Development and characteristics of a well-being enhancing psychotherapeutic strategy: well-being therapy

Giovanni A. Favaa,b,*, Chiara Ruinia

a Affective Disorders Program, Department of Psychology, University of Bologna, Viale Berti Pichat 5, Bologna 40127, Italy
b Department of Psychiatry, State University of New York at Buffalo, Buffalo, NY, USA

Received 16 April 2002; received in revised form 20 January 2003; accepted 25 February 2003

Abstract

This article describes the main characteristics and technical features of a novel psychotherapeutic strategy, well-being therapy. This paper outlines the background of its development, the structure of well-being therapy, its key concepts and technical aspects. Well-being therapy is based on Ryff's multidimensional model of psychological well-being, encompassing six dimensions: autonomy, personal growth, environmental mastery, purpose in life, positive relations and self-acceptance. The goal of this therapy is improving the patients’ levels of psychological well-being according to these dimensions, using cognitive-behavioral techniques. It may be applied as a relapse-preventive strategy in the residual phase of affective (mood and anxiety) disorders, as an additional ingredient of cognitive-behavioral packages, in patients with affective disorders who failed to respond to standard pharmacological or psychotherapeutic treatments and in body image disturbances. The clinical studies supporting its efficacy are illustrated.

Keywords: Psychological well-being; Quality of life; Affective disorder; Recovery; Residual symptoms

1. Background

In the recent decades, the development of psychotherapeutic strategies which may lead to symptom reduction has been the main focus of research. Such developments...
have been particularly impressive for cognitive behavioral therapies (Fava, 2000). Even though as early as in Parloff, Kelman, and Frank (1954) suggested that the goals of psychotherapy were increased personal comfort and effectiveness, these latter achievements were viewed only as by-products of the reduction of symptoms or as a luxury that clinical investigators could not afford. A number of converging developments have, however, modified such a stance.

1.1. Relapse and recurrence in mood and anxiety disorders

There has been increasing awareness of the bleak long term outcome of mood and anxiety disorders (Fava, 1996), and particularly in unipolar major depression (Labbate & Doyle, 1997; Fava, 1999a). For instance, Ramana et al. (1995) reported on the course of depression with respect to remission and relapse in a 2-year prospective study. Remission was rapid with 70% of patients remitting with pharmacological treatment within 6 months and only 6% failing to do so by 15 months. However, 40% relapsed over the subsequent months, with all relapses occurring during the first 10 months. As a result, the challenge of treatment of depression today appears to be the prevention of relapse more than the attainment of recovery. Thunedborg, Black, and Bech (1995) found that quality of life measurement, and not symptomatic ratings, could predict recurrence of depression. It has thus become a legitimate question to wonder whether an increase in psychological well-being may protect against relapse and recurrence.

1.2. Clinical response mistaken as recovery

There is increasing awareness that clinicians and researchers in clinical psychiatry confound response to treatment with full recovery (Fava, 1996). A substantial residual symptomatology (anxiety, irritability, interpersonal problems) was found to characterize the majority of patients who were judged to be remitted according to DSM criteria and no longer in need of active treatment. Further, psychological well-being needs to be incorporated in the definition of recovery (Fava, 1996). Ryff and Singer (1996) have suggested that the absence of well-being creates conditions of vulnerability to possible future adversities and that the route to enduring recovery lies not exclusively in alleviating the negative, but in engendering the positive. Interventions that bring the person out of the negative functioning (e.g., exposure treatment in panic disorder with agoraphobia) are one form of success, but facilitating progression toward the restoration of positive is quite another (Ryff & Singer, 1996).

1.3. Quality of life and positive health

There has been an upsurge of interest in quality of life assessment in health care (Frisch, 1998; Fava & Sonino, 2000) and in the concept of positive health (Ryff & Singer, 2000). Clinical researchers have turned their attention to quality of life assessment as a means of broadening the evaluation of treatment outcome (Gladis,
Gosch, Dishuk, & Crits-Cristoph, 1999). There appears to be theoretical and empirical justification for a broad definition of quality of life (encompassing satisfaction, functioning and objective life circumstances). This creates the necessity of multidimensional instruments (Gladis et al., 1999). Such directions in health care call for strategies to enhance the well-being which underlies these constructs.

1.4. The growth of positive psychology

There is increasing interest in the road to positive psychology (Gillham & Seligman, 1999). Issues such as the building of human strength in different psychotherapeutic strategies and the characteristics of subjective well-being have become increasingly important in psychological research (Diener, Suh, Lucas, & Smith, 1999; Gillham & Seligman, 1999). A recent review by Ryan and Deci (2001) examines the concept of well-being and describes two main approaches adopted by researchers: the hedonic one and the eudaimonic one. According to the former, well-being consists of subjective happiness, pleasure and pain avoidance. Thus, the concept of well-being is equated with the experience of positive emotions versus negative emotions and with satisfaction in various domains of one’s life. According to the eudaimonic perspective, well-being consists of fulfilling one’s potential in a process of self-realization. Under this umbrella some researchers describe concepts such as fully functioning person, meaningfulness, self-actualization and vitality. These two approaches are quite different and have lead to different areas of research, but they complement each other in defining the construct of well-being (Ryan & Deci, 2001). However, in clinical psychology the eudaimonic view has found much more feasibility because it concerns human potential and personal strength (Ryff & Singer, 1996). In particular, Ryff’s model of psychological well-being, encompassing autonomy, personal growth, environmental mastery, purpose in life, positive relations and self-acceptance has been found to fit specific impairments of patients with affective disorders (Rafanelli et al., 2000, 2002; Fava et al., 2001; Ruini et al., 2002).

These four developments have paved the way for well-being enhancing psychotherapeutic strategies in clinical medicine. However there has been a very limited response to these emerging needs. Notable exceptions are Ellis and Becker’s (1982) guide to personal happiness, Fordyce’s (1983) program to increase happiness, Padesky’s (1994) work on schema change processes, Frisch’s (1998) quality of life therapy, and Horowitz and Kaltreider (1979) work on positive states of mind. Unfortunately, these approaches have not affected clinical practice.

Not surprisingly, in Bergin and Garfield’s (1994)“Handbook of Psychotherapy and Behavior Change” the words “well-being” or “happiness” do not appear in the subject index. There seem to be three main reasons for this absence. First of all—as Ryff and Singer (1996) remark — historically mental health research is dramatically weighted on the side of psychological dysfunction and health is equated with the absence of illness rather than the presence of wellness. In a naive conceptualization, yet the one implicitly endorsed by DSM, well-being and distress may be seen as mutually exclusive (i.e., well-being is lack of distress). According to this model,
well-being should result from removal of distress. Yet, there is evidence both in psychiatric (Rafanelli et al., 2000) and psychosomatic (Fava, Mangelli, & Ruini, 2001) research to call such views in question. A second reason is concerned with the conceptual model a psychotherapeutic approach should refer to. In order to justify therapeutic efforts aimed at increasing psychological well-being, we should demonstrate impaired levels of psychological well-being in a clinical population. This was achieved by using an instrument, the psychological well-being scales (PWB) developed by Ryff (1989) on the basis of her synthesis of the literature available, including Jahoda’s (1958) criteria of positive human health.

In a controlled investigation (Rafanelli et al., 2000), 20 remitted patients with mood or anxiety disorders displayed significantly lower levels in all 6 dimensions of well-being according to the PWB—14 items version—compared to healthy control subjects matched for sociodemographic variables. It is obvious, however, that the quality and degree of impairment may vary from patient to patient and, within the same patient, according to the clinical status. A fair degree of overlap and correlations among dimensions of well-being (Ryff, 1989; Rafanelli et al., 2000) should be expected.

Further, Fava et al. (2001) administered the PWB to 30 remitted patients with panic disorder and 30 matched controls and found impairments in some specific areas, but not in others. The model described by Ryff (1989) and Ryff and Keyes (1995) was thus found to satisfactorily describe the variations in psychological well-being which may occur in a clinical setting. The concept of salutogenesis developed by the medical sociologist Aaron Antonovsky (1987) was an important, yet partial, element.

Finally, until recently, it was unclear what types of clinical applications might be feasible for a well-being enhancing psychotherapy. This was because therapeutic efforts were aimed only at the acute phase of psychiatric disorders and subclinical symptomatology was viewed as devoid of substantial clinical interest (Fava, 1997). The application of a well-being enhancing psychotherapeutic strategy as a relapse preventive measure was thus not envisioned. The helpfulness of positive cognitions within cognitive therapy was only recently highlighted by a number of investigators (MacLeod & Moore, 2000).

This clinical and conceptual framework was thus instrumental in developing a well-being enhancing psychotherapeutic strategy, defined as well-being therapy (Fava et al., 1998a).

2. Structure of well-being therapy

Well-being therapy is a short-term psychotherapeutic strategy, that extends over 8 sessions, which may take place every week or every other week. The duration of each session may range from 30 to 50 minutes. It is a technique which emphasizes self-observation (Emmelkamp, 1974), with the use of a structured diary, and interaction between patients and therapists. Well-being therapy is based on Ryff’s cognitive model of psychological well-being (Ryff, 1989). This model was selected on the basis
of its easy applicability to clinical populations (Rafanelli et al., 2000; Fava et al., 2001). Well-being therapy is structured, directive, problem-oriented and based on an educational model. The development of sessions is as follows.

2.1. Initial sessions

These sessions are simply concerned with identifying episodes of well-being and setting them into a situational context, no matter how short lived they were. Patients are asked to report in a structured diary the circumstances surrounding their episodes of well-being, rated on a 0–100 scale, with 0 being absence of well-being and 100 the most intense well-being that could be experienced (Table 1). When patients are assigned this homework, they often object that they will bring a blank diary, because they never feel well. It is helpful to reply that these moments do exist but tend to pass unnoticed. Patients should therefore monitor them anyway.

Meehl (1975) described “how people with low hedonic capacity should pay greater attention to the “hedonic book keeping” of their activities than would be necessary for people located midway or high on the hedonic capacity continuum. That is, it matters more to someone cursed with an inborn hedonic defect whether he is efficient and sagacious in selecting friends, jobs, cities, tasks, hobbies, and activities in general” (p. 305).

This initial phase generally extends over a couple of sessions. Yet its duration depends on the factors that affect any homework assignment, such as resistance and compliance.

2.2. Intermediate sessions

Once the instances of well-being are properly recognized, the patient is encouraged to identify thoughts and beliefs leading to premature interruption of well-being. For instance, in the example reported in Table 1, the patients added “it is just because I brought two presents”. The similarities with the search for irrational, tension-evoking thoughts in Ellis and Becker’s (1982) rational-emotive therapy and automatic thoughts in cognitive therapy (Beck, Rush, Shaw, & Emery, 1979) are obvious. The trigger for self-observation is, however, different, being based on well-being instead of distress.

This phase is crucial, since it allows the therapist to identify which areas of psychological well-being are unaffected by irrational or automatic thoughts and which are saturated with them. The therapist may challenge these thoughts with

| Table 1 |
|-------------------|-------------------|
| **Situation** | **Feeling of well-being** | **Intensity (0–100).** |
| I went to visit my nephews and they greeted me with great enthusiasm and joy. | They like me and care for me. | 40 |
appropriate questions, such as “what is the evidence for or against this idea?” or “are you thinking in all-or none terms?” (Beck et al., 1979). The therapist may also reinforce and encourage activities that are likely to elicit well-being (for instance, assigning the task of undertaking particular pleasurable activities for a certain time each day). Such reinforcement may also result in graded task assignments (Beck et al., 1979). However, the focus of this phase of well-being therapy is always on self-monitoring of moments and feelings of well-being. The therapist refrains from suggesting conceptual and technical alternatives, unless a satisfactory degree of self-observation (including irrational or automatic thoughts) has been achieved. This intermediate phase may extend over 2 or 3 sessions, depending on the patient’s motivation and ability, and it paves the way for the specific well-being enhancing strategies.

2.3. Final sessions

The monitoring of the course of episodes of well-being allows the therapist to realize specific impairments in well-being dimensions according to Ryff’s conceptual framework. An additional source of information may be provided by Ryff’s PWB, an 84-item self-rating inventory (Ryff, 1989). In the original validation study of well-being therapy (Fava et al., 1998a), however, PWB results were not available to the therapist, who just worked from the patient’s diary. Ryff’s six dimensions of psychological well-being are progressively introduced to the patients, as long as the material which is recorded lends itself to it. For example, the therapist could explain that autonomy consists of possessing an internal locus of control, independence and self-determination; or that personal growth consists of being open to new experience and considering self as expanding over time, if the patient’s attitudes show impairments in these specific areas. Errors in thinking and alternative interpretations are then discussed.

3. Key concepts in well-being therapy

Cognitive restructuring in well-being therapy follows Ryff’s conceptual framework (Ryff & Singer, 1996). The goal of the therapist is to lead the patient from an impaired level to an optimal level in the six dimensions of psychological well-being:

3.1. Environmental mastery

This is the most frequent impairment that emerges (Table 2). It was expressed by a patient as follows “I have got a filter that nullifies any positive achievement (I was just lucky) and amplifies any negative outcome, no matter how much expected (this once more confirms I am a failure)”. This lack of sense of control leads the patient to miss surrounding opportunities, with the possibility of subsequent regret over them.
Table 2
Modification of the six dimensions of psychological Well-being according to Ryff’s model (1989)

<table>
<thead>
<tr>
<th>Dimensions</th>
<th>Impaired level</th>
<th>Optimal level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Environmental mastery</td>
<td>The subject has or feels difficulties in managing everyday affairs; feels unable to change or improve surrounding context; is unaware of surrounding opportunities; lacks sense of control over external world.</td>
<td>The subject has a sense of mastery and competence in managing the environment; controls external activities; makes effective use of surrounding opportunities; able to create or choose contexts suitable to personal needs and values.</td>
</tr>
<tr>
<td>Personal growth</td>
<td>The subject has a sense of personal stagnation; lacks sense of improvement or expansion over time; feels bored and uninterested with life; feels unable to develop new attitudes or behaviors.</td>
<td>The subject has a feeling of continued development; sees self as growing and expanding; is open to new experiences; has sense of realizing own potential; sees improvement in self and behavior over time.</td>
</tr>
<tr>
<td>Purpose in life</td>
<td>The subject lacks a sense of meaning in life; has few goals or aims, lacks sense of direction, does not see purpose in past life; has no outlooks or beliefs that give life meaning.</td>
<td>The subject has goals in life and a sense of directedness; feels there is meaning to present and past life; holds beliefs that give life purpose; has aims and objectives for living.</td>
</tr>
<tr>
<td>Autonomy</td>
<td>The subject is overconcerned with the expectations and evaluation of others; relies on judgment of others to make important decisions; conforms to social pressures to think or act in certain ways.</td>
<td>The subject is self-determining and independent; able to resist to social pressures; regulates behavior from within; evaluates self by personal standards.</td>
</tr>
<tr>
<td>Self-acceptance</td>
<td>The subject feels dissatisfied with self; is disappointed with what has occurred in past life; is troubled about certain personal qualities; wishes to be different than what he or she is.</td>
<td>The subject has a positive attitude toward the self; accepts his/her good and bad qualities; feels positive about past life.</td>
</tr>
<tr>
<td>Positive relations with others</td>
<td>The subject has few close, trusting relationships with others; finds difficult to be open and is isolated and frustrated in interpersonal relationship; not willing to make compromises to sustain important ties with others.</td>
<td>The subject has warm and trusting relationships with others; is concerned about the welfare of others; capable of strong empathy affection, and intimacy; understands give and take of human relationships.</td>
</tr>
</tbody>
</table>

3.2. Personal growth

Patients often tend to emphasize their distance from expected goals much more than the progress that has been made toward goal achievement (Table 2). A basic impairment that emerges is the inability to identify the similarities between events and situations that were handled successfully in the past and those that are about to come (transfer of experiences). Impairments in perception of personal growth and environmental mastery thus tend to interact in a dysfunctional way. A university
students who are unable to realize the common contents and methodological similarities between the exams he or she successfully passed and the ones that are to be given, shows impairments in both environmental mastery and personal growth.

3.3. Purpose in life

An underlying assumption of psychological therapies (whether pharmacological or psychotherapeutic) is to restore premorbid functioning (Table 2). In case of treatments which emphasize self-help such as cognitive-behavioral, therapy itself offers a sense of direction and hence a short-term goal. However, this does not persist when acute symptoms abate and/or premorbid functioning is suboptimal. Patients may perceive a lack of sense of direction and may devalue their function in life. This particularly occurs when environmental mastery and sense of personal growth are impaired.

3.4. Autonomy

It is a frequent clinical observation that patients may exhibit a pattern whereby a perceived lack of self-worth leads to unassertive behavior. For instance, patients may hide their opinions or preferences, go along with a situation that is not in their best interests, or consistently put their needs behind the needs of others. This pattern undermines environmental mastery and purpose in life and these, in turn, may affect autonomy, since these dimensions are highly correlated in clinical populations. Such attitudes may not be obvious to the patients, who hide their considerable need for social approval. A patient who tries to please everyone is likely to fail to achieve this goal and the unavoidable conflicts that may ensue result in chronic dissatisfaction and frustration.

3.5. Self-acceptance

Patients may maintain unrealistically high standards and expectations (Table 2), driven by perfectionistic attitudes (that reflect lack of self-acceptance) and/or endorsement of external instead of personal standards (that reflect lack of autonomy). As a result, any instance of well-being is neutralized by a chronic dissatisfaction with oneself. A person may set unrealistic standards for her performance. For instance, it is a frequent clinical observation that patients with social phobia tend to aspire to outstanding social performances (being sharp, humorous, etc.) and are not satisfied with average performances (despite the fact that these latter would not put them under the spotlights, which could be seen as their apparent goal).

3.6. Positive relations with others

Interpersonal relationships may be influenced by strongly held attitudes of which the patient may be unaware and which may be dysfunctional (Table 2). For instance,
a young woman who recently got married may have set unrealistic standards for her marital relationship and find herself frequently disappointed. At the same time she may avoid pursuing social plans which involve other people and may lack sources of comparison. Impairments in self-acceptance (with the resulting belief of being rejectable and unlovable) may also undermine positive relations with others.

4. Technical aspects

The techniques that are used in overcoming these impairments in psychological well-being may include cognitive restructuring (modification of automatic or irrational thoughts), scheduling of activities (mastery, pleasure, and graded task assignments), assertiveness training, and problem solving (Ellis & Becker, 1982; Beck et al., 1979; Pava, Fava, & Levenson, 1994; Weissman & Markowitz, 1994).

The goal of the therapist is to lead the patient through the transitions outlined in Table 2. As happens with symptom oriented cognitive behavioral therapy, at times the simple discovery of untested standards and assumptions for well-being may lead to challenge and growth. Other times, modification of these patterns may be time consuming and require working on repeated instances through the structured diary. However, it is only when such insights about these impairments in well-being dimensions are translated into behavioral terms that a significant improvement has been made. For instance, a patient after his third recurrent episode of major depression may learn how his lack of autonomy leads his work-mates to consistently take advantage of him. This situation results in a workload that, because of its diverse nature, undermines his environmental mastery and constitutes a significant stress, also in terms of working hours. The situation is accepted in virtue of a low degree of self-acceptance: the patient claims that this is the way he is, but at the same time he is dissatisfied with self and chronically irritable. When he learns to say no to his colleagues (assertive training) and consistently endorses this attitude, a significant degree of distress ensues, linked to perceived disapproval by others. However, as time goes by, his tolerance for self-disapproval gradually increases and in the last session is able to make the following remark: “Now my work-mates say that I am changed and have become a bastard. In a way I am sorry, since I always tried to be helpful and kind to people. But in another way I am happy, because this means that—for the first time in my life—I have been able to protect myself”. The patient had no further relapse at a 6-year follow-up, while being drug free.

This clinical picture illustrates how an initial feeling of well-being (being helpful to others) that was identified in the diary, was likely to lead to an overwhelming distress. Its appraisal and the resulting change in behavior initially led to more distress, but then yielded a lasting remission. The example clarifies that a similar behavioral change might have been achieved by distress-oriented psychotherapeutic strategies, (indeed, the approach that was used to tackle this specific problem was no different). However, these changes would have not been supported by specific modifications of well-being dimensions.
The standard format that has been outlined involves 8 sessions; however, the number of sessions may vary according to the patient’s needs and collaboration with therapy. In certain cases, 12–16 sessions may be necessary; in other cases (when, for instance, the patient already underwent a traditional, symptom oriented cognitive behavioral therapy and is thus familiar with daily homework and the diary), the number of sessions may be shortened.

A question which may arise is what differentiates well-being therapy from standard cognitive therapies, which may also involve positive thinking (MacLeod & Moore, 2000). A main difference is the focus (which in well-being therapy is on instances of emotional well-being, whereas in cognitive therapy is on psychological distress). A second important distinction is that in cognitive therapy the goal is abatement of distress through automatic thought control or contrast, whereas in well-being therapy the goal is promotion of psychological well-being along Ryff’s (1989) dimensions (see Table 2). Since both may share similar techniques and therapeutic ingredients, well-being therapy may be conceptualized as a specific strategy within the broad spectrum of self-therapies (Fava, 2000).

A final distinction is the fact that, unlike cognitive behavioral frameworks, well-being therapy refrains from explaining from the onset to the patient its rationale and strategies, but relies on his/her progressive appraisals of positive self. The patient who struggles against anxiety, for instance, may be helped to view anxiety as an unavoidable element of everyday life which can be counteracted by a progressive increase in environmental mastery and self-acceptance.

5. Potential mechanisms of action

Well-being therapy’s effectiveness may be based on two distinct yet ostensibly related clinical phenomena. The first has to do with the fact that an increase in psychological well-being may have protective effect in terms of vulnerability to chronic and acute life stresses (Ryff & Singer, 1998; 2000). The second has to do with the complex balance of positive and negative affects. There is extensive research—reviewed in detail elsewhere (Rafanelli et al., 2000)—which indicates a certain degree of inverse correlation between positive and negative affects. As a result, changes in well-being may induce a decrease in distress, and vice versa. In the acute phase of illness, removal of symptoms may yield the most substantial changes, but the reverse may be true in its residual phase. An increase in psychological well-being may decrease residual symptoms which direct strategies (whether cognitive behavioral or pharmacological) would be unlikely to affect.

Further, it has been suggested that cognitive behavioral psychotherapy may work at the molecular level to alter stress-related gene expression and protein synthesis or influence mechanisms implicated in learning and memory acquisition in neuronal structures (Goddard & Charney, 1997). For instance, in one study sadness and happiness affected different brain regions: sadness activates limbic and paralimbic structures, whereas happiness was associated with temporal parietal decreases in cortical activity (George et al., 1995). Such effects were not merely opposite activity
in identical brain regions. The pathophysiological substrates of well-being therapy may thus be different compared to symptom-oriented cognitive behavioral strategies, to the same extent that well-being and distress are not merely opposites (Rafanelli et al., 2000).

6. Preliminary validation studies

Well-being therapy, according to the format previously outlined, has been employed in several clinical studies. Other studies are currently in progress.

6.1. Residual phase of affective disorders

The effectiveness of well-being therapy in the residual phase of affective disorders has been tested in a small controlled investigation (Fava et al., 1998a). Twenty patients with affective disorders (major depression, panic disorder with agoraphobia, social phobia, generalized anxiety disorder, obsessive compulsive disorder) who had been successfully treated by behavioral (anxiety disorders) or pharmacological (mood disorders) methods, were randomly assigned to either a well-being therapy or cognitive behavioral treatment of residual symptoms. Both well-being and cognitive behavioral therapies were associated with a significant reduction of residual symptoms, as measured by the Clinical Interview for Depression (CID) (Paykel, 1985), and in PWB well-being. However, when the residual symptoms of the two group were compared after treatment, a significant advantage of well-being therapy over cognitive behavioral strategies was observed with the CID ($p<0.001$). Well-being therapy was associated also with a significant increase in PWB well-being ($p<0.05$), particularly in the Personal Growth scale. The small number of subjects suggests caution in interpreting this difference and the need for further studies with larger samples of patients with specific affective disorders. However, these preliminary results point to the feasibility of well-being therapy in the residual stage of affective disorders.

The improvement in residual symptoms may be explained on the basis of the balance between positive and negative affect (Fava et al., 1998a). If treatment of psychiatric symptoms induces improvement of well-being—and indeed subscales describing well-being are more sensitive to drug effects than subscales describing symptoms (Kellner, 1987)—it is conceivable that changes in well-being may affect the balance of positive and negative affect. In this sense, the higher degree of symptomatic improvement that was observed with well-being therapy in this study is not surprising: in the acute phase of affective illness, removal of symptoms may yield the most substantial changes, but the reverse may be true in its residual phase.

6.2. Prevention of recurrent depression

Well-being therapy was a specific and innovative part of a cognitive behavioral package that was applied to recurrent depression (Fava et al., 1998b), defined as the
occurrence of 3 or more episodes of unipolar depression, with the immediately preceding episode being no more than 2.5 years before the onset of the current episode (Frank et al., 1990). This package included also cognitive behavioral treatment of residual symptoms (Fava et al., 1994; Fava, Grandi, Zielezny, Rafanelli, & Canestra 1996) and lifestyle modification (Fava et al., 1998b). Forty patients with recurrent major depression, who had been successfully treated with antidepressant drugs, were randomly assigned to either this cognitive behavioral package including well-being therapy or clinical management. In both groups, antidepressant drugs were tapered and discontinued. The group that received cognitive behavioral therapy had a significantly lower level of residual symptoms after drug discontinuation in comparison with the clinical management group ($p < 0.001$). Cognitive behavioral therapy also resulted in a significantly lower relapse rate (25%) at a 2-year follow-up than did the control (80%): using Cox proportional hazards regression model, cognitive behavioral therapy was highly significant in delaying recurrence ($p = 0.003$). Since well-being therapy here was only a part of cognitive behavioral package and therefore it was associated with two other main ingredients (cognitive behavioral treatment of residual symptoms and lifestyle modification), it is not possible to know from this study whether it yielded a significant contribution (Picardi & Biondi, 2002).

6.3. Loss of clinical effect

The return of depressive symptoms during maintenance antidepressant treatment is a common and vexing clinical phenomenon (Baldessarini, Ghaemi, & Viguera, 2002). A number of pharmacological strategies have been suggested for addressing loss of antidepressant efficacy, but with limited effects (Schmidt et al., 2002). Ten patients with recurrent depression who relapsed while taking antidepressant drugs were randomly assigned to dose increase or to a sequential combination of cognitive-behavior and well-being therapy (Fava, Ruini, Rafanelli, & Grandi, 2002). Four out of five patients responded to a larger dose, but all relapsed again on that dose by 1-year follow-up. Four out of the 4 patients responded to psychotherapy and only one relapsed. The data suggest that application of well-being therapy may counteract loss of clinical effect during long-term antidepressant treatment. Tolerance to antidepressant treatment has been associated with activation of the hypothalamic-pituitary-adrenal (HPA) axis (Sonino & Fava, 2003). In a single case report, well-being therapy induced a normalization of the HPA axis (Sonino & Fava, 2003). It is thus conceivable that well-being therapy may, through this mechanism, restore and maintain remission with antidepressant drugs when response fails or is about to fail.

7. Examples of additional potential clinical applications

Well-being therapy was originally designed as a specific psychotherapeutic strategy for the residual of affective disorders (Fava et al., 1998a). The application of this therapy to acutely ill patients, whose life is dominated by mental pain and
suffering, indeed appeared to be difficult. While this remains its most important clinical application, there are several other areas that may be potentially beneficial.

7.1. Cognitive behavioral treatment packages

Well-being therapy may not be necessarily used on its own; it may become a part of a more complex, symptom oriented cognitive behavioral strategy. By adding monitoring of episodes of well-being, it may provide a more comprehensive coverage of automatic thoughts and dysfunctional schemas. This hypothesis needs to be tested in controlled studies comparing cognitive behavioral therapy alone and with well-being therapy. We are currently comparing the use of symptom oriented cognitive therapy with or without the addition of well-being therapy in generalized anxiety disorder.

7.2. Treatment refractoriness in affective disorders

There is increasing awareness of the high proportion of patients with affective disorders who fail to respond to standard pharmacological and psychotherapeutic treatments (Pollack, Otto, & Rosenbaum, 1996). For instance, drug-resistant depression is a clinical problem that occurs in about 20% of depressive episodes (Ananth, 1998) and is amenable to cognitive behavioral treatment (Fava, Savron, Grandi, & Rafanelli, 1997). Resistance to exposure to phobic situations in panic disorder was found to be associated with lower compliance with regard to exposure homework (Fava et al., 1997). Compliance, particularly in cognitive behavioral settings, requires the patient’s endurance and motivation. It is thus conceivable that well-being therapy may either complete the degree of improvement afforded by symptom oriented treatments or increase compliance or both. This was found in a preliminary study on 3 patients with panic disorder associated with agoraphobia who failed 3 sequential trials of exposure, imipramine and cognitive therapy (Fava, 1999b). There has been little exploration, outside of the psychodynamic realm, of psychological factors affecting progression to full recovery in affective illness (Strean, 1985). Yet, clinical phenomena such as refusal to comply with basic requests are common observations in this setting. The strategies for handling psychological resistances derive from psychodynamic psychotherapy. It is possible that Ryff’s conceptual framework and well-being therapy may provide an empirically based approach to the understanding and treatment of these clinical phenomena. For instance, a low level of self-acceptance may affect the initial phase of exposure treatment: the patient may perceive the difficulties and ups and downs of treatment as a demonstration of his/her poor personal qualities, instead of as unavoidable drawbacks of the process of graded exposure.

7.3. Body image disorders

Even though there is little specific investigation in the area of body image disorders, psychological dimensions related to well-being may be related to them,
with particular reference to body dysmorphic disorder. Current treatment of body image disorder appears to lack specific therapies (Kanayama, Pope, & Hudson, 2001; Mangweth et al., 2001; Jaeger et al., 2002), aside from cognitive restructuring of unrealistic thoughts on one’s appearance. Well-being therapy may have a therapeutic potential in this area. If specific impairments in psychological well-being are demonstrated in body dysmorphic disorder, they may be amenable to improvement and this may lead either to a more effective contrast of body-image related automatic thoughts or to a decrease in the patient’s perceived importance. Such a study is currently in progress.

7.4. Psychosomatic medicine

Ryff and Singer (1998) discussed the contours of positive human health, and how it is rooted in a biopsychosocial consideration of the patient (Engel, 1997; Sivik, 2000; Wise, 2000; Rigatelli, Ferrari, Uguzzoni, & Natali, 2000). An extensive body of evidence suggests the influence of psychological well-being in altering individual vulnerability to disease (Ryff & Singer, 1998; Mangelli, Gribbin, Buchi, Allard, & Sensky, 2002) or quality of life (Fava & Sonino, 2000; Ryff & Singer, 2000). An increase in psychological well-being may counteract the feelings of demoralization and loss which are part of chronic disease and thus improve the individual coping. It is thus conceivable that well-being therapy may yield clinical benefits in improving quality of life, coping style and social support in chronic and life-threatening illnesses, as was shown for cognitive behavioral strategies (Emmelkamp & Van Oppen, 1993). Disorders related to somatization—defined as the tendency to experience and communicate psychological distress in the form of physical symptoms and to seek medical help for them (Lipowski, 1987)—may also derive some benefit from well-being enhancing strategies.

7.5. Obsessive-compulsive disorder

Intrusive anxiety-provoking thoughts are a core feature of obsessive-compulsive disorder (Marks, 1997). Recent research (Amir, Cashman, & Foa, 1997) suggests that obsessive patients use punishment, worry, reappraisal, and social control, as techniques of thought control, more frequently than healthy subjects. Punishment appears to be the strongest discriminator (Amir et al., 1997). Clinical observation suggests that anxiety-provoking thoughts may often be preceded by instances of well-being in obsessive-compulsive disorder. These patients may thus have a low-threshold for well-being related anxiety. This hypothesis needs to be tested in controlled studies on cognitive therapy of obsessive-compulsive disorder (Cottraux et al., 2001; Mataix-Cols, Marks, Greist, Kobak, & Baer, 2002). The following example illustrates this point.

Tom is a 23-year-old philosophy student with a severe obsessive illness, fulfilling the DSM-IV criteria, and refractory to drug treatment (fluvoxamine up to 200 mg per day and clomipramine 150 mg per day) and cognitive behavioral therapy (he dropped out of treatment after 6 sessions). He is treated by the first author with
well-being therapy. After the first two sessions he is able to identify that obsessions start when well-being ensues (Table 3). Adding an observer’s interpretation column makes the patient realize that an effective contrast of pre-obsessive thoughts triggered by well-being may prevent obsessions and ruminations (Table 4). As long as therapy goes on (one session every other week) the intensity and perceived importance of obsessions decrease. After 8 sessions, the patient no longer meets DSM-IV criteria for obsessive-compulsive disorder and feels much better. He is able to finish his studies. He no longer reports obsessive-compulsive disturbances at a 4-year follow-up.

7.6. Geriatrics

A vast literature has accumulated on interventions aimed to increasing subjective well-being in the elderly (Okun, Olding, & Cohn, 1990). Interventions seem to have a significant immediate post-treatment beneficial influence, but such gains fade in subsequent months. The use of well-being therapy in an elderly population may yield more enduring effects. Also this hypothesis needs to be tested in controlled studies.

8. Conclusions

Well-being therapy is obviously at a very preliminary stage. Adequate validation studies should elucidate its specific role in psychiatry and psychosomatic medicine. Unlike several psychotherapeutic techniques that have been affected by orthodoxy, it
is hoped that its current format may undergo major changes in the next few years, according to research evidence as well as the clinical experience of practicing clinicians (Fava, 1986). It is also hoped that it may contribute to changing outcome definitions in psychiatric disorders (Fava, 1996; Mischoulon et al., 2001; MacLeod, Pankhania, Lee & Mitchell, 1997; Lam, Green, Power & Checkley, 1994).

The goal of well-being therapy may appear to be ambitious. As the Latin philosopher Seneca warns in “De vita beata”, the more we look for happiness, the less likely we are to achieve it. Happiness is not everything—as Carol Ryff demonstrated about 19 centuries later (Ryff, 1989)—and what is required is “felicitatis intellectus”, the awareness of well-being. Subjective happiness, positive emotions and pleasure cannot be equated with well-being, because they tend to be short-lived and do not produce improvement or development of personality. True wellness and healthy living, thus, can be promoted by realizing one’s true potential, being fully engaged with other people and giving meaning to everyday activities, in a process of self-realization, just as Seneca wrote some centuries ago:

“Happy is thus the life that is in accordance to its nature, and this is possible only when the mind, first of all, is healthy at any time; then, if it is strong and energetic, definitely patient, capable of mastering everything; concerned with the body and its belongings, but without anxiety; lover of what is life, but with detachment; willing to take advantage of the gifts of fortune, without being its slave”. (Seneca, De vita beata, Authors’ translation).

Acknowledgements

This paper was supported in part by a grant from the Mental Health Outcome Evaluation Project (Istituto Superiore di Sanità, Roma, Italy) and a grant from the Ministero dell’Università e della Ricerca Scientifica e Tecnologica (MURST, Roma, Italy). Dr. Carol D. Ryff’s work, criticism and guidance were instrumental in developing the psychotherapeutic technique described in this paper.

References


