

Beyond cognitive behavior therapy:

A revolutionary approach to improve psychological well-being

Giovanni A. Fava

Well-Being Therapy

Treatment Manual and Clinical Applications

Well-Being Therapy (WBT) is the psychotherapeutic approach developed by Giovanni Fava, a world-renowned psychiatrist and psychotherapist, and the editor-in-chief of *Psychotherapy and Psychosomatics*. WBT is an innovative strategy that is based on monitoring psychological well-being, whereby the patient progressively learns how to make it grow. This type of therapy has enjoyed much success and is increasing in popularity around the world.

The first part of this long-awaited book describes how the idea for WBT was formed, the first patient treated, and the current evidence that supports this approach. In Part II, Giovanni Fava provides the treatment manual of WBT, describing what each session entails, and includes many examples from his own cases. The last part covers some of the specific conditions for which WBT can be used and how sessions can be conducted. It includes sections on depression, mood swings, generalized anxiety disorder, panic and agoraphobia, and posttraumatic stress disorder. There is also information on the application of WBT in interventions in school settings. Throughout the book, Dr. Fava keeps things interesting by peppering his narrative with anecdotes from his medical career.

The primary audience for this book is professionals within psychology, psychiatry, and other fields of medicine (e.g., family practice, pediatrics, and rehabilitation). However, the book is written in a relaxed, clear, and accessible style that also makes it of interest to counselors, educators, and family and friends of patients, not to mention patients themselves.

'The publication of this first book on Well-Being Therapy (WBT) is a landmark event.'

Jesse H. Wright (University of Louisville, Louisville, Ky.)



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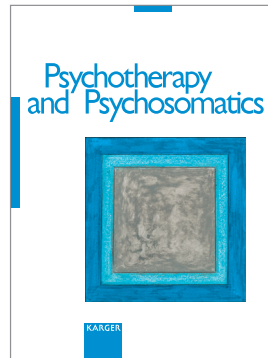
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Part I: THE BACKGROUND

Chapter 1: The development

When I decided to study medicine, I was not particularly convinced of my choice. The early years were tough: I did not like the topics I was studying in my medical school in Padova, Italy. I was aware that I should consider myself lucky, with a future full of promise, but I kept on wondering whether I had made the right choice. Until something happened. In those days (early seventies), medical students had yearly chest X-rays. At the beginning of my third year (medical courses extend over six years in Italy), I had mine. A few days later I got a letter stating that there was something wrong and I had to come back for further checking in a couple of days. My first thought was “I got tuberculosis”. When I got the letter, I was reading Thomas Mann’s *Magic Mountain* and I concluded that this could not be a coincidence. “ I have not been feeling well, recently – I thought – I am more tired than I used to be”. I imagined myself in a sanatorium, far away from my family, friends and classes. When I eventually went to the clinic for the new check up, I was a wreck. But I was told “There should have been a mistake: your chest is fine”. In a matter of seconds, I felt fine and when I got out of the clinic the sky was blue and there could not be any other medical student happier than I was. I understood that regaining health is a wonderful experience. But I was never actually sick by a medical viewpoint.

I thus became interested in psychosomatic medicine, a comprehensive framework for assessing the role of psychosocial factors in the development, course and outcome of illness (1). No one seemed to be interested in psychosomatic medicine in Padova or in other Italian universities. Some lucky circumstance brought me to spend the summer of 1975 in Rochester, New York, for

studying with someone who was considered to be probably the most prominent scholar in the psychosomatic field, George Engel.

The Rochester experience

George Engel was Professor of Medicine and Professor of Psychiatry at the University of Rochester School of Medicine and Dentistry. Trained as an internist, he had criticized the traditional concept of disease restricted to what can be understood or recognized by the physician (2). In other words, only what the physician allows it is recognized as disease and deserves the sick role by the patient. Engel elaborated a unified concept of health and disease (2): there is no health and no disease, only a dynamic balance between health and disease. Such view, expressed in 1960, was subsequently elaborated in the biopsychosocial model (3). Psychosocial factors are a class of etiological factors in every type of disease, even though their relative weight may change from one disease to another, from one patient to another and even from one episode to another of the same illness in the same patient (4). It is not that certain diseases, defined as “functional”, lack an explanation; it is our assessment that is inadequate in most of the clinical encounters (5).

I spent the summer in his medical-psychiatric unit and the experience was for me an endless source of knowledge and inspiration. One day a psychosomatic consultation was requested from a medical ward. With another medical student, Sam, I went to see the patient. She was a lady in her fifties and manifested what appeared to be an unbearable abdominal pain. Medical work-up could not establish a potential cause. Her condition seemed to be deteriorating and explorative surgery was planned in a couple of days (in 1975, today’s minimally invasive explorative procedures were not available). Our job was to interview her and get some preliminary history. Dr. Engel would have come later in the day. We started with some questions, but she appeared to be in great pain. Sam and I agreed that it was not probably the right time. We would have come back with Dr Engel. Which

we did. Dr Engel got immediately her attention and collaboration. At a certain point, during the medical interview, he became interested in a scar the patient had. The lady suddenly brightened up and described a surgical operation she had in the past. Dr Engel asked whether she had undergone other surgical interventions. The lady showed other scars and provided detailed descriptions of each surgery. She seemed to forget about her pain. Sam and I could not understand what was going on. She looked so well, while only hours earlier she was so much in pain. Dr Engel asked how things were going in her life and she replied that, after a very troubled time with a lot of problems in her family, things were going reasonably well. When we got out of her room, Dr Engel told us that the lady had a pain-prone personality and was a surgery addict (6). When life is treating these patients worst, when circumstances are the hardest, their physical health is likely to be at its best and the individuals are free of pain. When things improve, when some success is imminent, then painful symptoms develop (6). Sam asked what could be done for these patients. Dr Engel replied “not much, unfortunately. I will speak with her physician and at least this time we will avoid surgery”. Sam and I, with our juvenile wish to help, were very dissatisfied by that answer. I thought “may-be one day someone will find the way”.

When the summer was over and I went back to Padova, I intended to become like George Engel and to be knowledgeable of both internal medicine and psychiatry. In due course, I realized that one specialty was already more than I could handle and I chose psychiatry, the field where most of the psychosomatic researchers came from.

Treating depression

I started my residency training program in psychiatry in Padova, but my idea was to go back to Rochester to complete my training. For certain circumstances that in those days I judged to be unfavorable, I ended up in Albuquerque, New Mexico instead of Rochester. My teacher and mentor

was someone I had met at a psychosomatic conference, Robert Kellner. He had become psychiatrist after several years as primary care physician and thus shared something in common with George Engel. He really showed me how the psychosomatic approach could balance pharmacological and psychological therapies in psychiatric practice. Depression was the psychiatric disorder that attracted my attention the most. After one year in the South-West of the U.S., I moved to Buffalo, New York, where I was offered to establish a depression unit. I was convinced that depression was essentially an episodic disorder, that there were powerful remedies against it (antidepressant drugs) and chronicity was essentially a consequence of inadequate diagnosis and treatment. Today if I think of my views then, I am surprised of my naivete and clinical blindness. We have become aware that depression is essentially a chronic disorder with multiple acute episodes along its course (7). But my view then was shared by almost any expert in the field.

When I worked in the U.S., I had essentially a cross-sectional view of the disorder (I was seeing and treating the patients only in the hospital, with little follow-up). But when I decided to go back to Italy and to establish an outpatient clinic at the University of Bologna with opportunities for follow-up, I began to appraise that also patients I had personally treated with antidepressant drugs and whom I judged to have completely remitted, relapsed into depression after some time. What was I missing?

The concept of recovery

I became more and more sceptical of the long-term effectiveness of antidepressant drugs, to the point that in 1994 I introduced in the literature the hypothesis that these medications could be a cause for chronicity (8). I was inspired by the “antibiotic paradox”: the best agents for treating bacterial infections are also the best agents for selecting and propagating resistant strains, which persist in the environment even when exposure to the drug is stopped (9). On the basis of some data

that were available I postulated that long-term use of antidepressant drugs may worsen the long-term outcome and symptomatic expression of illness, decreasing both the likelihood of subsequent response to pharmacological treatment and duration of symptom free periods (8). Two decades later the evidence supporting this hypothesis is quite impressive (10), but in those days swimming against the tide of pharmaceutical propaganda was not easy. In Albuquerque, under the guidance of Robert Kellner, I had learnt to practice cognitive behavior therapy (CBT). I was using it with my depressed patients, whether associated with antidepressant drugs or not, but it did not seem to affect their long-term outcome, as also reported in the literature (7). This was in striking contrast with the use of CBT in anxiety disorders, where positive and lasting effects could be observed (8).

In the meanwhile, an increasing amount of studies was pointing to the fact that pharmacological treatment of depression was not solving all the problems and, despite substantial improvement, important residual symptoms were present (11). Such symptoms particularly included anxiety and irritability and were associated with impaired functional capacity. Most residual symptoms also occurred in the prodromal phase of illness and might progress to become prodromal symptoms of relapse (11). As a result, the concept of recovery could not be limited to the abatement of certain symptoms (12). As Engel indicated (2,3), health is not simply the absence of disease but also requires the presence of wellness. We knew how to bring people out of the negative functioning, but regaining psychological well-being was quite different and we did not have a clue about how to achieve it.

Psychological well-being

In the mid-nineties, I attended an international conference in psychiatry in Copenhagen, organized by my friend Per Bech, one of the most important and original researchers in psychological assessment of mood disorders (13). When I met him, he recommended me to attend a session on

quality of life. One of the speakers, he said, was an American developmental psychologist who had some interesting ideas. I went and, as in other occasions, he was right. The speaker was Carol Ryff, who gave an account of her model of psychological well-being, that was a synthesis of various contributions from the literature (14). She remarked that well-being cannot be equated to happiness or life satisfaction. She had developed a questionnaire for measuring the various dimensions of psychological well-being, the Psychological Well-Being scales (PWB), that she had applied to non-clinical populations in longitudinal studies (14). She gave a brief description of each of the 6 dimensions. I belong to the endangered species of clinician-researchers, those who do clinical research but also assess and treat individual patients. When I examine research constructs my starting point is always whether these constructs make sense with the patients I see. And those formulations did: autonomy (a sense of self-determination), environmental mastery (the capacity to manage effectively one's life), positive interpersonal relationships, personal growth (a sense of continued growth and development), purpose in life (the belief that life is purposeful and meaningful) and self-acceptance (a positive attitude toward self). After the presentation, I started thinking of many patients I had encountered who seemed to have these dimensions impaired or exaggerated with resulting clashes against everyday life. I was surprised that a developmental psychologist could have articulated such deeply clinical formulations. Many years later I discovered that those dimensions had indeed a clinical root and were developed by Marie Jahoda, Professor of Social Psychology at New York University, in a fantastic book on positive mental health that was published in 1958 (15). The book was waiting for me in an American library and became a further source of reflection and inspiration. Marie Jahoda had outlined 6 criteria for positive mental health. As described in Table 1, in five cases these criteria were only slightly different compared to those later outlined by Carol Ryff: autonomy (regulation of behavior from within), environmental mastery, satisfactory interactions with other people and the milieu, the

individual's style and degree of growth, development and self-actualization (that was split by Ryff in the dimensions of personal growth and purpose in life), the attitudes of an individual toward his/her own self (self-perception/acceptance). There was, however, a sixth important dimension whose formulation became particularly important to me at some later point in time: the individual's balance and integration of psychic forces, that encompasses both outlook on life and resistance to stress.

How to implement a psychological work aimed to improving psychological well-being appeared to be quite difficult and I did not know how it could be achieved.

In 1954, Parloff, Kelman and Frank (16) suggested that the goals of psychotherapy were not necessarily the reduction of symptoms, but increased personal comfort and effectiveness. However, there had been a very limited response to these needs in subsequent years. Notable exceptions were

Table 1. Dimensions of psychological well-being

Jahoda's model (1958)	Ryff's model (1989)
1. Positive attitudes toward self	Self-acceptance
2. Growth, development and self-actualization	Personal growth and purpose in life
3. Integration and balance	
4. Autonomy	Autonomy
5. Satisfactory interactions	Interpersonal relationships
6. Environmental mastery	Environmental mastery

Ellis and Becker's guide to personal happiness (17), a modification of rationale-emotive therapy for removing the main blocks to personal happiness (shyness, feeling of inadequacy, feeling of guilt, etc.), Fordyce's program to increase happiness (18), Padesky's work on schema change processes (19), Frisch's quality of life therapy (20) and Horowitz and Kaltreider's work on positive states of mind (21). Unfortunately these approaches had not undergone sufficient clinical validation and did not seem to target what I had in mind in terms of psychological well-being.

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