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Review

The emerging role of euthymia in psychotherapy research and practice

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ABSTRACT

Euthymia is generally conceived in negative terms (absence of psychiatric disorders), yet it may also indicate a trans-diagnostic construct where lack of mood disturbances is associated with positive affects and psychological well-being (flexibility, consistency and resilience). Specific strategies for the assessment of euthymia are available, including both observer- and self-rated instruments that may be applied within a clinimetric framework encompassing macro-analysis and staging. Self-observation of psychological distress in a diary is the basic, neglected method of cognitive and behavioral strategies. Self-observation of instances of well-being may become the source of psychotherapeutic work geared to euthymia, combined with cognitive restructuring, homework assignments and clinical interaction. Well-Being Therapy (WBT) specifically pursues this approach. It may be incorporated in a therapeutic plan based on clinical reasoning and case formulation. The target of euthymia may also be accomplished by other psychotherapeutic strategies, such as mindfulness-based cognitive therapy and acceptance and commitment therapy. Clinical applications encompass decreasing vulnerability to relapse, increasing the level of recovery and modulating mood. The practice of self-observation of psychological well-being in a diary, as manualized in WBT, may trigger important developments in clinical assessment and in other psychotherapeutic techniques geared to a state of euthymia.

1. Introduction

In recent decades, the development of psychotherapeutic strategies which may lead to symptom reduction has been the main focus of psychotherapy research. Such developments have been particularly impressive for cognitive-behavioral therapies (Wright, Brown, Thase, & Ramirez-Basco, 2017). However, as early as in 1954, Parloff, Kelman and Frank suggested that the goals of psychotherapy were increased personal comfort and effectiveness and the spontaneous mobilization of patient's recuperative forces (Parloff, Kelman, & Frank, 1954). A few years later, Marie Jahoda denied that "the concept of mental health can be usefully defined by identifying it with the absence of a disease. It would seem, consequently, to be more fruitful to tackle the concept of mental health in its more positive connotation, noting, however, that the absence of disease may constitute a necessary, but not sufficient, criterion for mental health" (Jahoda, 1958). Jahoda (1958) postulated that a full recovery can be reached only through interventions which facilitate progress toward restoration or enhancement of psychological well-being, as was indeed recognized only a few decades later (Fava, Ruini, & Belaise, 2007).

Nonetheless, improvements in well-being and positive connotations tend to be regarded only as by-products of the reduction of symptoms, if not a luxury that clinical investigators cannot afford. Similar considerations seem to pertain also to psychotherapeutic approaches within the cognitive-behavioral realm, which address psychological well-being and flexibility, such as Mindfulness-Based Cognitive Therapy (MBCT; Segal, Williams, & Teasdale, 2002) and Acceptance and Commitment Therapy (ACT; Hayes, Strosahal, & Wilson, 1999).

The positive psychology movement initiated by the American Psychological Association in 2000 (Seligman & Csikszentmihalyi, 2000) had a huge impact on psychology and the society in general in a very short time. The movement can be credited with delivering the message that psychology needed to consider the positive as well as the negative, an issue that was much later extended to psychiatry (Jeste & Palmer, 2015). Yet, in due course, it attracted considerable criticism (Fava & Tomba, 2009; Wood & Tarrier, 2010). Positive psychology developed outside the clinical field and, not surprisingly, its oversimplified approach (happiness and optimism, the more the better) was likely to clash with the complexity of the clinical reality (Fava & Tomba, 2009; Wood & Tarrier, 2010).

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The aim of this review is to illustrate how a novel formulation of the clinical concept of euthymia (Fava & Bech, 2016; Fava & Guidi, 2020) and its psychotherapeutic translation into a specific strategy, Well-Being Therapy (Fava, 2016; Fava, Rafanelli, Cazzaro, Conti, & Grandi, 1998; Fava & Tomba, 2009), may unravel innovative and promising prospects for psychotherapy research and practice, with particular reference to cognitive and behavioral techniques. There is in fact extensive evidence that positive affects and well-being represent protective factors for health and increase resistance to stressful life situations (Fava, Cosci, & Sonino, 2017; Hasler, 2016; McEwen, 2017; Ryff, 2014).

2. The development of the concept of euthymia

The origins of the clinical concept of euthymia can be ascribed to Marie Jahoda (1958). Based on a careful inspection of the available literature, she identified six major categories of concepts and outlined criteria for positive mental health: autonomy, environmental mastery, satisfactory interactions with other people and the milieu, the individual's style and degree of growth, development or self-actualization, the attitudes of an individual toward his/her own self. Further, she introduced integration as a criterion for mental health, that is the individual's balance of psychic forces (flexibility), a unifying outlook on life which guides actions and feelings for shaping future accordingly (consistency), and resistance to stress (resilience and anxiety- or frustration-tolerance). It is thus a dynamic, evolving balance of psychic forces according to changing needs, and not simply a generic effort of avoiding excesses and extremes.

Jahoda's work (Jahoda, 1958) anticipated major developments in basic and clinical psychology that occurred in the following decades. One area has been concerned with the exploration of character strengths and virtues, such as wisdom, humanity, compassion and gratitude (Petersen & Seligman, 2004). Another field can be subsumed under the rubric of hedonic psychology, the study of what makes experience and life pleasant or unpleasant (Kahneman, Diener, & Schwarz, 1999). Complementary developments have emerged from the study of the characteristics and health implications of positive emotions (Frederickson, 2009). All these areas have entailed major neurobiological insights (Hasler, 2016; Kahneman et al., 1999).

In 1991, Garamoni, Reynolds and Thase suggested that healthy functioning is characterized by an optimal balance of positive and negative cognitions or affects, and that psychopathology is marked by deviations from this optimal balance. As pointed out by Wood and Tarrier (2010), also excessively elevated levels of positive emotions can become detrimental and lead to impaired functioning. The psychological dimensions conceptualized by Jahoda have a bipolar nature, ranging from suboptimal to excessively elevated levels (Table 1), and interact with each other producing clinical effects. The impact of psychological well-being dimensions will depend on the individual's characteristics and on the integration with concurrent distress and other psychological attributes (Wood & Tarrier, 2010). Clinical attention to psychological well-being require an integrative framework, which may be subsumed under the transdiagnostic concept of euthymia.

Fava and Bech (2016) have discussed the concept of euthymia. The term has a Greek origin and results from the combination of "*eu*", well, and "*thymós*" soul, emotion. This latter term encompasses however four different meanings: life energy; feelings and passions; will, desire and inclination; thought and intelligence. Interestingly its verb (*euthyméo*) means both I am happy, in good spirits and I make other people happy, I reassure and encourage. The definition of euthymia is generally ascribed to Democritus: one is satisfied with what is present and available, taking little heed of people who are envied and admired and observing the lives of those who suffer and yet endure (Kahn, 1985). It is a state of quiet satisfaction, a balance of emotions, which defeats fears. The Latin philosopher Seneca translated the Greek term euthymia with "*tranquillitas animi*" (a state of internal calm and contentment) and linked it to psychological well-being as a learning process, whereby "*felicitatis intellectus*", the awareness of well-being, was required. Plutarch, who attempted a synthesis of Greek and Latin cultures, criticized a concept of euthymia involving detachment from current events, as portrayed by Epicurus, and underscored the learning potential of mood alterations and adverse life situations.

Table 1
Bipolar dimensions of psychological well-being (from: Jahoda, 1958; Fava, 2016).

Impaired level	Balanced level	Excessive level
Environmental mastery		
The person has difficulties in managing everyday affairs, feels unable to improve things around and/or to seize opportunities.	The person has a sense of competence in managing the environment, makes good use of surrounding opportunities, is able to choose what is more suitable to personal needs	The person is looking for difficult situations to be handled, is unable to savoring positive emotions, is too engaged in work or family activities
Personal growth		
The person has a sense of being stuck, lacks sense of improvement over time, feels bored and uninterested in life	The person has a sense of continued development, sees one's self as growing and improving, is open to new experiences	The person is unable to elaborate past negative experiences, has unrealistic standards and goals that clash with the reality
Purpose in life		
The person lacks a sense of meaning in life, has few goals or aims, lacks sense of direction	The person has goals in life and feels there is meaning to present and past life	The person has unrealistic expectations and hopes, is constantly dissatisfied with performance, is unable to recognize failures
Autonomy		
The person is over-concerned with the expectations and evaluations of others, relies on judgment of others to make important decisions	The person is independent, able to resist to social pressures, regulates behavior by personal standards	The person is unable to get along with other people, to work in team, to learn from others, to ask for advice or help
Self-acceptance		
The person feels dissatisfied with one's self, is disappointed with what has occurred in past life, wishes to be different	The person accepts his/her good and bad qualities and feels positive about past life	The person has difficulties in admitting his/her own mistakes, attributes all problems to others' faults
Positive relations with others		
The person has few close, trusting relationships with others, finds difficult to be open	The person has trusting relationships with others, is concerned about welfare of others, understands give and take of human relationships	The person sacrifices his/her needs and well-being for those of others; low self-esteem and sense of worthlessness induce excessive readiness to forgive

In the psychiatric literature, however, the term euthymia essentially refers to the lack of significant distress (e.g., a patient no longer meeting the threshold for a disorder such as depression or mania) (Blumberg, 2012; Canales-Rodriguez et al., 2014; Dunner, 1999; Fava, 1999; Hannestad et al., 2013; Judd et al., 2002; Martini et al., 2014; Rocha, Neves, & Correa, 2013).

Fava and Bech (2016) have defined a state of euthymia as characterized by the features depicted in Table 2. Guidelines for the clinical assessment of euthymia have recently been provided (Fava & Guidi, 2020).

Accordingly, clinical assessment is aimed at exploring the presence of positive affects and psychological well-being, as well as their interactions with the course and characteristics of psychiatric symptoms. For analyzing these characteristics in an integrative way, a clinimetric perspective (Fava, Carrozzino, Lindberg, & Tomba, 2018; Fava, Tomba, & Sonino, 2012; Feinstein, 1987) is needed. The term "clinimetrics" indicates a domain concerned with the measurement of clinical issues

Table 2
Characteristics of euthymia (from: Fava & Bech, 2016).

A. Lack of mood disturbances that can be subsumed under diagnostic rubrics; if the subject has a prior history of mood disorder, he/she should be in full remission. If sadness, anxiety or irritable mood are experienced, they tend to be short-lived, related to specific situations and do not significantly affect everyday life.
B. The subject has positive affects, i.e., feels cheerful, calm, active, interested in things and sleep is refreshing or restorative.
C. The subject manifests psychological well-being, i.e., displays balance and integration of psychic forces (flexibility), a unifying outlook on life which guides actions and feelings for shaping future accordingly, and resistance to stress (resilience and anxiety- or frustration-tolerance).

that do not find room in customary clinical taxonomy. Such issues include the types, severity and sequence of symptoms; rate of progression in illness (staging); severity of comorbidity; problems of functional capacity; reasons for medical decisions (e.g., treatment choices), and many other aspects of daily life, such as well-being and distress (Fava, Carrozzino, et al., 2018; Fava, Sonino, & Wise, 2012; Fava, Tomba, & Sonino, 2012; Feinstein, 1987).

Clinimetrics has a set of rules that govern the structure of indices, the choice of component variables, the evaluation of consistency and validity. The most important clinimetric requirement is sensitivity (the ability to discriminate between different groups of patients and to reflect changes induced by therapies), whereas homogeneity of components of a scale (essential for psychometrics) is not deemed to be necessary and, indeed, may obscure the ability of an index to detect changes (Fava, Tomba, & Sonino, 2012). As a result, scales may be valid and reliable by psychometric criteria, but may lack sensitivity and, vice versa, clinimetric indices may be highly sensitive but heterogenous in their components (Benasi, Fava, & Rafanelli, 2020; Carrozzino, Patierno, Fava, & Guidi, 2020; Fava, Carrozzino, et al., 2018).

3. Assessment of euthymia

In most instances of diagnostic reasoning in psychiatry, the clinical process ends with the identification of a disorder, according to the Diagnostic and Statistical Manual of Mental Disorders (DSM-5; American Psychiatric Association, 2013). A DSM diagnosis (e.g., Major Depressive Disorder), however, encompasses a wide range of manifestations, comorbidity, seriousness, prognosis and responses to treatment (Fava, Rafanelli, & Tomba, 2012). Exclusive reliance on diagnostic criteria does not reflect the complex presentations that are encountered in clinical practice (Fava, Rafanelli, & Tomba, 2012). Psychiatric assessment thus needs to be integrated with positive affects and psychological well-being, as well as with a broad range of information, including stress, lifestyle, subclinical symptoms, illness behavior and social support, in a longitudinal perspective (Fava, Rafanelli, & Tomba, 2012).

Fava and Guidi (2020) developed a structured interview for the clinimetric evaluation of euthymia, the Clinical Interview for Euthymia (CIE), that consists of 22 items covering the contents of positive affects, both polarities of psychological well-being dimensions, and information about flexibility, resilience and consistency. The first 5 items, which were derived from the World Health Organization-5 Well-Being Index (WHO-5; Topp, Ostergaard, Sondergaard, & Bech, 2015), explore the contents of positive affects and refer to feeling cheerful, calm, active, interested in things and rested. Items 6 to 17 allow to detect both impaired and excessive levels in the dimensions of psychological well-being developed by Jahoda (1958). The bipolar nature of psychological well-being dimensions is not revealed by other self-rating assessment tools (e.g., the Psychological Well-Being scales), whereas such information is included in the CIE. The interview also provides information about flexibility, consistency and resistance to stress (items 18 to 22). Responses are rated on a yes/no format based on interviewing and clinical judgment. The interview provides an overall initial assessment of the individual's assets and well-being, and is suitable for repeated ratings of progress during psychotherapeutic treatment geared to enhance psychological well-being, such as Well-Being Therapy.

Two technical steps may facilitate the integration of the assessments of psychological well-being and distress.

The first technical step has to do with the clinimetric use of macro-analysis and micro-analysis (Emmelkamp, Bouman, & Scholing, 1993; Fava, Rafanelli, & Tomba, 2012; Fava, Sonino, & Wise, 2012). Macro-analysis has been developed in clinical psychology for organizing data as variables according to clinical reasoning (a relationship between co-occurring syndromes and problems is established on the basis of where treatment should commence at first). This method starts from the assumption that in most cases there are functional relationships with other more or less clearly defined problem areas and that the targets of treatment may vary during the course of disturbances.

For instance, we may want to examine the case of a 27-year old woman who presents with a panic disorder and agoraphobia, only partially remitted after an initial course of treatment (Fig. 1). Clinical interviewing focused on symptoms may disclose the presence of anxiety, hypochondriacal fears and phobic avoidance; interpersonal problems in the family (i.e., frictions with her parents) and with her boyfriend (i.e., repeated quarrels, mainly due to her avoidance of certain situations). Clinical interviewing focused on euthymia may unveil low levels of autonomy (i.e., overconcern with parents' expectations), personal growth (i.e., a sense of being stuck in her studying) and purpose in life (i.e. lack of sense of direction). As depicted in Fig. 1, macro-analysis helps to identify the main problem areas in her specific situation.

Macro-analysis can be supplemented by micro-analysis, a detailed analysis of specific symptoms (onset and course of the complaints, circumstances that worsen symptoms and consequences), which may encompass dimensional measurements, such as observer- or self-rating scales for assessing positive affects and psychological well-being (Emmelkamp et al., 1993; Fava, Rafanelli, & Tomba, 2012; Fava, Sonino, & Wise, 2012). Choice of these instruments relies on the concept of incremental validity (Fava, Rafanelli, & Tomba, 2012), whereby each distinct aspect of psychological measurement should deliver a unique increase in information in order to qualify for inclusion.

There are several instruments that can be used in micro-analysis. Self-rating scales or questionnaires have been the preferred method of evaluation of positive affects (Bech, 2015; Rafanelli & Ruini, 2012). Two instruments, in particular, stand for their clinimetric properties: the WHO-5 (Topp et al., 2015) and the Symptom Questionnaire (SQ; Kellner, 1987). The WHO-5 scale (Topp et al., 2015) consists of 5 items that cover a basic life perception of a dynamic state of well-being. Such items have also been incorporated in the Euthymia Scale (Fava & Bech, 2016), a 10-item self-rating scale which incorporates Jahoda's conceptualization of euthymia and has been found to entail clinimetric validity and reliability (Carrozzino, Svicher, Patierno, Berrocal, & Cosci, 2019). The Symptom Questionnaire (Kellner, 1987) is a self-rating scale that has 24 items referring to relaxation, contentment, physical well-being and friendliness, and 68 items covering symptoms of anxiety, depression, somatization and hostility-irritability (Kellner, 1987). Extensive clinical research has documented its sensitivity to change and in discriminating between different populations and subgroups (Benasi et al., 2020; Rafanelli & Ruini, 2012).

As to the assessment of psychological well-being states and dimensions (Bech, 2015; Rafanelli & Ruini, 2012), the self-rating Psychological Well-Being scales (PWB) have been used extensively in clinical settings (Ryff, 2014). They encompass 84 items and six dimensions (environmental mastery, personal growth, purpose in life, autonomy, self-acceptance and positive relations with others) (Ryff, 1989). The questionnaire, because of its length, may be problematic in a busy clinical setting. A shorter version, the 6-item well-being scale of the PsychoSocial Index (Piolanti et al., 2016; Sonino & Fava, 1998), has been developed and submitted to clinimetric validation: it was found to be a sensitive measure of well-being, yet it does not allow differentiation

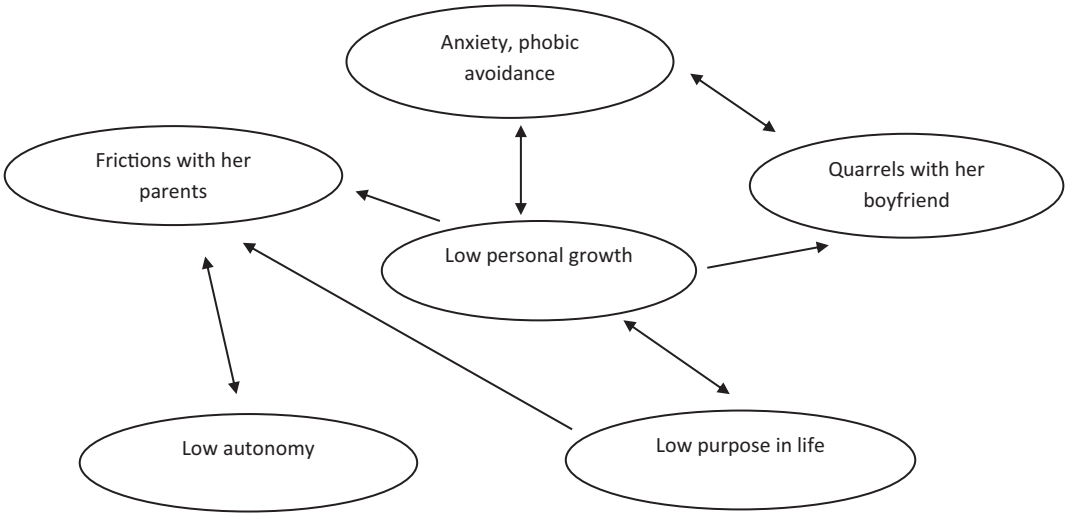

Fig. 1. Macro-analysis of a partially remitted patient with panic disorder and agoraphobia.

of the various dimensions. A structured interview based on the PWB (Ryff, 1989) has also been devised (Fava & Tomba, 2009). Further, a 10-item self-rating scale, the Acceptance and Action Questionnaire (AAQ-II) to measure psychological flexibility, is available (Bond et al., 2011; Fledderus, Bohlmeijer, Fox, Schreurs, & Spinhoven, 2013). Yet, flexibility is only one component of euthymia.

The second technical step for incorporating euthymia in clinical assessment requires reference to the staging method, whereby a disorder is characterized according to seriousness, extension and longitudinal development (Cosci & Fava, 2013; Fava & Kellner, 1993). The clinical meaning linked to the presence of dimensions of psychological well-being varies according to the stage of development of a disorder, whether prodromal, acute, residual or chronic (Fava, Rafanelli, & Tomba, 2012). Further, certain psychotherapeutic strategies can be deferred to a residual stage of psychiatric illness, when state-dependent learning has been improved by use of antidepressant drugs (Guidi, Tomba, Cosci, Park, & Fava, 2017). The planning of treatment thus requires determination of the symptomatic target of the first line approach (e.g. pharmacotherapy), and tentative identification of other areas of concern to be addressed by subsequent treatment (e.g., psychotherapy) (Guidi et al., 2017).

Yet, another step is required for placing euthymia in the psychotherapeutic work, and has to do with self-observation.

4. Self-observation, the basic neglected ingredient of cognitive and behavioral strategies

More than fifty years ago, Aaron Beck (1967) suggested that depression results from negative and distorted internal representations (schemas) that affect how individuals perceive themselves and the world around them. He defined schemas as organized, enduring representations of knowledge and experience, which guide the processing of information and interaction with life circumstances (Beck, 1967). For instance, depressed patients tend to have schemas that are characterized by themes of loss, failure, worthlessness, and rejection, that lead to have negative perceptions of themselves, the world, and the future (the cognitive triad) and to exhibit negative information-processing biases (Beck, 1967; Beck, Rush, Shaw, & Emery, 1979). The formulation of dysfunctional cognitive schemas paved the ground for the development of cognitive therapy (Beck et al., 1979).

In the cognitive therapy framework, keeping a structured diary of instances of distress (self-observation) soon became a basic cognitive-behavioral technique (Beck et al., 1979), as a source of awareness and reflection. As Wright et al. (2017) remark, writing automatic thoughts down on paper (or using a computer or smart-phone) "draws the patient's attention to important cognitions, provides a systematic method to practice identifying automatic thoughts, and often stimulates a sense of inquiry about the validity of the thoughts pattern. Just seeing thoughts written down on paper often sets off a spontaneous effort to revise or correct maladaptive cognitions" (Wright et al., 2017).

Indeed, self-observation paves the ground for cognitive restructuring: schemas can be modified in the course of psychotherapy to achieve a functional role (Beck et al., 1979; Wright et al., 2017). Keeping diary of distress as itself, however, is an important therapeutic ingredient linked to the role of self-disclosure (Guidi, Rafanelli, & Fava, 2018). Pennebaker (1997) pioneered the therapeutic use of the diary and developed a protocol for the disclosure of traumatic experiences in writing. An impressive body of experimental studies has indicated that, compared to neutral writing, expressing traumatic experiences by writing may improve the psychological status and physical health, and may enhance immune function, with reduction in autonomic nervous system activity (Pennebaker, Kiecolt-Glaser, & Glaser, 1988; Pennebaker & Smyth, 2016).

Self-observation has a major role also in behavioral therapy, with particular reference to homework exposure therapy of anxiety disorders (Marks, 1987). The central principle of treatment is to persuade the patient to re-enter the phobic situation and to remain there despite the ensuing anxiety (Marks, 1987). A structured diary of exposure tasks and subsequent accomplishments (how each exposure task went) is planned with the patient. The therapist reviews the diary with the patient and provides reassurance and guidance. The structured diary contains a mixture of negative and positive experiences, which should be properly modulated by the patient with the use of positive reinforcement (Fava, Grandi, Canestrari, Grasso, & Pesarin, 1991). This type of self-observation performed by the patient is by itself therapeutic (Emmelkamp, 1974).

5. A revolution in self-observation: well-being therapy

In 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). There has been confirmation of Meehl's observations in two controlled trials (Burton & King, 2004; Emmons & McCullough, 2003). A recent controlled study (Moieni et al., 2020) provides an

example of the therapeutic potential of written expressive writing (Pennebaker, 1997) concerned with generativity. The desire to be generative, the need to be needed and to leave a legacy after death (McAdams & De St. Aubin, 1992) plays an important role in successful aging (Fisher, 1995). Writing about life experiences and sharing advice with others in elderly women, compared to neutral writing, was found to yield significant improvement in multiple domains, including well-being and inflammation (Moieni et al., 2020).

However, this exclusive use of diary does not deal directly with the complex balance of psychological forces described by Jahoda (1958).

A psychotherapeutic approach based on Jahoda's model (Jahoda, 1958) was developed in the late nineties (Fava, Rafanelli, Cazzaro, et al., 1998). The technique originated from asking a patient with obsessive-compulsive disorder, resistant to both pharmacological and cognitive-behavioral therapy, to monitor instances of well-being instead of distress (Fava, 2016). Such monitoring in a structured diary disclosed cognitive schemas that hindered balanced levels of psychological well-being, i.e. environmental mastery, personal growth, purpose in life, autonomy, self-acceptance, and positive relations with others (Fava, 2016). Well-Being Therapy (WBT) is a manualized, short-term psychotherapeutic strategy that emphasizes self-observation of instances of well-being, with the use of a structured diary, homework and interaction between patients and therapists (Fava, 2016; Fava, Cosci, Guidi, & Tomba, 2017; Fava & Tomba, 2009).

It can be differentiated from positive psychology interventions (Quoidbach, Mikolajczak, & Gross, 2015) on the basis of the following features: a) patients are encouraged to identify episodes of well-being and to set them into a situational context; b) 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 (automatic thoughts) as is performed in cognitive-behavioral therapy (CBT); c) the therapist may also reinforce and encourage activities that are likely to elicit well-being and optimal experiences; d) the monitoring of the course of episodes of well-being allows the therapist to realize specific impairments or, conversely, excessive levels in well-being dimensions according to Jahoda's conceptual framework (Jahoda, 1958); e) patients are not simply encouraged to pursue the highest possible levels in psychological well-being in all dimensions, as is found to be the case in most positive interventions, but to obtain a balanced functioning (euthymia) (Fava & Bech, 2016).

Any successful psychotherapy, regardless of its target, is likely to improve subjective well-being and to reduce symptomatic distress (Howard, Lueger, Maling, & Martinovich, 1993). Many psychotherapeutic techniques purported to increase psychological well-being have been developed, even though only a few have been tested in clinical settings (Quoidbach et al., 2015; Rashid, 2013; Weiss, Westerhof, & Bohlmeijer, 2016).

In particular, a psychotherapeutic strategy aimed to increasing psychological well-being is Mindfulness-Based Cognitive Therapy (Segal et al., 2002), which is built on the Buddhist philosophy of a good life. Its main aim is to reduce the impact of potentially distressing thoughts and feelings, but it also introduces techniques such as mindful, non-judgemental attention, and mastery and pleasure tasks that may be geared to a good life (MacLeod & Luzon, 2014). However, the good life that is strived for is a state involving detachment and not necessarily euthymia.

Acceptance and Commitment Therapy (Hayes et al., 1999), is another technique designed to enhance psychological flexibility (Fledderus et al., 2013). It is an integration of behavioral theories of change with mindfulness and acceptance strategies, whose goal is to improve flexibility. Unlike WBT, ACT argues that attempts at changing thoughts can be counterproductive and instead it encourages awareness and acceptance through mindfulness practice. However, the issues regarding the specific role of psychological well-being in ACT parallel those raised for MBCT (MacLeod & Luzon, 2014).

There are also other psychotherapeutic approaches, such as Padesky and Mooney's Strengths-based CBT (Padesky & Mooney, 2012) and Forgiveness therapy (Enright & Fitzgibbons, 2014), that have been suggested to increase well-being, and yet await adequate clinical validation (MacLeod & Luzon, 2014). The trigger for self-observation, however, is distress and not well-being as in WBT.

6. New clinical developments

The pursuit of euthymia in a clinical setting cannot be conceived as a cure for specific mental disorders, but as a trans-diagnostic strategy to be incorporated in a therapeutic plan. As a general indication, psychotherapeutic interventions geared to psychological well-being have problems in being applied as first line treatment of an acute psychiatric disorder (Fava, 2016; Fava, Cosci, Guidi, & Tomba, 2017). They may be more suitable for second- or third-line treatments. Most of the patients who are seen in clinical practice have complex and chronic disorders (Fava, Rafanelli, & Tomba, 2012). It is simply wishful thinking to believe that one course of treatment will be sufficient for yielding lasting and satisfactory remission.

The application of psychotherapeutic strategies aimed at euthymia should thus follow clinical reasoning and case formulation, by using the clinimetric tools of macro- and micro-analysis, and staging. The treatment plan should be filtered by clinical judgment taking into consideration a number of clinical variables, such as characteristics and severity of the psychiatric episode, co-occurring symptoms and problems (not necessarily syndromes), medical comorbidities, patient's history, and levels of psychological well-being (Fava, Rafanelli, & Tomba, 2012). Such information should be placed within other therapeutic ingredients, what is actually available in the specific treatment setting, and needs to be integrated with patient's preferences (Guidi et al., 2018).

We will illustrate a number of potential applications of strategies that target euthymia. All these indications should be seen as tentative, since, even when the findings are supported by randomized controlled trials, the specific role of strategies modulating psychological well-being in determining the outcome cannot be elucidated with certainty, because they are incorporated with more traditional approaches and a dismantling strategy was seldom endorsed. These studies unravel, however, new, promising pathways for research and practice in clinical psychology, with particular reference to psychological assessment including monitoring of psychological well-being and psychotherapeutic interventions.

Well-being is also a crucial component of patients' satisfaction and perceived change (Hasler, 2016). In a study investigating relevant outcome domains in the patient's perspective following psychiatric outpatient treatment for non-psychotic, non-substance-related disorders, psychotherapy contributed more to well-being-related outcomes than pharmacotherapy (Hasler, Moergeli, & Schnyder, 2004). It increased patients' satisfaction, which showed to be particularly related to interpersonal goals, ability to cope with specific problems and symptoms, handling of and confidence in drug treatment.

Relapse prevention. In 1994, a randomized controlled trial introduced the sequential design in depression (Fava, Grandi, Zielezny, Canestrari, & Morphy, 1994). Depressed patient who had responded to drug treatment were randomly assigned to cognitive-behavioral therapy or to clinical management, while antidepressant drugs were tapered and discontinued (Fava et al., 1994). This design was subsequently used in a number of randomized controlled trials and was found to entail significant benefits in a meta-analysis (Guidi, Tomba, & Fava, 2016). The sequential model is an intensive, two-stage approach, where one type of treatment (psychotherapy) is employed to improve symptoms which another type of treatment (pharmacotherapy) was unable to affect. The rationale of this approach is to use psychotherapeutic strategies when they are most likely to make a unique and separate contribution to patient well-being and to achieve a more pervasive recovery by addressing residual symptomatology. The sequential design is different from maintenance strategies for prolonging clinical responses that therapies

of the acute episodes have obtained, as well as from augmentation or switching strategies because of lack of response to the first line of treatment (Fava et al., 1994; Guidi et al., 2016).

Three independent randomized controlled trials using the sequential combination of cognitive therapy and WBT were performed in Italy (Fava et al., 2004; Fava, Rafanelli, Grandi, Conti, & Belluardo, 1998), Germany (Stangier et al., 2013) and the United States (Kennard et al., 2014). In other trials that took place in Canada (Farb et al., 2018) and the Netherlands (Bockting et al., 2018) some principles of WBT were used in addition to standard cognitive therapy.

Further, there have been several investigations (Bondolfi et al., 2010; Godfrin & van Heeringen, 2010; Huijbers et al., 2015, 2016; Kuyken et al., 2008, 2015; Ma & Teasdale, 2004; Segal et al., 2010; Shallcross et al., 2018; Teasdale et al., 2000; Williams et al., 2014) where MBCT was applied to the residual stage of depression after pharmacotherapy. MBCT has been shown to be an effective second-stage intervention in sequential treatment of residual depressive symptoms and prevention of relapse in patients with recurrent depression (Piet & Hougaard, 2011; Segal & Walsh, 2016). Preliminary data have suggested additional indications of MBCT for a variety of patient populations (Alsubaie et al., 2017).

From the available studies we have no way to know whether the pursuit of euthymia was a specific effective ingredient and what was the mechanism decreasing the likelihood of relapse. Nonetheless, the clinical results that have been obtained are impressive and the sequential model appears a strategy that has enduring effects on the prevention of the vexing problem of relapse in depression. It is conceivable, and yet to be tested, that similar strategies may entail significant advantages in terms of relapse rates also in other psychiatric disorders.

Increasing the level of recovery. The studies that used a sequential design clearly indicated that level of remission that could be obtained by successful pharmacotherapy could be increased by a subsequent psychotherapeutic treatment (Guidi et al., 2016). Clinicians and researchers in clinical psychiatry often confound response to treatment with full recovery (Fava et al., 2007). Indeed, full recovery can be reached only through interventions which facilitate progress toward restoration or enhancement of psychological well-being (Jahoda, 1958). Twenty patients with mood and anxiety disorders who had been successfully treated by behavioral (anxiety disorders) or pharmacological (mood disorders) methods, were randomly assigned to either WBT or CBT of residual symptoms (Fava, Rafanelli, Cazzaro, et al., 1998). Both WBT and CBT were associated with a significant reduction of residual symptoms and well-being improvement. However, when residual symptoms of the two groups were compared after treatment, a significant advantage of WBT over CBT was observed. WBT was associated also with a significant increase in PWB scores, particularly in the personal growth scale (Fava, Rafanelli, Cazzaro, et al., 1998). The higher degree of symptomatic improvement that was observed with WBT could reflect the fact that, 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 (Fava, Rafanelli, Cazzaro, et al., 1998).

A dismantling study that was performed in generalized anxiety disorder (Fava et al., 2005) suggested that an increased level of recovery could indeed be obtained with the addition of WBT to CBT. Twenty patients were randomly assigned to 8 sessions of CBT or the sequential administration of CBT followed by other 4 sessions of WBT. Both treatments were associated with a significant reduction of anxiety. However, significant advantages of the sequential combination of CBT/WBT over CBT alone were observed, both in terms of symptom reduction and psychological well-being improvement (Fava et al., 2005).

While the achievement of an increased level of recovery was found to yield substantial clinical benefits in depression (Fava, Cosci, Guidi, & Tomba, 2017) and generalized anxiety disorder (Fava et al., 2005), this appears to be target for a number of other psychiatric disorders. For instance, Penn et al., 2004 postulated a role for WBT in improving functional outcomes as an additional ingredient to CBT in psychotic disorders. Indeed, the issue of personal growth is attracting increasing interest in psychoses (Slade, Blacke, & Longden, 2019). Further, subjective well-being appears to be impaired in schizophrenia and is associated with reduced anterior cingulated activity during reward processing, that may impair integration of environmental stimuli, motivated behavior and reward outcome (Favrod et al., 2019; Gilleen, Shergill, & Kapur, 2015). Recently, a randomized controlled trial (Favrod et al., 2019) indicated that a program designed to improve pleasure and motivation in schizophrenic patients by targeting emotion regulation and cognitive skills relevant to apathy and anhedonia, significantly reduced anhedonia compared to treatment as usual.

Modulating mood. WBT was applied to treatment of cyclothymic disorder (Fava, Rafanelli, Tomba, Guidi, & Grandi, 2011), that involves mild or moderate fluctuations of mood, thoughts and behavior without meeting formal diagnostic criteria for either major depressive disorder or mania (American Psychiatric Association, 2013). Patients with cyclothymic disorder were randomly assigned to the sequential combination of CBT and WBT or clinical management. At post-treatment, significant differences were found in outcome measures, with greater improvements in the CBT/WBT group compared to clinical management. Therapeutic gains were maintained at 1- and 2- year follow-ups (Fava et al., 2011). The results thus indicated that WBT may address both polarities of mood swings and is geared to a state of euthymia (Fava & Bech, 2016). Can the target of euthymia decrease vulnerability to relapse in bipolar spectrum disorders (Nierenberg, 2008), with particular reference to the occurrence of hypomania among depressive episodes? This would be an important area that deserves specific studies.

Treatment resistance. A considerable number of patients fail to respond to appropriate pharmacotherapy and/or psychotherapy (Fava, Cosci, Guidi, & Rafanelli, 2020). MBCT was found to yield some advantages over treatment as usual in treatment-resistant depressed patients (Cladder-Micus et al., 2018; Eisendrath et al., 2016). A number of case reports have suggested that WBT may provide a viable alternative when standard cognitive techniques based on monitoring distress do not yield any improvement or even cause symptomatic worsening in depression, panic disorder, and anorexia nervosa (Cosci, 2015; Meulenbeek, Christenhusz, & Bohlmeijer, 2015; Schamong, 2019; Sonino & Fava, 2003; Tomba & Tecuta, 2016). The data are clearly insufficient to postulate a role for psychotherapies enhancing or modulating psychological well-being in these patient populations, yet this approach may yield new insights into this area.

Suicidal behavior. Treating suicidal behavior has proven to be difficult (de Leon, Baca-Garcia, & Blasco-Fontecilla, 2015). Andrew MacLeod (2020) has recently analyzed the relationship between future-directed thinking (prospection) and suicidality and has postulated a potential, innovative role for well-being enhancing psychotherapies: working on dimensions such as purpose in life may counteract suicidal behavior, since there is strong evidence that the way people think about their future holds the key for understanding their suicidal thinking. Positive mental health was found to moderate the association between suicidal ideation and suicide attempts (Brailovskaia et al., 2019).

An issue that is not sufficiently appreciated is also the experience of mental pain many suicidal patients may present with (de Leon et al., 2015; Fava et al., 2019; Guidi, Piolanti, Gostoli, Schamong, & Brakemeier, 2019). In particular, Guidi et al. (2019) reported an inverse relationship between mental pain and euthymia. Further, mental pain was found to be related not only to depression and suicidality, but also to allostatic overload, anxiety, and abnormal illness behavior (Guidi et al., 2019). ACT was found to significantly reduce suicidal ideation and mental pain compared to relaxation in adult patients suffering from a current suicidal behavior disorder (Ducasse et al., 2018). The pursuit of euthymia (particularly, psychological flexibility) may play a role in decreasing mental pain, yet it should be tested by appropriate controlled studies.

Discontinuing psychotropic drugs. Psychotropic drug treatment, particularly when protracted over time, may cause various forms of

dependence (Cosci & Chouinard, 2020). Withdrawal symptoms do not necessarily wane after drug discontinuation and may build into persistent post-withdrawal disorders (Cosci & Chouinard, 2020). These symptoms may constitute a iatrogenic comorbidity that affects course of illness and response to subsequent treatments (Fava & Rafanelli, 2019). Discontinuation of antidepressant drugs such as selective serotonin reuptake inhibitors, duloxetine and venlafaxine constitute a major clinical challenge (Baldessarini & Tondo, 2019; Fava et al., 2018; Fava, Gatti, Belaise, Guidi, & Offidani, 2015). A protocol based on the sequential combination of CBT and WBT has been devised (Fava & Belaise, 2018) and tested in case reports (Belaise, Gatti, Chouinard, & Chouinard, 2014).

Post-traumatic stress disorder. There has been growing awareness of the fact that traumatic experiences can also give rise to positive transformations, subsumed under the rubric of post-traumatic growth (Vazquez, Pérez-Sales, & Ochoa, 2014). Positive changes can be observed in self-concept (e.g., new evaluation of one's strength and resilience), appreciation of new possibilities in life, social relations, hierarchy of values and priorities, spiritual growth. Two cases have been reported on the use of WBT alone or in sequential combination with exposure for overcoming post-traumatic stress-disorder, with the central trauma being discussed only in the initial history taking session (Belaise, Fava, & Marks, 2005).

Improving medical outcomes. Psychosocial factors (functioning in daily life, psychiatric and psychological symptoms, quality of life, illness behavior) have emerged as a crucial component of patient care in medical settings (Fava, Cosci, & Sonino, 2017). These aspects have become particularly important in chronic diseases, where cure cannot take place, and also extend to family caregivers of chronically ill patients and health providers (Fava, Cosci, & Sonino, 2017). There has also been recent interest in the relationship between psychological flexibility and chronic pain (Feliu-Soler et al., 2018; McCracken & Morley, 2014). It is thus conceivable to postulate a role for psychotherapeutic interventions modulating psychological well-being in the setting of chronic pain (Mansueto, 2019; Rotterman & Wright, 2019). The process of rehabilitation, in fact, requires the promotion of well-being and changes in lifestyle as primary targets of intervention (Nierenberg et al., 2016).

In a recent randomized controlled trial of depressed patients with acute coronary syndromes (ACS) (Rafanelli et al., 2020), the sequential combination of CBT and WBT, supplemented by lifestyle suggestions, was found to yield significant improvements in depressive symptoms and biomarkers compared to clinical management. Treatment gains persisted at a 30-month follow-up, even though differences between groups faded over time.

Empirical evidence has indicated that also MBCT may be effective in decreasing psychological and physical symptoms across a range of chronic somatic conditions, particularly cancer and cardiovascular disorders (Alsubaie et al., 2017). Some promising data support the clinical utility of ACT in chronic pain and long-term conditions (Graham, Gouick, Krahé, & Gillanders, 2016; Hughes, Clark, Colclough, Dale, & McMillan, 2017).

Improving health attitudes and behavior. Unhealthy lifestyle (e.g. smoking, physical inactivity, excessive eating) is a major risk factor for many of the most prevalent medical and psychiatric diseases (Fava, Cosci, & Sonino, 2017; Sartorius, Holt, & Maj, 2015). Switching the general population to healthy lifestyles is a major source of prevention, including patients with mental illness (Sartorius et al., 2015). Yet, health promotion entails considerable difficulties in its application (Fava, Cosci, & Sonino, 2017; Sartorius et al., 2015). Lifestyle modification focused on weight reduction, increased physical activity, and dietary change is advised as first-line therapy in a number of disorders, yet psychological distress and low levels of well-being are commonly observed among patients with chronic conditions and represent important obstacles to behavioral change (Holt, 2019).

It has been argued that enduring lifestyle changes can only be achieved with a personalized approach that targets psychological well-being (Guidi, Rafanelli, & Fava, 2018; Rafanelli et al., 2020). As a result, strategies pointing to euthymia need to be tested in lifestyle interventions and in the prevention of mental and physical disorders.

7. Potential technical developments

WBT originated from the combination of monitoring of psychological well-being with CBT techniques (Fava, 2016; Fava, Rafanelli, Cazzaro, et al., 1998). However, systematic monitoring of well-being with a structured diary may lend itself to the application of other techniques. There are several lines of potential application.

One is concerned with rational-emotive therapy. As was found to occur with CBT in generalized anxiety disorder (Fava et al., 2005), it is conceivable, but yet to be tested, that monitoring of well-being may yield increased recognition of irrational beliefs not only as related to distress (Vîslă, Flückiger, Grosse Holtforth, & David, 2016), but also as to positive situations.

Another line of potential application refers to current modifications of classic CBT, often subsumed under the rubric of third-generation CBT. Once again, it is worth remembering that one thing is the simple recollection of positive events and memories in the diary; another thing is the use of the diary for correcting cognitive schemas associated with the experience of well-being. Such considerations apply also to MBCT and ACT. Both positive and negative schemas may affect treatment response (Fava & Guidi, 2020).

An additional source of technical developments may derive from the application of techniques of monitoring psychological well-being to couple and family therapy. Kauffman and Silberman (2009) have illustrated adaptations of positive psychology interventions that may improve couple therapy outcomes. Fostering the positive in relationships is indeed a target of many family and couple approaches (Keitner, Heru, & Glick, 2010) and elements of WBT may facilitate such process. Brakemeier (2019) has developed a modification of WBT to be used in couple therapy.

Further, WBT was originally conceptualized as an individual therapy (Fava, 2016; Fava, Rafanelli, Cazzaro, et al., 1998), but it may be amenable to a group format (Moeenizadeh & Salagame, 2010). This modality may increase sharing optimal experiences and personal meanings of psychological well-being.

Finally, an emerging modality for WBT involves the growing area of computer-assisted methods. Treatment programs or mobile apps could help clinicians and reach a wider audience.

8. Conclusions

An important characteristic of WBT is self-observation of psychological well-being associated with specific homework and having euthymia as a therapeutic target. Such perspective substantially differentiates WBT from other psychological interventions that are considered as positive, but are actually distress-oriented.

Disregard of the concept of euthymia may lead to targeting inappropriately elevated levels of positive emotions that can become detrimental (Wood & Tarrier, 2010), and to disruption of the complex balance of well-being and distress (Garamoni, Reynolds III, & Thase, 1991; Rafanelli et al., 2000). An additional novel area in psychotherapy research can ensue from exploring euthymia as a characteristic of successful psychotherapists, as the Greek verb equivalent implies (Lavardiere, Kealy, Ogrodniczuk, & Descoteuax, 2019; Skovholt & Trotter-Mathison, 2011).

Standard psychiatric assessment does not include psychological well-being, which may indeed demarcate major prognostic and therapeutic differences among patients who otherwise seem to be deceptively similar since they share the same diagnosis. The evidence supporting the clinical value of the pursuit of euthymia is still limited. However, the insights gained may unravel innovative approaches to assessment and treatment of psychiatric disorders, with particular reference to

decreasing vulnerability to relapse, increasing the level of recovery and modulating mood (Fava, 2016; Fava & Guidi, 2020).

Progress can be achieved in psychotherapy research and practice by modifying our clinical approach to mental disturbances, still shifted on the side of psychological dysfunction, and by promoting self-observation of psychological well-being and the pursuit of euthymia (Fava & Guidi, 2020).

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References

Alsubaie, M., Abbott, R., Dunn, B., Dickens, C., Keil, T. F., Henley, W., & Kuyken, W. (2017). Mechanisms of action in mindfulness-based cognitive therapy (MBCT) and mindfulness-based stress reduction (MBSR) in people with physical and/or psychological conditions: A systematic review. *Clin. Psychol. Rev., 55*, 74–91.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington: APA.

Baldessarini, R. J., & Tondo, L. (2019). Effects of treatment discontinuation in clinical psychopharmacology. *Psychother. Psychosom.*, 65–70.

Bech, P. (2015). Clinical assessments of positive mental health. In D. V. Jeste, & B. W. Palmer (Eds.), *Positive psychiatry* (pp. 127–143). Washington, DC: American Psychiatric Publishing.

Beck, A. T. (1967). *Depression: Clinical, experimental and theoretical aspects*. New York: Hoeber Medical Division.

Beck, A. T., Rush, A. J., Shaw, B. F., & Emery, G. (1979). *Cognitive therapy of depression*. New York: Guilford.

Belaise, C., Fava, G. A., & Marks, I. M. (2005). Alternatives to debriefing and modifications to cognitive behavior therapy for post-traumatic stress disorder. *Psychother. Psychosom., 74*, 212–217.

Belaise, C., Gatti, A., Chouinard, V. A., & Chouinard, G. (2014). Persistent postwithdrawal disorders induced by paroxetine, a selective serotonin reuptake inhibitor, and treated with specific cognitive behavioral therapy. *Psychother. Psychosom., 83*, 247–248.

Benasi, G., Fava, G. A., & Rafanelli, C. (2020). Kellner's symptom questionnaire, a highly sensitive patient-reported outcome measure: Systematic review of clinimetric properties. *Psychother. Psychosom., 89*(2), 74–89.

Blumberg, H. P. (2012). Euthymia, depression, and mania: What do we know about the switch? *Biol. Psychiatry, 71*, 570–571.

Bockting, C. L. H., Klein, N. S., Elgersma, H. J., van Rijsbergen, G. D., Slofstra, C., Ormel, J., … Burger, H. (2018). The effectiveness of preventive cognitive therapy while tapering antidepressants compared with maintenance antidepressant treatment and their combination in the prevention of depressive relapse or recurrence (DRD study). *Lancet Psychiatry, 5*, 401–410.

Bond, F. W., Hayes, S. C., Baer, R., Carpenter, K. M., Guenole, N., Orcutt, H. K., … Zettle, R. D. (2011). Preliminary psychometric properties of the acceptance and action questionnaire II: A revised measure of psychological inflexibility and experiential avoidance. *Behav. Ther., 42*, 676–688.

Bondolfi, G., Jermann, F., der Linden, M. V., Gex-Fabry, M., Bizzini, L., Weber Rouget, B., … Bertschy, G. (2010). Depression relapse prophylaxis with mindfulness-based cognitive therapy: Replication and extension in the Swiss health care system. *J. Affect. Disord., 122*, 224–231.

Brailovskaia, J., Forkmann, T., Glaesmer, H., Paashaus, L., Rath, D., Schönfelder, A., … Teismann, T. (2019). Positive mental health moderates the association between suicide ideation and suicide attempts. *J. Affect. Disord., 245*, 246–249.

Brakemeier, E.-L. (2019). The role of well-being therapy in the treatment of couples. *Psychother. Psychosom., 88*(Suppl. 1), 16.

Burton, C. M., & King, L. A. (2004). The health benefits of writing about intensely positive experiences. *J. Res. Pers., 38*, 150–163.

Canales-Rodriguez, E. J., Pomarol-Clotet, E., Radua, J., Sarró, S., Alonso-Lana, S., Del Mar Bonnín, C., … Salvador, R. (2014). Structural abnormalities in bipolar euthymia: A multicontrast molecular diffusion imaging study. *Biol. Psychiatry, 76*, 239–248.

Carrozzino, D., Patierno, C., Fava, G. A., & Guidi, J. (2020). The Hamilton rating scales for depression: A critical review of clinimetric properties of different versions. *Psychother. Psychosom., 89*, 133–150.

Carrozzino, D., Svicher, A., Patierno, C., Berrocal, C., & Cosci, F. (2019). The Euthymia scale: A clinimetric analysis. *Psychother. Psychosom., 88*, 119–121.

Cladder-Micus, M. B., Speckens, A. E. M., Vrijsen, J. N., Donders, A. R. T., Becker, E. S., & Spijker, J. (2018). Mindfulness-based cognitive therapy for patients with chronic, treatment-resistant depression: A pragmatic randomized controlled trial. *Depress. Anxiety, 35*, 914–924.

Cosci, F. (2015). Well-being therapy in a patient with panic disorder who failed to respond to paroxetine and cognitive behavior therapy. *Psychother. Psychosom., 84*, 318–319.

Cosci, F., & Chouinard, G. (2020). Acute and persistent withdrawal syndromes following discontinuation of psychotropic medications. *Psychother. Psychosom., 89*, 283–306.

Cosci, F., & Fava, G. A. (2013). Staging of mental disorders: Systematic review. *Psychother. Psychosom., 82*, 20–34.

Ducasse, D., Jaussent, I., Arpon-Brand, V., Vienot, M., Laglaoui, C., Béziat, S., … Olié, E. (2018). Acceptance and commitment therapy for the management of suicidal patients: A randomized controlled trial. *Psychother. Psychosom., 87*, 211–222.

Dunner, D. L. (1999). Duration of periods of euthymia in patients with dysthymic disorder. *Am. J. Psychiatr., 156*, 1992–1993.

Eisendrath, S. J., Gillung, E., Delucchi, K. L., Segal, Z. V., Nelson, J. C., McInnes, L. A., … Feldman, M. D. (2016). A randomized controlled trial of mindfulness-based cognitive therapy for treatment-resistant depression. *Psychother. Psychosom., 85*, 99–110.

Emmelkamp, P. M. G. (1974). Self-observation versus flooding in the treatment of agoraphobia. *Behav. Res. Ther., 12*, 229–237.

Emmelkamp, P. M. G., Bouman, T. K., & Scholing, A. (1993). *Anxiety disorders*. Chichester, UK: Wiley.

Emmons, R. A., & McCullough, M. E. (2003). Counting blessings versus burdens. *J. Pers. Soc. Psychol., 84*, 377–389.

Enright, R. D., & Fitzgibbons, R. P. (2014). *Forgiveness therapy*. Washington, DC: American Psychological Association.

Farb, N., Anderson, A., Ravindran, A., Hawley, L., Irving, J., Mancuso, E., … Segal, Z. V. (2018). Prevention of relapse/recurrence in major depressive disorder with either mindfulness-based cognitive therapy or cognitive therapy. *J. Consult. Clin. Psychol., 88*, 200–204.

Fava, G. A. (1999). Subclinical symptoms in mood disorders: Pathophysiological and therapeutic implications. *Psychol. Med., 29*, 47–61.

Fava, G. A. (2016). *Well-being therapy. Treatment manual and clinical applications*. Basel: Karger.

Fava, G. A., & Bech, P. (2016). The concept of euthymia. *Psychother. Psychosom., 85*, 1–5.

Fava, G. A., & Belaise, C. (2018). Discontinuing antidepressant drugs. *Psychother. Psychosom., 87*, 257–267.

Fava, G. A., Benasi, G., Lucente, M., Offidani, E., Cosci, F., & Guidi, J. (2018). Withdrawal symptoms after serotonin-noradrenaline reuptake inhibitor discontinuation: Systematic review. *Psychother. Psychosom., 87*, 195–203.

Fava, G. A., Carrozzino, D., Lindberg, L., & Tomba, E. (2018). The clinimetric approach to psychological assessment. *Psychother. Psychosom., 87*, 321–326.

Fava, G. A., Cosci, F., Guidi, J., & Rafanelli, C. (2020). The deceptive manifestations of resistance in depression. *Psychother. Psychosom., 89*, 265–273.

Fava, G. A., Cosci, F., Guidi, J., & Tomba, E. (2017). Well-being therapy in depression: New insights into the role of psychological well-being in the clinical process. *Depress. Anxiety, 34*, 801–808.

Fava, G. A., Cosci, F., & Sonino, N. (2017). Current psychosomatic practice. *Psychother. Psychosom., 86*, 13–30.

Fava, G. A., Gatti, A., Belaise, C., Guidi, J., & Offidani, E. (2015). Withdrawal symptoms after selective serotonin reuptake inhibitor discontinuation: A systematic review. *Psychother. Psychosom., 84*, 72–81.

Fava, G. A., Grandi, S., Canestrari, R., Grasso, P., & Pesarin, F. (1991). Mechanisms of change of panic attacks with exposure treatment of agoraphobia. *J. Affect. Disord., 22*, 65–71.

Fava, G. A., Grandi, S., Zielezny, M., Canestrari, R., & Morphy, M. A. (1994). Cognitive behavioral treatment of residual symptoms in primary major depressive disorder. *Am. J. Psychiatr., 151*, 1295–1299.

Fava, G. A., & Guidi, J. (2020). The pursuit of euthymia. *World Psychiatry, 19*(1), 40–50.

Fava, G. A., & Kellner, R. (1993). Staging: A neglected dimension in psychiatric classification. *Acta Psychiatr. Scand., 87*, 225–230.

Fava, G. A., & Rafanelli, C. (2019). Iatrogenic factors in psychopathology. *Psychother. Psychosom., 88*, 129–140.

Fava, G. A., Rafanelli, C., Cazzaro, M., Conti, S., & Grandi, S. (1998). Well-being therapy: A novel psychotherapeutic approach for residual symptoms of affective disorders. *Psychol. Med., 28*, 475–480.

Fava, G. A., Rafanelli, C., Grandi, S., Conti, S., & Belluardo, P. (1998). Prevention of recurrent depression with cognitive behavioral therapy: Preliminary findings. *Arch. Gen. Psychiatry, 55*, 816–820.

Fava, G. A., Rafanelli, C., & Tomba, E. (2012). The clinical process in psychiatry. *J. Clin. Psychiatry, 73*, 177–184.

Fava, G. A., Rafanelli, C., Tomba, E., Guidi, J., & Grandi, S. (2011). The sequential combination of cognitive behavioral treatment and well-being therapy in cyclothymic disorder. *Psychother. Psychosom., 80*, 136–143.

Fava, G. A., Ruini, C., & Belaise, C. (2007). The concept of recovery in major depression. *Psychol. Med., 37*, 307–317.

Fava, G. A., Ruini, C., Rafanelli, C., Finos, L., Conti, S., & Grandi, S. (2004). Six-year outcome of cognitive behavior therapy for prevention of recurrent depression. *Am. J. Psychiatr., 161*, 1872–1876.

Fava, G. A., Ruini, C., Rafanelli, C., Finos, L., Salmaso, L., Mangelli, L., & Sirigatti, S. (2005). Well-being therapy of generalized anxiety disorder. *Psychother. Psychosom., 74*, 26–30.
Fava, G. A., Sonino, N., & Wise, T. N. (2012). *The psychosomatic assessment*. Basel: Karger.
Fava, G. A., & Tomba, E. (2009). Increasing psychological well-being and resilience by psychotherapeutic methods. *J. Pers., 77*, 1902–1934.
Fava, G. A., Tomba, E., Brakemeier, E.-L., Carrozzino, D., Cosci, F., Eöry, A., … Guidi, J. (2019). Mental pain as a transdiagnostic patient-reported outcome measure. *Psychother. Psychosom., 88*, 341–349.
Fava, G. A., Tomba, E., & Sonino, N. (2012). Clinimetrics: The science of clinical measurements. *Int. J. Clin. Pract., 66*, 11–15.
Favrod, J., Nguga, A., Chaix, J., Pellet, J., Frobert, L., Fankhauser, C., … Bonsack, C. (2019). Improving pleasure and motivation in schizophrenia. *Psychother. Psychosom., 88*, 84–95.
Feinstein, A. R. (1987). *Clinimetrics*. New Haven, CT: Yale University Press.
Feliu-Soler, A., Montesinos, F., Gutiérrez-Martínez, O., Scott, W., McCracken, L. M., & Luciano, J. V. (2018). Current status of acceptance and commitment therapy for chronic pain: A narrative review. *J. Pain Res., 11*, 2145–2159.
Fisher, B. J. (1995). Successful aging, life satisfaction, and generativity in later life. *Int. J. Aging Hum. Dev., 41*, 239–250.
Fledderus, M., Bohlmeijer, E. T., Fox, J. P., Schreurs, K. M. G., & Spinhoven, P. (2013). The role of psychological flexibility in a self-help acceptance and commitment therapy intervention for psychological distress in a randomized controlled trial. *Behav. Res. Ther., 51*, 142–151.
Frederickson, B. L. (2009). *Positivity*. New York: Crown.
Garamoni, G. L., Reynolds, C. F., III, & Thase, M. E. (1991). The balance of positive and negative affects in major depression: A further test of the states of the mind model. *Psychiatry Res., 39*, 99–108.
Gilleen, J., Shergill, S. S., & Kapur, S. (2015). Impaired subjective well-being in schizophrenia is associated with reduced anterior cingulated activity during reward processing. *Psychol. Med., 45*, 589–600.
Godfrin, K. A., & van Heeringen, C. (2010). The effects of mindfulness-based cognitive therapy on recurrence of depressive episodes, mental health and quality of life: A randomized controlled study. *Behav. Res. Ther., 48*, 738–746.
Graham, C. D., Gouick, J., Krahé, C., & Gillanders, D. (2016). A systematic review of the use of acceptance and commitment therapy (ACT) in chronic disease and long-term conditions. *Clin. Psychol. Rev., 46*, 46–58.
Guidi, J., Brakemeier, E.-L., Bockting, C. L. H., Cosci, F., Cuijpers, P., Jarrett, R. B., … Fava, G. A. (2018). Methodological recommendations for trials of psychological interventions. *Psychother. Psychosom., 87*, 285–295.
Guidi, J., Piolanti, A., Gostoli, S., Schamong, I., & Brakemeier, E.-L. (2019). Mental pain and euthymia as transdiagnostic clinimetric indices in primary care. *Psychother. Psychosom., 88*(4), 252–253.
Guidi, J., Rafanelli, C., & Fava, G. A. (2018). The clinical role of well-being therapy. *Nordic J. Psychiatry, 72*, 447–453.
Guidi, J., Tomba, E., Cosci, F., Park, S. K., & Fava, G. A. (2017). The role of staging in planning psychotherapeutic interventions in depression. *J. Clin. Psychiatry, 78*, 456–463.
Guidi, J., Tomba, E., & Fava, G. A. (2016). The sequential integration of pharmacotherapy and psychotherapy in the treatment of major depressive disorder: A meta-analysis of the sequential model and a critical review of the literature. *Am. J. Psychiatr., 173*, 128–137.
Hannestad, J. O., Cosgrove, K. P., DellaGioia, N. F., Perkins, E., Bois, F., Bhagwagar, Z., … Esterlis, I. (2013). Changes in the cholinergic system between bipolar depression and euthymia as measured with 123I 5IA single photon emission computed tomography. *Biol. Psychiatry, 74*, 768–776.
Hasler, G. (2016). Well-being: An important concept for psychotherapy and psychiatric neuroscience. *Psychother. Psychosom., 85*, 255–261.
Hasler, G., Moergeli, H., & Schnyder, U. (2004). Outcome of psychiatric treatment: What is relevant for our patients? *Compr. Psychiatry, 45*, 199–205.
Hayes, S. C., Strosahal, K., & Wilson, K. G. (1999). *Acceptance and commitment therapy*. New York: Guilford Press.
Holt, M. I. (2019). The management of obesity in people with severe mental illness. *Psychother. Psychosom., 88*, 327–332.
Howard, K. I., Lueger, R. J., Maling, M. S., & Martinovich, Z. (1993). A phase model of psychotherapy outcome: Causal mediation of change. *J. Consult. Clin. Psychol., 61*, 678–685.
Hughes, L. S., Clark, J., Colclough, J. A., Dale, E., & McMillan, D. (2017). Acceptance and commitment therapy (ACT) for chronic pain: A systematic review and meta-analyses. *Clin. J. Pain, 33*, 552–568.
Huijbers, M. J., Spinhoven, P., Spijker, J., Ruhé, H. G., van Schaik, D. J., van Oppen, P., … Speckens, A. E. (2015). Adding mindfulness-based cognitive therapy to maintenance antidepressant medication for prevention of relapse/recurrence in major depressive disorder: Randomised controlled trial. *J. Affect. Disord., 187*, 54–61.
Huijbers, M. J., Spinhoven, P., Spijker, J., Ruhé, H. G., van Schaik, D. J. F., van Oppen, P., … Speckens, A. E. (2016). Discontinuation of antidepressant medication after mindfulness-based cognitive therapy for recurrent depression: Randomised controlled non-inferiority trial. *Br. J. Psychiatry, 208*, 366–373.
Jahoda, M. (1958). *Current concepts of positive mental health*. New York: Basic Books.
Jeste, D. V., & Palmer, B. W. (2015). *Positive psychiatry. A clinical handbook*. Washington, DC: American Psychiatric Publishing.
Judd, L. L., Akiskal, H. S., Schettler, P. J., Endicott, J., Maser, J., Solomon, D. A., … Keller, M. B. (2002). The long-term natural history of the weekly symptomatic status of bipolar I disorder. *Arch. Gen. Psychiatry, 59*, 530–537.
Kahn, C. H. (1985). Democritus and the origins of moral psychology. *Am. J. Philol., 106*, 1–31.
Kahneman, D., Diener, E., & Schwarz, N. (1999). *Well-being: The foundations of hedonic psychology*. New York: Russel Sage Foundation.
Kauffman, C., & Silberman, J. (2009). Finding and fostering the positive in relationships: Positive interventions in couples therapy. *J. Clin. Psychol., 65*, 520–531.
Keitner, G. I., Heru, A. M., & Glick, I. D. (2010). *Clinical manual of couples and family therapy*. Washington, DC: American Psychiatric Publishing.
Kellner, R. (1987). A Symptom Questionnaire. *J. Clin. Psychiatry, 48*, 269–274.
Kennard, B. D., Emslie, G. J., Mayes, T. L., Nakonezny, P. A., Jones, J. M., Foxwell, A. A., & King, J. (2014). Sequential treatment with fluoxetine and relapse-prevention CBT to improve outcomes in pediatric depression. *Am. J. Psychiatr., 171*, 1083–1090.
Kuyken, W., Byford, S., Taylor, R. S., Watkins, E., Holden, E., White, K., … Teasdale, J. D. (2008). Mindfulness-based cognitive therapy to prevent relapse in recurrent depression. *J. Consult. Clin. Psychol., 76*, 966–978.
Kuyken, W., Hayes, R., Barrett, B., Byng, R., Dalgleish, T., Kessler, D., … Byford, S. (2015). Effectiveness and cost-effectiveness of mindfulness-based cognitive therapy compared with maintenance antidepressant treatment in the prevention of depressive relapse or recurrence (PREVENT): A randomised controlled trial. *Lancet, 386*, 63–72.
Lavardiere, O., Kealy, D., Ogrodniczuk, J. S., & Descoteuax, J. (2019). Got empathy? A latent profile analysis of psychotherapists' empathic abilities. *Psychother. Psychosom., 88*, 41–42.
de Leon, J., Baca-Garcia, E., & Blasco-Fontecilla, H. (2015). From the serotonin model of suicide to a mental pain model of suicide. *Psychother. Psychosom., 84*, 323–329.
Ma, S. H., & Teasdale, J. D. (2004). Mindfulness-based cognitive therapy for depression: Replication and exploration of differential relapse prevention effects. *J. Consult. Clin. Psychol., 72*, 31–40.
MacLeod, A. (2020). Euthymia: Why it really does matter. *World Psychiatry, 19*(1), 1–2.
MacLeod, A. K., & Luzon, O. (2014). The place of psychological well-being in cognitive therapy. In G. A. Fava, & C. Ruini (Eds.), *Increasing psychological well-being in clinical and educational settings* (pp. 41–55). Dordrecht: Springer.
Mansueto, G. (2019). The effects of well-being therapy in chronic migraine. *Psychother. Psychosom., 88*(Suppl. 1), 80–81.
Marks, I. (1987). *Fears, phobias and rituals*. New York: Oxford University Press.
Martini, D. J., Strejilevich, S. A., Marengo, E., Ibanez, A., Scapola, M., & Igoa, A. (2014). Toward the identification of neurocognitive subtypes in euthymic patients with bipolar disorder. *J. Affect. Disord., 167*, 118–124.
McAdams, D. P., & De St. Aubin, E. (1992). A theory of generativity and its assessment through self-report, behavioural acts, and narrative themes in autobiography. *J. Pers. Soc. Psychol., 62*, 1003–1015.
McCracken, L. M., & Morley, S. (2014). The psychological flexibility model: A basis for the integration and progress in psychological approaches to chronic pain management. *J. Pain, 15*, 221–234.
McEwen, B. S. (2017). Epigenetic interactions and the brain-body communication. *Psychother. Psychosom., 86*, 1–4.
Meehl, P. E. (1975). Hedonic capacity: Some conjectures. *Bull. Menn. Clin., 39*, 295–307.
Meulenbeek, P., Christenhusz, L., & Bohlmeijer, E. (2015). Well-being therapy in the Netherlands. *Psychother. Psychosom., 84*, 316–317.
Moeenizadeh, M., & Salagame, K. K. K. (2010). The impact of well-being therapy on symptoms of depression. *Int. J. Psychol. Stud., 2*, 223–230.
Moieni, M., Irwin, M. R., Seeman, T. E., Robles, T. F., Lieberman, M. D., Breen, E. C., … Eisenberg, N. I. (2020). Feeling needed. Effects of a randomized generativity intervention on well-being and inflammation in older women. *Brain Behav. Immun., 84*, 97–105.
Nierenberg, A. A. (2008). An analysis of the efficacy of treatments for bipolar depression. *J. Clin. Psychiatry, 69*(Suppl. 5), 4–8.
Nierenberg, B., Mayersohn, G., Serpa, S., Holovatyk, A., Smith, E., & Cooper, S. (2016). Application of well-being therapy to people with disability and chronic illness. *Rehab. Psychol., 61*, 32–43.
Padesky, C. A., & Mooney, K. (2012). Strengths based cognitive-behavioural therapy. *Clin. Psychol. Psychother., 19*, 283–290.
Parloff, M. B., Kelman, H. C., & Frank, J. D. (1954). Comfort, effectiveness, and self-awareness as criteria of improvement in psychotherapy. *Am. J. Psychiatr., 11*, 343–351.
Penn, D. L., Mueser, K. T., Tarrier, N., Gloege, A., Cather, C., Serrano, D., & Otto, M. W. (2004). Supportive therapy for schizophrenia. Possible mechanisms and implications for adjunctive psychosocial treatments. *Schizophr. Bull., 30*, 101–112.
Pennebaker, J. W. (1997). Writing about emotional experiences as a therapeutic process. *Psychol. Sci., 8*, 162–166.
Pennebaker, J. W., Kiecolt-Glaser, J. K., & Glaser, R. (1988). Disclosure of traumas and immune function. Health implications for psychotherapy. *J. Consult. Clin. Psychol., 56*, 239–245.
Pennebaker, J. W., & Smyth, J. (2016). *Opening up by writing it down: The healing power of expressive writing* (3rd ed.). New York, NY: Guilford.
Petersen, C., & Seligman, M. E. P. (2004). *Character strengths and virtues*. New York: Oxford University Press.
Piet, J., & Hougaard, E. (2011). The effect of mindfulness-based cognitive therapy for prevention of relapse in recurrent major depressive disorder: A systematic review and meta-analysis. *Clin. Psychol. Rev., 31*, 1032–1040.
Piolanti, A., Offidani, O., Guidi, J., Gostoli, S., Fava, G. A., & Sonino, N. (2016). Use of the PsychoSocial index (PSI), a sensitive tool in research and practice. *Psychother. Psychosom., 85*, 337–345.
Quoidbach, J., Mikolajczak, M., & Gross, J. J. (2015). Positive interventions: An emotion regulation perspective. *Psychol. Bull., 141*, 655–693.

Rafanelli, C., Gostoli, S., Buzzichelli, S., Guidi, J., Sirri, L., Gallo, P., … Fava, G. A. (2020). Sequential combination of cognitive-behavioral treatment and well-being therapy in depressed patients with acute coronary syndromes: A randomized controlled trial (TREATED-ACS study). *Psychother. Psychosom., 89*, 345–356.
Rafanelli, C., Park, S. K., Ruini, C., Ottolini, F., Cazzaro, M., & Fava, G. A. (2000). Rating well-being and distress. *Stress Med., 16*, 55–61.
Rafanelli, C., & Ruini, C. (2012). Assessment of psychological well-being in psychosomatic medicine. In G. A. Fava, N. Sonino, & T. N. Wise (Eds.), *The psychosomatic assessment* (pp. 182–202). Basel: Karger.
Rashid, T. (2013). Positive psychology in practice: Positive psychotherapy. In S. A. David, I. Boniwell, & A. Conley Ayers (Eds.), *The Oxford handbook of happiness* (pp. 978–993). Oxford: Oxford University Press.
Rocha, P. M., Neves, F. S., & Correa, H. (2013). Significant sleep disturbances in euthymic bipolar patients. *Compr. Psychiatry, 54*, 1003–1008.
Rotterman, E., & Wright, J. H. (2019). Well-being therapy for recurrent depression and chronic pain. *Psychother. Psychosom., 88*, 378–379.
Ryff, C. D. (1989). Happiness is everything, or is it? Explorations on the meaning of psychological well-being. *J. Pers. Soc. Psychol., 6*, 1069–1081.
Ryff, C. D. (2014). Psychological well-being revisited. *Psychother. Psychosom., 83*, 10–28.
Sartorius, N., Holt, R. I. G., & Maj, M. (2015). *Comorbidity of mental and physical disorders*. Basel: Karger.
Schamong, I. (2019). From CBASP to WBT. Clinical case presentation of WBT as second line treatment in a patient with depression. *Psychother. Psychosom., 88*(Suppl. 1), 114.
Segal, Z. V., Bieling, P., Young, T., MacQueen, G., Cooke, R., Martin, L., … Levitan, R. D. (2010). Antidepressant monotherapy vs sequential pharmacotherapy and mindfulness-based cognitive therapy, or placebo, for relapse prophylaxis in recurrent depression. *Arch. Gen. Psychiatry, 67*, 1256–1264.
Segal, Z. V., & Walsh, K. M. (2016). Mindfulness-based cognitive therapy for residual depressive symptoms and relapse prophylaxis. *Curr. Opin. Psychiatry, 29*, 7–12.
Segal, Z. V., Williams, J. M. G., & Teasdale, J. D. (2002). *Mindfulness-based cognitive therapy for depression*. New York: Guilford.
Seligman, M. E. P., & Csikszentmihalyi, M. (2000). Positive psychology: An introduction. *Am. Psychol., 55*, 5–14.
Shallcross, A. J., Willroth, E. C., Fisher, A., Dimidjian, S., Gross, J. J., Visvanathan, P. D., & Mauss, I. B. (2018). Relapse/recurrence prevention in major depressive disorder: 26-month follow-up of mindfulness-based cognitive therapy versus an active control. *Behav. Ther., 49*(5), 836–849.
Skovholt, T. M., & Trotter-Mathison, M. (2011). *The resilient practitioner* (2nd ed.). New York: Routledge.
Slade, M., Blacke, L., & Longden, E. (2019). Personal growth in psychosis. *World Psychiatry, 18*, 29–30.
Sonino, N., & Fava, G. A. (1998). A simple instrument for assessing stress in clinical practice. *Postgrad. Med. J., 74*, 408–410.
Sonino, N., & Fava, G. A. (2003). Tolerance to antidepressant treatment may be overcome by ketoconazole. *J. Psychiatr. Res., 37*, 171–173.
Stangier, U., Hilling, C., Heidenreich, T., Risch, A. K., Barocka, A., Schlosser, R., … Hautzinger, M. (2013). Maintenance cognitive-behavioral therapy and manualized psychoeducation in the treatment of recurrent depression: A multicenter prospective randomized controlled study. *Am. J. Psychiatr., 170*, 624–632.
Teasdale, J. D., Segal, Z. V., Williams, J. M. G., Ridgeway, V. A., Soulsby, J. M., & Lau, M. A. (2000). Prevention of relapse/recurrence in major depression by mindfulness-based cognitive therapy. *J. Consult. Clin. Psychol., 68*, 615–623.
Tomba, E., & Tecuta, L. (2016). Well-being therapy in a patient with anorexia nervosa. *Psychother. Psychosom., 85*, 369–370.
Topp, C. W., Ostergaard, S. D., Sondergaard, S., & Bech, P. (2015). The WHO-5 well-being index: A systematic review of the literature. *Psychother. Psychosom., 84*, 167–176.
Vazquez, C., Pérez-Sales, P., & Ochoa, C. (2014). Post-traumatic growth. In G. A. Fava, & C. Ruini (Eds.), *Increasing psychological well-being in clinical and educational settings* (pp. 57–74). Dordrecht: Springer.
Vîslă, A., Flückiger, C., Grosse Holtforth, M., & David, D. (2016). Irrational beliefs and psychological distress: A meta-analysis. *Psychother. Psychosom., 85*(1), 8–15.
Weiss, L. A., Westerhof, G. J., & Bohlmeijer, E. T. (2016). Can we increase psychological well-being? The effects of interventions on psychological well-being. *PLoS One, 11*, Article e0158092.
Williams, J. M. G., Crane, C., Barnhofer, T., Brennan, K., Duggan, D. S., Fennell, M. J. V., … Russell, I. T. (2014). Mindfulness-based cognitive therapy for preventing relapse in recurrent depression: A randomized dismantling trial. *J. Consult. Clin. Psychol., 82*, 275–286.
Wood, A. M., & Tarrier, N. (2010). Positive clinical psychology. *Clin. Psychol. Rev., 30*, 819–829.
Wright, J. H., Brown, G. K., Thase, M. E., & Ramirez-Basco, M. (2017). *Learning cognitive-behavior therapy* (2nd ed.). Arlington, VA: American Psychiatric Association Publishing.

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