of character. Engagement shifts from occupations of recovery to those associated with sobriety.

The term sobriety designates the radical change in viewpoint of the self as dominated by negative traits and self-destructive tendencies to that of the self as human with both positive and negative aspects. In other words, occupational failures no longer have to lead to an overall decline in function with a corresponding relapse in using alcohol to cope. Instead, they are considered temporary setbacks that function as learning experiences for more fully understanding the self as sober. Consequently, mean-
meaningful occupations are those that allow exploration of sobriety, such as assuming leadership responsibilities in AA and in other role areas, helping others, and assuming new roles. For instance, the occupational therapy treatment plan might help the client redefine his or her qualifications, select and begin a program of intensive retraining, and eventually obtain a more satisfying and interesting job. Hence, the meaning of sobriety for this client may be the possession of an exciting career that was not possible when he or she engaged in drinking occupations. In this case, occupations serve as a transition to a valued future goal. Treatment level three thus involves intentionally making major life changes through establishing new habits that are supportive of occupational growth. The Big Book eloquently describes sobriety as an ongoing growth process:

I have learned how to relate to people... I could never do that comfortably without alcohol. I have learned to deal with disappointments and problems that once would have sent me right to the bottle. I have come to realize that the name of the game is not so much to stop drinking as to stay sober. (AAWS, 1976, p. 559)

**Case Study**

The following case study explains the process of reinvention through the use of selected occupations guided by the therapist's conditional reasoning. The study is primarily illustrative of the first treatment level. It focuses on occupational therapy strategies for facilitating acceptance of powerlessness, reestablishing intentionality, implementing meaningful habits, and articulating the symbolic nature of the new occupations.

John was a "social drinker" for many years, and it was typical for him to use alcohol when entertaining clients during his job as a salesman. John elected to take early retirement at age 58 and was suddenly faced with the problem of how to occupy his time. His wife is 10 years younger and is often away from home because of her job as a real estate broker. After retirement, John began drinking daily and was usually intoxicated by the time his wife came home. She threatened to leave him unless he sought help for his problem drinking.

John was hospitalized 3 days for detoxification. After a successful and uneventful detoxification, John was transferred to a partial hospitalization program for 7 days to be followed by intensive outpatient (3 days per week for 3 weeks) and aftercare services (evening programming) for 6 months. Occupational therapy was initiated at admission to the partial hospitalization program.

Because John had difficulty understanding the concept of powerlessness, the occupational therapist conducted an occupational history during which John fully delineated his gradual loss of control and increasing dependency on his wife. To prevent relapse, John worked with the occupational therapist to establish constructive habits that he could implement in the evenings when away from the day program. Because of his interest in gourmet cooking, his newly devised habit pattern involved stopping on the way home from the program to shop for the evening meal and then preparing dinner for himself and his wife. John verbalized that cooking was symbolic of working with his higher power to "cook up" a new life. He enjoyed the multiple decisions involved, such as selecting cookbooks, figuring out the menu, determining the right ingredients, and locating some of the ingredients in gourmet specialty shops. As John progressed in treatment, his activities broadened to include watching cooking shows on television, shopping for just the right cooking tools, and enrolling in a cooking class at a community college. John became known for the delicacies that he brought to his AA meetings.

**Conclusion**

In contrasting the AA model of intervention with the Moyers Model for occupational therapy, I identified conflicting and missing elements in the Moyers Model. The Moyers Model did not address conditional reasoning, which could contribute to the therapist's neglecting to promote the client's discovery of occupational meanings as an aspect of spirituality. Therefore, I revised the model to include a conditional reasoning structure that uses occupations to reestablish intentionality, organize habits, and explore symbolic meanings.

The three treatment levels of the Moyers Model describe the way in which the therapist's conditional reasoning structure leads to reinvention of the person with alcohol dependence from one who engages primarily in drinking occupations to one who engages progressively in the occupations of abstinence, recovery, and sobriety. Thus, progression through the three treatment levels of the model now seems more consistent with the AA principles of spirituality but remains in keeping with the occupational therapy philosophy of addressing the needs of the whole person.

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