

A Meaning-Centered Approach to Addiction and Recovery

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The problem of addiction has reached epidemic proportions, affecting every segment of society. About 1 out of 6 is dealing with some form of addiction problem. The track record of addiction treatment has not been very promising, with relapse rates hovering around 90%. Many suffer from the revolving-door phenomenon and the false-hope syndrome. Addiction is more than a disease; it is also a societal, economic, and spiritual problem. It can kill the individual, hurt the family, and harm society.

This paper considers the addiction problem in Vancouver, critically evaluates the four-pillar solution and other mainstream treatments for addiction, and proposes the meaning-centered approach (MCA) as a better alternative.

A critique of mainstream treatment approaches

The four-pillar solution as advocated by Vancouver

The City of Vancouver has been promoting the “four pillars” of prevention, treatment, law enforcement, and harm reduction as a comprehensive and compassionate solution to the drug problem in the Downtown Eastside.

- (1) Prevention—education about the dangers of drugs and how to avoid addiction, without the moralistic and unrealistic message of abstinence.
- (2) Treatment—a continuum of interventions and support programs enabling addicts to make healthier decisions and move towards abstinence.
- (3) Enforcement—more police in the Downtown Eastside and more efforts to target drug dealers and organized crime.
- (4) Harm reduction—a pragmatic way of accepting the reality but minimizing the harm of drug use (e.g., with a needle exchange and methadone). MacPherson (2001) recognizes that abstinence may not be a realistic or desirable goal for certain users, particularly in the short term. Harm reduction instead follows a hierarchy of achievable goals, which, taken one at a time, can lead to a fuller, healthier life for drug users and a safer community for others. This approach is evidence-based and supported by outcome studies.

The four-pillar solution, however, has not been effective—the addiction problem in the Downtown Eastside is not getting better. Bruce Alexander (2001) observes that “There has been little impact, because, no matter how well they are coordinated, the four pillars encompass only a small corner of the addiction problem—illicit drugs—and are not founded upon an analysis of the root cause.” Two of these root causes are existential vacuum (meaninglessness) and social dislocation.

Existential vacuum refers to chronic feelings of meaninglessness, boredom, and despair. The two related aspects of existential crisis are: (1) the existential anxieties of boredom, alienation, despair, meaninglessness, stress, suffering, sickness, and fear of death and (2)

the existential frustrations of the quest for meaning, purpose, fulfillment and personal significance.

Existential crisis is exacerbated by societal malaise. Since we are wired for community, with a strong need for belonging, social displacement can deepen one's existential crisis. Dislocation or insufficient psychosocial integration results from the breakdown of community and the depersonalization of individual.

The societal malaise of modern free market societies is characterized by the following: (1) depersonalization and dehumanization due to global competition and technological domination; (2) the disintegration of communities, the unraveling of social institutions, and the displacement of individuals.

Pharmacotherapy

Pharmacotherapy is based on the disease model of addiction (Bloom 1992; Heinz et al. 1998). According to this model, addiction is a chronic disease (American Society of Addiction Medicine, 2001) to which some are genetically predisposed. Prolonged drug use leads to structural and chemical changes in the brain (Kalat, 2001; Niehoff, 1999). Medications are used in detox and in reducing withdrawal symptoms. Pharmacotherapy stems from the belief that the cure for addiction will come from neuroscience and the use of medication. But drugs do not cure the social and personal issues that initially trigger addiction.

Cognitive-behavioral therapy

Cognitive-behavioral therapy (CBT) has been long been a standard practice in psychotherapy and addiction treatment. The basic assumption of CBT is that addiction is a learned maladaptive coping skill (Marlatt & Gordon, 1985). In this view, addiction is simply a bad habit, not a disease (Peele, 2000). Many addicts report childhood abuse and family dysfunction (Sayette, 1999); addiction is a maladaptive way to deal with the inner pain and anger. Relapse is precipitated by triggers, stress, and cravings.

CBT treatment focuses on anticipating problems and helping addicts develop effective coping skills. Self-monitoring helps recognize early signs of drug cravings and avoid high-risk situations for use. Coping skills learned in relapse prevention therapy remain after the completion of treatment (Carroll, Rounsaville, & Keller, 1991; Marlatt & Gordon, 1985). Recently, mindfulness meditation has been found effective in preventing relapse (Marlatt, 2002). CBT continues to play a major role in addiction treatment, but it does not address existential and spiritual issues.

Solution-focused brief therapy (S. D. Miller, 2000)

In solution-focused brief therapy, the therapist helps clients reframe and reduce problems to small, specific, and solvable goals, and then encourages them to use their own resources to accomplish the treatment goals. The therapist elicits information on how to

repeat “exceptions” (periods of time when problems are not experienced) and “instances” (periods of time when problems are experienced), thus giving clients a sense of control. Solutions may have little to do with the addiction problems, as long as they contribute to clients’ sense of self-control and awareness of the less remembered positive moments.

Motivational enhancement therapy (W. R. Miller, 2000)

Motivational enhancement therapy (MET) is based on the principles of cognitive and social psychology. MET recognizes that change of habit is a process and relapse is part of the cycles of change (Prochaska, Norcross, & DiClemente, 1995). MET focuses on intrinsic motivation—the client is the agent of change with some help from the counsellor. The approach is largely client-centered, but planned and directed to elicit from clients self-motivational statements of personal decisions and plans for change. This therapy is most suitable for the earliest states of change.

The goal of MET is to help clients confront painful reality, reduce their resistance, and initiate change. The therapy helps clients see the discrepancy between their self-destructive addictive behaviors and their significant personal goals. Strategies for decreasing resistance include asking open-ended questions, using reflective listening (giving voice to the client’s resistance), using amplified reflection (taking the client’s resistance a step further), reframing (giving new meaning to what the client has said), selectively agreeing with what has been said, eliciting the client’s own verbalization of the need for change, supporting the client’s expressions for change, and giving a summary reflection at the end of each session. Common themes include good and not-so-good things about drug use, a typical day involving use, reasons to quit or change, and ideas about how change might occur.

Supportive-expressive psychotherapy (Luborsky, 1984)

Supportive-expressive psychotherapy is a time-limited psychotherapy based on principles of psychoanalytical psychotherapy. Supportive techniques help patients feel comfortable in discussing their personal experiences. Expressive techniques help patients identify and work through interpersonal relationship issues. This therapy emphasizes the role of drugs in relation to problem feelings and behaviors and discusses how problems may be solved without recourse to drugs. Supportive-expressive psychotherapy has proven efficacy with patients in methadone maintenance treatment with psychiatric problems (Woody, et al, 1995).

The Minnesota Model

Primarily developed at the Hazelden treatment centre, the Minnesota Model is abstinence-based and committed to the 12-step approach. It often uses confrontation as a counseling style to break through the client’s ‘denial’ and resistance. It then adds medical, psychological, and religious elements. The goal is to treat the whole person in addition to the disease of addiction. Its holistic approach works with the mind, body and spirit as components of a healthy life. This model is not regarded as a mainstream

addiction treatment in Canada because it is based on abstinence rather than harm reduction.

The Twelve Steps of Alcoholics Anonymous (Alcoholics Anonymous, 2002) form the spiritual core of the Minnesota Model recovery program. In essence, the 12 steps are designed for helping clients to get reconnected with self, others, and a higher power. Tonigan, Connors, and Miller (2003) have provided empirical support for the 12-step facilitation therapy.

Critique of mainstream addiction treatments

The same criticisms of the four-pillar approach apply to mainstream addiction treatments as well. One is that they fail to meet clients' existential and spiritual needs, which hinders the long-term efficacy of these treatments. Recovery needs to include spiritual healing: the process of reconnection to true self, others, and God. Recovery also needs to take place in a healing community, where addicts are treated with compassion, respect, and dignity. There is too much emphasis on sobriety, and not enough emphasis on healthy living. There is also not enough emphasis on the personal development of counselors and therapists and the need for them to model authentic, meaningful living.

The Meaning-Centered Approach

The meaning-centered approach (MCA) is intended to complement mainstream treatments and address existential and spiritual needs of the clients. MCA advocates the benefits of a healing community, which addresses clients' needs of psychosocial integration and continued social support. As providing hope is crucial to recovery, MCA also provides a tragic sense of optimism (Wong, 2009) that is based on faith and meaning.

The mission of MCA is the restoration of the total person to wholeness. The problem of addiction is not the drug, but the person. Treatment goals include not only recovery from addiction but also restoration to fullness of life and reintegration into society.

The treatment goal

According to MCA, addiction represents an inadequate and often self-destructive coping mechanism to escape the inner pain resulting from existential crisis (Frankl, 1984) and societal malaise (Alexander, 2001). According to Frankl, "The feeling of meaninglessness . . . underlies the mass neurotic triad of today, i.e., depression-addiction-aggression" (Frankl, 1984). Effective treatment must help people rise above their circumstances, overcome what was inhibiting the defiant human spirit, and discover a clear sense of meaning and purpose.

The treatment goal of MCA is not complete abstinence but complete restoration of the total person to wholeness. Complete abstinence is likely the outcome of complete restoration, but it is not necessary for this restoration. MCA's primary focus is therefore

not on substance avoidance, but rather on helping clients discover this purpose, embrace the joy of living, and obtain the freedom needed to pursue new-found passions.

There are seven pillars of MCA. 1) It is holistic—it treats the person rather than just the disease; it treats each individual as whole, based on the bio-psycho-social-spiritual model. 2) It is integrative—it incorporates other evidence-based addiction treatment modalities. 3) It is meaning-centered—it regards addiction as a symptom of existential crisis and seeks to address the underlying existential and spiritual issues. 4) It is community-oriented—it considers the healing community as a necessary part of effective addiction treatment. 5) It is comprehensive—it makes use of all available resources to achieve treatment goals. 6) It is psycho-educational—it teaches clients the underlying issues related to addiction and the need for more adaptive coping skills. 7) It is optimistic—it recognizes the bleak reality, but believes that there is hope for every addict.

The treatment and recovery process

MCA can be applied for the entire process of treatment and recovery. Basically, it involves a three-pronged approach: 1) treating the disease process and the harmful effects of addiction; 2) working through the psychological, existential and societal issues that underlie addiction; 3) providing a supportive healing community that facilitates healing, restoration and re-entry. This approach may be captured by the 3 R's for the recovery and restoration of the total person: 1) Recovering from addiction and its harmful effects; 2) Resolving the underlying issues of addiction; and 3) Rediscovering the purpose and passion for living.

The following strategies can be readily adapted to addiction treatment and recovery in individual counselling.

The PURE strategy of pursuing meaningful life

PURE provides an ideal framework to restore meaning in an addict's life, because it addresses the key components of meaningful living. Meaning is defined in terms of four inter-related components (Wong, 1998, 2010): Purpose, Understanding, Responsible action, and Evaluation (PURE). This PURE model is holistic because it incorporates all the major human faculties: motivation, cognition, morality, and emotion. It is also capable of incorporating most meaning research. PURE can also be referred to as *the four treasures of meaning therapy* because they represent the best practices of building a healthier and happier future.

1. **Purpose**—*the motivational component*, including goals, directions, incentive objects, values, aspirations, and objectives—is concerned with such questions as: What does life demand of me? What should I do with my life? What really matters in life? A purpose-driven life is an engaged life committed to pursuing a preferred future.
2. **Understanding**—*the cognitive component*, encompassing a sense of coherence, making sense of situations, understanding one's own identity and other people, and effective communications—is concerned with such questions as: What has happened?

What does it mean? How do I make sense of the world? What am I doing here? Who am I? A life with understanding is a life with clarity and coherence.

3. **Responsible action**—*the moral & behavioral component*, including appropriate reactions and actions, doing what is morally right, finding the right solutions, making amends—is concerned with such questions as: What is my responsibility in this situation? What is the right thing to do? What options do I have? What choices should I make? A responsible life is based on the exercise of human freedom and personal agency.
4. **Enjoyment/Evaluation**—*the affective component*, including assessing degree of satisfaction or dissatisfaction with the situation or life as a whole—is concerned with such questions as: Have I achieved what I set out to do? Am I happy with how I have lived my life? If this is love, why am I still unhappy? A meaningful life is a happy life based on reflection and judgment.

Each of these components includes a set of intervention skills. Some of the commonly used skills include goal-setting, decision-making, reality-checking, fast-forwarding of the consequences of choices, Socratic questioning, the use of Wong's Personal Meaning Profile, and challenging irrational or unrealistic thoughts. These four components of meaning work together and form an upward-spiral feedback loop. With each successful completion, one's positivity moves up one notch. However, when one encounters a serious setback or obstacle, one will switch to the avoidance system to manage the negative circumstances. It is unavoidable that we experience unpleasant events. We need to find a more effective way to overcome them than resorting to old habits of addiction as a way of escaping from pain and suffering.

The ABCDE strategy for overcoming negativity

The ABCDE intervention strategy is the main tool in dealing with negative life experiences. Totally different from the ABCDE sequence involved in the rational-emotive therapy process (Ellis 1962, 1987), this ABCDE is similar to Acceptance and Commitment Therapy in its emphasis on action rather than thinking.

Simply put, in MCCT, **A** stands for Acceptance, **B** for Belief and affirmation, **C** for Commitment to specific goals and actions, **D** for Discovering the meaning & significance of self and situations, and **E** for Evaluation of the outcome and enjoying the positive results. These components generate corresponding principles:

1. *Accept* and confront the reality—*the reality principle*.
2. *Believe* that life is worth living—*the faith principle*.
3. *Commit* to goals and actions—*the action principle*.
4. *Discover* the meaning and significance of self and situations—*the Aha! principle*.
5. *Evaluate* the above—*the self-regulation principle*.

Wong's 5-step approach to restoring hope

Given the importance of hope in recovery and the common false hope syndrome in the addiction literature, we need to find a way to instill a realistic sense of hope. Viktor

Frankl's (1984) concept of tragic optimism is uniquely suited for addicts. Through personal communication, I personally know that at least one addict credits tragic optimism for saving his life (he is now a graduate student after recovering from a life-long drug addiction).

Wong (2009) has identified five essential components of "tragic optimism":

- 1) Acceptance—confronting and accepting the reality of our condition, no matter how bleak or painful. This is the necessary step for healing.
- 2) Affirmation—saying 'yes' to life; believing that life is worth living in spite of the suffering and pain. This is the turning point for healing.
- 3) Courage—this involves the defiant human will to persist in spite of setbacks, fears, and obstacles. This is needed to see us through.
- 4) Faith—this is often the only source of strength and hope in a hopeless situation. It is needed to keep us going when everything else has failed.
- 5) Self-transcendence—transcend self-interest and reach out to others. This is the manifestation of affirmation, courage, and faith.

The double-vision strategy (e.g., Wong, 2010, 2012)

This is a two-pronged strategy designed to address both the immediate presenting problems and the underlying big picture issues such as death anxiety, the quest for meaning, and the struggle against injustice. Double-vision is an important macro strategy for several reasons:

1. If we focus on the trees, we may lose sight of the forest. We can gain a deeper insight into our clients' predicaments by looking at the larger context and the big picture issues.
2. If we can help restore clients' passion and purpose for living, this will reinforce their motivation to make the necessary changes.
3. By looking beyond their pressing, immediate concerns, MCA seeks to awaken clients' sense of responsibility and vision for something larger than themselves.

The usefulness of a double-vision strategy for addiction becomes clearer when we consider how it works with a solution-focused approach. Clients' expressions of a desire to change are translated into concrete plans and actions. This is what solution-focused therapy does. However, when these small solvable goals are related to the addict's larger values that really matter in their lives, it provides added incentive for change. Although addicts tend to focus on short-term goals and living one day at a time, deep down, they still have dreams and aspirations. The double-vision strategy empowers them to discover and restore those ideals.

The healing community

Another element of MCA is the inclusion of the healing community in the context of residential rehabilitation. The vision of a healing community is partially my answer to the problem of social malaise. Though we are not in a position to transform society into a

more humane and caring place to live, we can start on a smaller scale by creating such a healing community for addicts.

Most treatment facilities exist as an artificial bubble in which clients are sheltered from the stress and seductions of the real world. Furthermore, life within the bubble tends to be highly regimented and controlled. Fear is the primary motivation for the clients to stay clean—fear of reprimand and termination for violating institutional rules or behavioural contracts. In such an environment, therapists do things to the clients and for the clients, but rarely with the clients. Therefore, there is little opportunity for clients to develop self-control and responsible behaviours.

MCA proposes the healing community as a solution to these problems. The benefits of a healing community have been emphasized by Alcoholics Anonymous (1939/1990), Scott Peck (1978), and Michael Picucci (1996). By creating an accepting, caring, and trusting environment, an MCA community provides many opportunities for clients to experience psychosocial integration and learn new ways of relating and coming together.

The healing community, as we envision it, has the following characteristics:

- It goes beyond the healing community modeled after a 12-step recovery program, because our vision involves all units within and beyond the treatment center: the administration, clinical staff, support staff, clients, and alumni.
- The healing community should also involve clients' families.
- The healing community is based on the guiding principles of compassion, integrity, democracy and justice.
- It is also characterized by the Rogerian principles of client-centered counselling: (a) unconditional positive regard and acceptance, (b) genuineness or congruence, and (c) accurate empathic understanding.
- All members of the community are to be treated with dignity, respect, and consideration. All clients must be treated royally. The quality of relationship with clients is a major focus in the treatment plans. We believe that the hallmark of quality treatment rests in the quality of relationships.
- The corporate culture is characterized by transparency, integrity, and ethical concerns and social responsibility.
- The climate at the treatment center is supportive, validating, caring, and nurturing. Such a positive climate is needed for both staff and clients to freely explore avenues of healing and growth in their quest for meaning and authenticity.
- There will be a loosely connected healing community outside the treatment center to provide on-going after-care support to reduce relapse and reinforce progress.
- The whole person will be treated, as well as the illness.

Such a healing community not only provides models for authentic, meaningful living, but also offers opportunities for addicts to rediscover meaning and purpose. These transformative dynamics empower the clients to tap into the defiant human spirit and develop their capacity for making responsible choices and pursuing a healthy lifestyle. This existential approach to addiction treatment will significantly enhance the prospect of

recovery, because it addresses the two fundamental problems that plague mainstream addiction treatment programs.

The healing community concept can be extended beyond the residential treatment facility to Vancouver's Downtown Eastside or any area with a severe addiction problem. Social housing can also be planned and organized with a view to fostering the development of a community spirit that facilitates psychosocial integration and the personal quest for meaning.

Conclusions

MCA complements mainstream addiction treatments, especially in its emphasis on meeting the existential and spiritual needs of addicts. Providing hope is also crucial to recovery. MCA provides a tragic sense of optimism that is based both on accepting reality and affirming faith in a more fulfilling future. From the meaning perspective, hitting rock bottom may be the turning point for recovery. MCA describes both the skills and the stages necessary for building a new life.

In addition, MCA advocates the development of a healing community, which will facilitate clients' psychosocial integration and provide a supportive environment for their personal quest for meaning. There is empirical evidence that social and emotional support is important for addiction recovery (Hart & McGarragle, 2010).

The ultimate objective of MCA is the realization of clients' full potentials. Thus, the treatment goals include not only *recovery from addiction* but also *restoration of full functioning and passion for living*. The recovery process needs to move from healing of addiction and brokenness to personal transformation and full integration into society. Complete abstinence is likely the outcome of complete restoration. Through the PURE and ABCDE strategies, MCA facilitates clients' quests for meaning and discovery of life purpose, and prepares and supports clients' re-entry and re-integration into society.

Given that addiction is multidimensional with numerous causes, Peele (2000) proposes that an ideal addiction model needs to be holistic and integrative, incorporating pharmacological, experiential, cultural, situational, and psycho-social components in describing and understanding the addictive motivation. MCA represents such an integrative model.

MCA is based on Viktor Frankl's logotherapy (Frankl, 1984). If addiction is a symptom of meaninglessness, then the restoration of meaning seems a logical approach to treatment and recovery. This paper simply provides an overview of what can be done to combat the problem of addiction.

In sum, MCA can complement existential programs by equipping clinicians with the fundamental principles and skills to (a) motivate and empower clients in their struggle for survival and fulfillment regardless of life circumstances, (b) tap into people's capacity for meaning-construction in order to help clients restore purpose, faith, and hope in their

predicaments, (c) provide the necessary tools for clients to overcome personal difficulties/anxieties and achieve their life's mission, and (d) establish a genuine healing relationship with clients.

References

- Alcoholics Anonymous (1990). *Alcoholics Anonymous*. New York: AA World Services. (Original work published 1939).
- Alcoholics Anonymous (2002). *Twelve steps and twelve traditions*. Alcoholics Anonymous World Services.
- Alexander, B.K. (2001). The roots of addiction in free market society. Canadian Centre for Policy Alternatives. Retrieved January 11, 2004, from <http://www.policyalternatives.ca/bc/rootsofaddiction.html>.
- American Society of Addiction Medicine (2001). *Public policy of ASAM*. Retrieved March 28, 2003, from <http://www.asam.org/ppol>.
- Bloom, F. E. (1992). Molecular genetics and psychiatry. In D. Kupfer (Ed.), *Reflections on modern psychiatry*. Washington, DC: American Psychiatric Press, pp. 79–90.
- Carroll, K., Rounsaville, B., & Keller, D. (1991). Relapse prevention strategies for the treatment of cocaine abuse. *American Journal of Drug and Alcohol Abuse*, 17(3), 249–265.
- Ellis, A. (1962). *Reason and emotion in psychotherapy*. Oxford, England: Lyle Stuart.
- Ellis, A. (1987). *The practice of rational-emotive therapy*. NY: Springer.
- Frankl, V. (1984). *Man's search for meaning*. Toronto, ON: Simon & Schuster.
- Hart, K.E., & McGarragle, O. (2010). Perceived social support from addictions counselors and client sobriety during aftercare: A pilot study of emotional support and functional support. *Alcoholism Treatment Quarterly*, 28, 198–229
- Heinz, A., Ragan, P., Jones, D. W., Hommer, D., Williams, W., Knable, M. B., Gorey, J. G., Doty, L., Geyer, C., Lee, K. S., Coppola, R., Weinberger, D. R., & Linoila, M. (1998). Reduced central serotonin transporters in alcoholism. *American Journal of Psychiatry*, 155, 1544–1549.
- Kalat, J. (2001). *Biological psychology*. Toronto ON: Addison-Wesley.
- Luborsky, L. (1984). *Principles of psychoanalytic psychotherapy: A manual for supportive-expressive (SE) treatment*. New York: Basic Books.
- MacPherson, D. (2001). A framework for action: A four-pillar approach to drug problems in Vancouver (Revised).
- Marlatt, G.A. & Gordon, J. R., (Eds.) (1985). *Relapse prevention: Maintenance strategies in the treatment of addictive behaviors*. New York: Guilford Press.
- Marlatt, G.A. (2000). *Harm reduction*. New York: The Guilford Press.
- Marlatt, A. (2002), Substance Abuse Treatment and the Stages of Change. *Addiction*, 97, 607–608.
- Miller, S. D. (2000). Description of the solution-focused brief therapy approach to problem drinking. In K. M. Carroll (Ed.), *Approaches to drug abuse counseling*. Bethesda, MA: National Institutes of Health.
- Miller, W. R. (2000). Motivational enhancement therapy: Description of counseling approach. In K. M. Carroll (Ed.), *Approaches to drug abuse counseling*. Bethesda, MA: National Institutes of Health.

- Niehoff, D. (1999). *The biology of violence*. Toronto, ON: Prentice-Hall.
- Peck, M. S. (1978). *The road less traveled: A new psychology of love, traditional values and spiritual growth*. New York, NY: Simon & Schuster.
- Peele, S. (1998). *The meaning of addiction: An unconventional view*. San Francisco, CA: Jossey-Bass.
- Peele, S. (2000). The meaning of addiction. Retrieved January 25, 2002, from <http://www.peele.net/lib/moa1.html>.
- Picucci, M. (1996). *Complete recovery: An expanded model of community healing*. New York, NY: Mombaccus Publishing.
- Prochaska, J.O., Norcross, J., & DiClemente, C. (1995). *Changing for good*. New York: Avon.
- Sayette, M.A. (1999). Does drinking reduce stress? *Alcohol Research & Health* 23(4), 250–255.
- Tonigan, J. S., Connors, G.J., Miller, W.R. (2003). Participation and involvement in Alcoholics Anonymous. In T. F. Babor, & F. K. Del Boca (Eds.), *Matching in alcoholism* (pp. 184–204). Cambridge: Cambridge University Press.
- Wong, P.T.P., and Fry, P.S. (1998). (Eds.). *The human quest for meaning: A handbook of psychological research and clinical applications*. Mahwah, NJ: Erlbaum.
- Wong, P. T. P. (2009). Viktor Frankl: Prophet of hope for the 21st century. In A. Batthyany & J. Levinson (Eds.), *Existential psychotherapy of meaning: Handbook of logotherapy and existential analysis*. Phoenix, AZ: Zeig, Tucker & Theisen, Inc.
- Wong, P. T. P. (2010). Meaning therapy: An integrative and positive existential psychotherapy. *Journal of Contemporary Psychotherapy*, 40, 85–99.
- Wong, P. T. P. (2012). From logotherapy to meaning-centered counseling and therapy. In P. T. P. Wong (Ed.), *The human quest for meaning: Theories, research, and applications* (2nd ed., pp. 619–647). New York, NY: Routledge.
- Woody, G.E., McLellan, A.T., Luborsky, L., & O'Brien, C.P. (1995). Psychotherapy in community methadone programs: a validation study. *American Journal of Psychiatry*, 152(9), 1302–1308.