

Well-Being Therapy

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In the nineties, as other investigators, I was particularly concerned about the high risk of relapse in depression and its link with residual symptomatology (1). It was not easy to make the patients better, but it was even more difficult to keep them well. I was looking for a psychotherapeutic strategy that could increase the level of recovery. This was the setting where I developed a psychotherapeutic technique for increasing psychological well-being, Well-Being Therapy (WBT) (2). I thought that comparing the two strategies (CBT and WBT) could be the first step for testing this new therapy. 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 (3). Both well-being and cognitive-behavior therapies were associated with a significant reduction of residual symptom and increases in well-being. However, when residual symptoms of the two groups were compared after treatment, a significant advantage of WBT over CBT was observed. Well-being therapy was associated also with a significant increase in PWB well-being, particularly in the personal growth scale (3).

This is why I decided to include WBT in the treatment package, together with cognitive behavior treatment of residual symptoms and lifestyle modification, of a study concerned with patients with a severe form of recurrent depression 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 (4). Forty patients with recurrent major depression, who had been successfully treated with antidepressant drugs, were randomly assigned to either this package including WBT or clinical management. In clinical management the same number of sessions that was used in the experimental condition was given. Clinical management consisted of reviewing the patient clinical status and providing the patient with support and advice, if necessary. In both groups, antidepressant drugs were tapered and discontinued. The group that received CBT and WBT had a significantly lower level of residual symptoms after drug discontinuation in comparison with the clinical management group. CBT also resulted in significantly lower relapse rate (25%) at a 2 year follow-up than did clinical management (80%). At a 6 year follow-up (5), the relapse rate was 40% in the former group and 90% in the latter. Further, the group treated with CBT and WBT had significantly lower number of recurrences when multiple relapses were taken into account. Even though it was a small and preliminary study, the results were quite impressive: more than half of the patients treated with CBT and WBT were well and drug free at a 6 year follow-up (5). The findings were replicated by three independent studies (6-8).

In the course of the years WBT gained from the insights that derived from its application to other disorders; the original protocol (2) underwent a first modification in 2009 (9) and has eventually been finalized in a treatment manual (10).

Structure

Well-Being Therapy is a short-term psychotherapeutic strategy, that emphasizes self-observation, with the use of a structured diary, interaction between patients and

therapists and homework. WBT is based on a model of psychological well-being that was originally developed by Marie Jahoda in 1958 (11). She had outlined 6 criteria for positive mental health: autonomy (regulation of behaviour from within); 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 (self-perception/acceptance); the individual's balance and integration of psychic forces. Carol Ryff further elaborated the first 5 dimensions of positive functioning and introduced a method for their assessment, the Psychological Well-being scales (12). While initially WBT was simply aimed to increasing psychological well-being, its goal was subsequently refined in the achievement of a state of euthymia, Jahoda's sixth criterion (11). She defined it as the individual's balance 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). It is not simply a generic (and clinically useless) advise of avoiding excesses and extremes. It is how the individual adjusts the psychological dimensions of well-being to changing needs (13).

Structure

WBT may be used as the only therapeutic strategy. In this case the number of sessions may range from 8 to 16-20. The duration of each session may range from 45 to 60 minutes. WBT may also be used in sequential combination with other psychotherapeutic strategies, in particular CBT, and in this case the number of sessions may be abridged to 4-6 (10). The sequential combination of CBT/WBT has characterized its use so far (10).

The initial phase is concerned with self-observation of psychological well-being. Once the instances of well-being are properly recognized, the patient is encouraged to identify thoughts, beliefs and behaviors leading to premature interruption of well-being (intermediate phase). The final part involves cognitive restructuring of dysfunctional dimensions of psychological well-being and meeting the challenge that optimal experiences may entail (10).

Characteristic features

Within the broad and highly heterogeneous spectrum of positive interventions , WBT stands for some specific aspects:

1. Monitoring of psychological well-being in a diary. Patients are encouraged to identify episodes of well-being and to set them into a situational context. They 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. Such

search involves also optimal experiences. These are characterized by the perception of high environmental challenges and environmental mastery, deep concentration, involvement, enjoyment, control of the situation, clear feedback on the course of activity and intrinsic motivation.

2. Identification of low tolerance to well-being by seeking automatic thoughts. 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 therapy. The trigger for self-observation is, however, different, being based on well-being instead of distress.
3. Behavioral exposure. The therapist may also reinforce and encourage activities that are likely to elicit well-being and optimal experiences (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, with special reference to exposure to feared or challenging situations, which the patient is likely to avoid. Meeting the challenge that optimal experiences may entail is emphasized, because it is through this challenge that growth and improvement of self can take place.
4. Cognitive restructuring using specific psychological well-being models. The monitoring of the course of episodes of well-being allows the therapist to realize specific impairments or excessive levels in well-being dimensions according to Jahoda-Ryff's conceptual framework (11, 12). 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 experiences and considering self as expanding over time, if the patient's attitudes show impairments in these specific areas. The patient thus becomes able to readily identify moments of well-being, be aware of interruptions to well-being feelings (cognitions), utilize cognitive behavioral techniques to address these interruptions, and pursue optimal experiences.

5. Individualized and balanced focus. Patients are not simply encouraged pursuing 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, subsumed under the rubric of euthymia (13). This optimal-balanced well-being could be different from patient to patient, according to factors such as personality traits, social roles and cultural and social contexts.

Current indications

Well-Being Therapy has been tested in a number of controlled trials, mostly as an adjunctive treatment ingredient. Unlike many other psychotherapeutic strategies, it was not conceived as a cure for mental disorders, but as a therapeutic tool to be incorporated in a therapeutic plan. As a general indication, it is difficult to apply WBT as first line treatment of an acute psychiatric disorder. It 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. It is simply wishful thinking to believe that one course of treatment will be sufficient for yielding lasting and satisfactory remission. Further, WBT was not conceived to be used in every patient who meet specific diagnostic criteria . It should follow clinical reasoning. Not surprisingly the three main current indications of WBT are trans-diagnostic.

1. Increasing the level of recovery. The sequential combination of CBT and WBT in recurrent depression has resulted in a decreased rate of relapse (5). A dismantling study that was performed in generalized anxiety disorder (14) 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 CBT/WBT sequential combination over CBT were observed, both in terms of symptomatology and well-being.. While the clinical benefits have been substantiated in depression and GAD, this appears to be target for a number of other mental disorders.

2. Modulating mood. WBT was applied to treatment of cyclothymic disorder, that involves mild or moderate fluctuations of mood, thought and behavior without meeting formal diagnostic criteria for either major depressive disorder or mania (15). It is a common and disabling condition that does not attract much research attention since no drugs have been patented for its treatment. Sixty-two patients with cyclothymic disorder were randomly assigned to the sequential combination of CBT

and WBT or clinical management. An independent blind evaluator assessed the patients before treatment, after therapy and a 1- and 2-year follow-ups. 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 (15). The results thus indicated that WBT may address both polarities of mood swings and is geared to a state of euthymia.

3.Educational purposes. Three randomized controlled trials in educational settings indicated that protocols based on WBT may be suitable for promoting mechanisms of resilience and psychological well-being (16-18). In the first pilot study, school interventions (4 class sessions lasting a couple of hours) were performed in a population of 111 middle school students randomly assigned to: a) a protocol using theories and techniques derived from cognitive behavioral therapy; b) a protocol derived from WBT. Both school-based interventions resulted in a comparable improvement in symptoms and psychological well-being (16). This pilot investigation suggested that well-being enhancing strategies could match CBT in the prevention of psychological distress and promoting optimal human functioning among children. The differential effects of WBT and CBT approaches have been subsequently explored in another controlled school intervention, involving more sessions and an adequate follow-up (17). In this trial 162 students attending middle schools were randomly assigned to either: (a) a protocol derived from WBT; (b) an anxiety management (AM) protocol. The results of this investigation showed that

WBT was found to produce significant improvements in well-being, whereas AM ameliorated anxiety only.

WBT school interventions were extended to high-school students, who are considered to be a more “at risk” population for mood and anxiety disorders. School interventions were performed in a sample of 227 students (18). The classes were randomly assigned to either: (a) a protocol derived from WBT; (b) attention-placebo (AP) protocol, which consisted of relaxation techniques, group discussion of common problems reported by students and conflict resolution. The WBT intervention was found to be significantly more effective in promoting psychological well-being, with particular reference to personal growth, compared to AP. Further, it was found to be more effective also in decreasing distress, in particular anxiety and somatization. The beneficial effects of WBT protocol in decreasing anxiety and somatization were maintained at the follow-up, whereas in the AP group improvements faded and disappeared (18). The results thus indicated that WBT in educational settings may yield enduring results in terms of positive emotions and psychological well-being. Each session was conducted by two psychologists at the presence of the teacher.

CONCLUSIONS

The studies that are summarized indicate that the potential role of Well-Being Therapy (WBT) is broader than it was originally assumed, i.e. decreasing the risk of relapse in the residual phase of mood and anxiety disorders. Its updated scope encompasses increasing resilience in a variety of psychiatric and medical conditions, modulating psychological well-being and mood, developing alternative pathways to

established treatment modalities, including psychotropic drugs. An important characteristic of WBT is self-observation of psychological well-being associated with specific homework. Such perspective is different from interventions that are labelled as positive but are actually distress oriented. Another important feature of WBT is the assumption that imbalances in well-being and distress may vary from one illness to another and from patient to patient. The pursuit of euthymia (13) can thus only be achieved with a personalized approach that characterizes the treatment protocol and requires a comprehensive initial evaluation. The manualization of WBT (10) may facilitate its individualized application and the insights gained by clinicians and investigators may refine its current use and indications.

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