

The use of well-being therapy in clinical settings

İyi oluş terapisinin klinik uygulamalarda kullanımı

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Abstract

The concept of psychological well-being and its clinical implications are discussed. A specific psychotherapeutic strategy for increasing psychological well-being, Well-being therapy (WBT), is presented, with a focus on the promotion of an individualized and balanced path to achieve optimal human functioning. The polarities in positive psychological dimensions and their clinical implications are particularly described. WBT has been developed and tested in a number of randomized controlled trials. Recently, international validation studies have replicated the Italian results. The findings indicate that optimal human functioning can be promoted by specific techniques, leading to a positive evaluation of one's self, a sense of continued growth and development, the belief that life is purposeful and meaningful, the possession of quality relations with others, the capacity to manage effectively one's life, and a sense of self-determination.

Keywords: Well-being therapy, positive psychology, depression, anxiety, resilience

Özet

Çalışmada, psikolojik iyi-oluş kavramı ve onun klinik uygulamaları tartışılmıştır. Psikolojik iyi oluşu arttırmak için özel bir psikoterapi yöntemi olan İyi Oluş Terapisi (İOT), pozitif psikolojik boyutlardaki kutuplaşmalardan kaçınarak, özellikle ideal insan işleyişine ulaşmak için bireyselleştirilmiş ve dengeli bir yöntemin desteklenmesi olarak tanımlanmaktadır. İOT çok sayıda kontrollü deneysel araştırmalar sonucunda test edilmiş ve geliştirilmiştir. Son zamanlarda yapılan uluslararası geçerlilik çalışmaları İtalya'da elde edilen bulguları desteklemiştir. Bulgular, iyi psikolojik iyi oluşa, bireyin kendi ile ilgili pozitif değerlendirmesini destekleme, sürekli bir büyüme ve gelişme duygusu, hayatın anlamlı ve amaçlı olduğu inancı, başkalarıyla kaliteli ilişkilere sahip olma, kendi hayatını etkin şekilde yönetebilme becerisi ve otonomi duygusu sayesinde erişilebileceğine işaret etmektedir.

Anahtar Kelimeler: İyi oluş terapisini, pozitif psikoloji, depresyon, anksiyete, psikolojik dayanıklılık

Introduction

Since its early stages, clinical psychology research emphasized issues such as Jung's (1933) concept of individuation, Frankl (1959) conceptualization of resilience and meaning, and Jahoda (1958) criteria for positive mental health. Similarly, humanistic psychology suggested concepts such as self-realization and self-actualization as final therapeutic goal (Maslow, 1968; Rogers, 1961). In 1954, Parloff, Kelman and Frank suggested that the goals of psychotherapy were increased personal comfort and effectiveness. For a long time these latter achievements were

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viewed only as by-products of the reduction of symptoms. As a result, mental health research has been dramatically weighted on the side of psychological dysfunction and health was equated with the absence of illness, rather than the presence of wellness (Ryff & Singer, 1996).

However, the inadequacy of this medical model applied to mental health domains has emerged. First of all, there is increasing awareness that the concept of recovery in clinical psychology cannot simply be confounded with response to treatment or limited to the abatement of certain symptoms. In fact, there is a growing body of literature on residual symptoms after apparently successful treatment in mood and anxiety disorders. Most residual symptoms also occur in the prodromal phase of illness and may progress to become programs of relapse (Fava, Ruini, & Belaise, 2007). The recognition of residual symptomatology has led to psychotherapeutic treatment specifically addressed to residual symptomatology, which was indeed found to improve long-term outcome of major depressive disorders (Fava, Ruini, & Rafanelli, 2005).

Further, clinicians working with patients with mood and anxiety disorders are often confronted with the unsatisfactory degree of remission that current therapeutic strategies yield, and with the vexing problems of relapse and recurrence (Fava, Tomba, & Grandi, 2007). Various follow-up studies, in fact, have documented relapses and recurrence in affective disorders (Ramana, Paykel, Cooper, Hayburst, Saxty, & Surtees, 1995). As a result, the challenge of treatment of depression today appears to be the prevention of relapse more than the attainment of recovery.

Finally, partial remission after treatment was not found to be limited to negative affective symptoms. Remitted patients with mood and anxiety disorders displayed significantly lower levels of psychological well-being compared to healthy control subjects (Rafanelli, Park, Ruini, Ottolini, Cazzaro, & Fava, 2000). Unexpectedly, Thunedborg, Black and Bech (1995) found that quality of life measurement, could predict recurrence of depression, instead of symptomatic ratings. An increase in psychological well-being may thus protect against relapse and recurrence (Fava, 1999; Wood & Joseph, 2010). Therefore an intervention that targets the positive may address an aspect of functioning and health that is typically left unaddressed in conventional treatments. Ryff and Singer (1996) have suggested that the absence of well-being creates conditions of vulnerability to possible future adversities and that the route to enduring recovery lies not exclusively in alleviating the negative, but in engendering the positive. Interventions that bring the person out of the negative functioning (e.g., exposure treatment in panic disorder with agoraphobia) are one form of success, but facilitating progression toward the restoration of positive is quite another (Ryff & Singer, 1996). The need to develop intervention strategies and programs by including psychological well-being has then become manifest.

The Definition of Psychological Well-Being

A relevant methodological issue is the broad definition of psychological well-being and optimal functioning. A review by Ryan e Deci (2001) has shown that research on well-being has followed two main directions: a) one concerning happiness and hedonic well-being; b) one concerning development of human potential (eudaimonic well-being). In the first realm all studies dealing with concepts of subjective well-being (Diener, Suh, Lucas, & Smith, 1999), life satisfaction (Neugarten, Havinghurst, & Tobin, 1961), positive emotions (Fredrickson & Joiner, 2002) can be included. The concept of well-being here is equated with a cognitive process of evaluation of one's life, or with the experience of positive emotions. According to the eudaimonic perspective, happiness consists of fulfilling one's potential in a process of self-realization. Under this umbrella some researchers describe concepts such as fully functioning person, meaningfulness, self-actualization and vitality. In particular, Ryff's (1989) model of psychological well-being, encompassing autonomy, personal growth, environmental mastery, purpose in life, positive relations and self-acceptance has been found to be feasible in clinical psychology and

psychotherapy (Ryff & Singer, 1996; Rafanelli et. al., 2000; Fava, Rafanelli, Ottolini, Ruini, Cazzaro, & Grandi, 2001; Ruini, et al., 2002; Rafanelli, et al., 2002). Importantly, in describing optimal human functioning, Ryff and Singer (2008) emphasize Aristotele's admonishment to seek "that which is intermediate", avoiding excess and extremes. The pursuit of well-being may in fact be so self-absorbing and individualistic to leave no room for human connection; or it could be so focused on responsibilities and duties outside the self that personal talents and capacities are unrecognized and underdeveloped (Ryff & Singer, 2008).

These two approaches have led to different areas of research, but they complement each other in defining the construct of well-being (Ryan & Deci, 2001). Some authors have also suggested that they can compensate each other; thus individuals may have profiles of high eudemonic well-being and low hedonic well-being, or vice versa. These profiles are also associated to sociodemographic variables, such as age, years of education and employment (Keyes, Shmotkin, & Ryff, 2002). However, in this investigation, the Authors underlined the fact that only a small proportion of individuals presents optimal well-being that is high hedonic and eudemonic well-being paving the way for possible psychosocial interventions.

Well-Being Therapy

In order to justify therapeutic efforts aimed at increasing psychological well-being, we should demonstrate impaired levels of psychological well-being in a clinical population. This was achieved by using an instrument, the Psychological Well-being Scales (PWB) developed by Ryff (1989). In a controlled investigation (Rafanelli, et al., 2000), 20 remitted patients with mood or anxiety disorders displayed significantly lower levels in all 6 dimensions of well-being according to the Scales of Psychological Well-being (PWB) compared to healthy control subjects matched for sociodemographic variables. It is obvious, however, that the quality and degree of impairment may vary from patient to patient and, within the same patient, according to the clinical status. Further, Fava, et al. (2001) administered the PWB to 30 remitted patients with panic disorder and 30 matched controls and found impairments in some specific areas, but not in others. The model described by Ryff (1989) and Ryff and Keyes (1995) was thus found to satisfactorily describe the variations in psychological well-being which may occur in a clinical setting.

These clinical frameworks was thus instrumental in developing a well-being enhancing psychotherapeutic strategy, defined as well-being therapy (Fava, 1999b; Fava, Rafanelli, Cazzaro, Conti, & Grandi, 1998a; Fava & Ruini, 2003, Ruini & Fava, 2012). Well-being therapy is a short-term psychotherapeutic strategy that extends over 8 sessions, which may take place every week or every other week. The duration of each session may range from 30 to 50 minutes. It is a technique which emphasizes self-observation (Emmelkamp, 1974), with the use of a structured diary, and interaction between patients and therapists. Well-being therapy is based on Ryff's cognitive model of psychological well-being (Ryff, 1989). Well-being therapy is structured, directive, problem-oriented and based on an educational model. The development of sessions is as follows:

Initial Sessions (1-2): These sessions are simply concerned with identifying episodes of well-being and setting them into a situational context, no matter how short lived they were. Patients are asked to report in a structured diary the circumstances surrounding their episodes of well-being, rated on a 0-100 scale, with 0 being absence of well-being and 100 the most intense well-being that could be experienced. When patients are assigned this homework, they often object that they will bring a blank diary, because they never feel well. It is helpful to reply that these moments do exist but tend to pass unnoticed. Patients should therefore monitor them anyway.

Patients are particularly encouraged to search for well-being moments, not only in special hedonic –stimulating situations, but also during their daily activities. Several studies have shown that individuals preferentially invest their attention and psychic resources in activities associated with rewarding and challenging states of consciousness, in particular with optimal experience

(Csikszentmihalyi, 1990; Delle Fave & Massimini, 2003). Patients are thus asked to report when they feel optimal experiences in their daily life and are invited to list the associated activities or situations.

Intermediate Sessions (3-5): 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. The similarities with the search for irrational, tension-evoking thoughts in Ellis and Becker's rational-emotive therapy (1982) and automatic thoughts in cognitive therapy (Beck, Rush, Shaw, & Emery, 1979) are obvious. The trigger for self-observation is, however, different, being based on well-being instead of distress. This phase is crucial, since it allows the therapist to identify which areas of psychological well-being are unaffected by irrational or automatic thoughts and which are saturated with them. The therapist may challenge these thoughts with appropriate questions, such as "what is the evidence for or against this idea?" or "are you thinking in all-or none terms?" (Beck, et al., 1979). The therapist may also reinforce and encourage activities that are likely to elicit well-being (for instance, assigning the task of undertaking particular pleasurable activities for a certain time each day). Such reinforcement may also result in graded task assignments (Beck, et al., 1979), with special reference to exposure to feared or challenging situations, which the patient is likely to avoid. Over time patients may develop ambivalent attitudes toward well-being. They complain of having lost it, or they long for it, but at the same time they are scared when positive moments actually happen in their lives. These moments trigger specific negative automatic thoughts, usually concerning the fact that they will not last (i.e., it's too good to be true) or that they are not deserved by patients, or that they are attainable only by overcoming difficulties and distress. Encouraging patients in searching and engaging in optimal experiences and pleasant activities is therefore crucial at this stage of WBT.

Final Sessions (6-8): The monitoring of the course of episodes of well-being allows the therapist to realize specific impairments in well-being dimensions according to Ryff's conceptual framework. An additional source of information may be provided by Ryff's Scales of Psychological Well-Being (PWB), an 84-item self-rating inventory (Ryff, 1989). In the original validation study of well-being therapy (Fava, et al., 1998a), however, PWB results were not available to the therapist, who just worked from the patient's diary. Ryff's six dimensions of psychological well-being are progressively introduced to the patients, as long as the material which is recorded lends itself to it. For example, the therapist could explain that autonomy consists of possessing an internal locus of control, independence and self-determination; or that personal growth consists of being open to new experience and considering self as expanding over time, if the patient's attitudes show impairments in these specific areas. Errors in thinking and alternative interpretations are then discussed. At this point in time the patient is expected to be 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 to pursue optimal experiences. 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.

Cognitive restructuring in well-being therapy follows Ryff's conceptual framework (Ryff & Singer, 1996). The goal of the therapist is to lead the Patients with an initial impaired level in the six dimensions of psychological well-being are guided toward an optimal level. Patients, thus, are not simply encouraged to pursue the highest possible levels in psychological well-being, in all dimensions, but to obtain a balanced functioning. This optimal-balanced well-being could be different from patient to patient, according to factors, such as personality traits, social roles and socio-cultural contexts (Ruini et al., 2003; Ruini & Fava, 2012). The clinical insight concerning this optimal-balanced level confirms Garamoni et al. (1991) observation that human healthy functioning is characterized by an optimal balance of positive and negative cognitions or affects, and that psychopathology is marked by deviations from this balance. More recently, Grant &

Schwartz (2011) suggested that all positive traits, states, and experiences have costs that, at high levels, may begin to outweigh their benefits, creating the no monotonicity of an inverted U. For this reason, Well-being therapy and other Positive interventions should not be simply aimed to increase happiness and well-being, but should consider the complex balance between psychological well-being and distress (MacLeod & Moore, 2000) and be targeted to specific and individualized needs.

The Use of WBT in Clinical Settings

Well-being therapy has been employed in several clinical studies. Other studies are currently in progress.

Residual Phase of Affective Disorders

The effectiveness of well-being therapy in the residual phase of affective disorders was first tested in a small controlled investigation (Fava et al., 1998a). Twenty patients with affective disorders previously treated by behavioral (anxiety disorders) or pharmacological (mood disorders) methods, were randomly assigned to either a well-being therapy or cognitive behavioral treatment (CBT) for their residual symptoms. Both well-being and cognitive behavioral therapies yielded a significant reduction of residual symptoms, as measured by the Clinical Interview for Depression (CID) (Guidi, Fava, Bech, & Paykel, 2011; Paykel, 1985), and improvements in well-being. However, when the residual symptoms of the two groups were compared after treatment, well-being therapy resulted superior to cognitive behavioral strategies, as observed with the CID scores. Well-being therapy was associated also with a significant increase in PWB well-being, particularly in the Personal Growth scale.

The improvement in residual symptoms was explained on the basis of the balance between positive and negative affect (Fava et al., 1998a). If treatment of psychiatric symptoms induces improvement of well-being, and indeed subscales describing well-being are more sensitive to drug effects than subscales describing symptoms (Kellner, 1987; Rafanelli & Ruini, 2012), it is conceivable that changes in well-being may affect the balance of positive and negative affect. In this sense, the higher degree of symptomatic improvement that was observed with well-being therapy in this study is not surprising: in the acute phase of affective illness, removal of symptoms may yield the most substantial changes, but the reverse may be true in its residual phase.

Prevention of Recurrent Depression

Well-being therapy was a specific and innovative part of a cognitive behavioral package that was applied to recurrent depression (Fava, Rafanelli, Grandi, Conti, & Belluardo, 1998b). This package included also CBT of residual symptoms and lifestyle modification. Forty patients with recurrent major depression, who had been successfully treated with antidepressant drugs, were randomly assigned to either this cognitive behavioral package including well-being therapy or clinical management. In both groups, antidepressant drugs were tapered and discontinued. The group that received cognitive behavioral therapy-WBT had a significantly lower level of residual symptoms after drug discontinuation in comparison with the clinical management group. Cognitive behavioral therapy-WBT also resulted in a significantly lower relapse rate (25%) at a 2 year follow-up than did clinical management (80%). At a 6 year follow-up (Fava et al., 2004) the relapse rate was 40% in the former group and 90% in the latter. Further, the group treated with CBT-WBT had a significantly lower number of recurrences when multiple relapses were taken into account (Fava et al., 2004).

Loss of Clinical Effect During Drug Treatment

The return of depressive symptoms during maintenance antidepressant treatment is a common and vexing clinical phenomenon (Fava & Offidani, 2011) that was addressed by WBT. Ten patients with recurrent depression who relapsed while taking antidepressant drugs were randomly assigned to dose increase or to a sequential combination of cognitive-behavior and well-being therapy (Fava, Ruini, Rafanelli, & Grandi, 2002). Four out of five patients responded to a larger dose, but all relapsed again on that dose by 1 year follow-up, whilst those 5 patients treated by CBT-WBT. Four improved and only one relapsed. The data suggest that application of well-being therapy may counteract loss of clinical effect during long-term antidepressant treatment.

Treatment of Generalized Anxiety Disorder

Well-Being Therapy has been applied for the treatment of generalized anxiety disorder (Fava et al., 2005, Ruini & Fava, 2009). Twenty patients with DSM-IV GAD were randomly assigned to 8 sessions of CBT or the sequential administration of 4 sessions of CBT + 4 sessions of WBT. Both psychotherapies were associated with a significant reduction of anxiety. However, the WBT-CBT sequential combination was superior to CBT, both in terms of symptom reduction and psychological well-being improvements. These results suggest the clinical advantages of adding WBT to the treatment of GAD. A possible explanation to these findings is that self-monitoring of episodes of well-being may lead to a more comprehensive identification of automatic thoughts than the one entailed by the customary monitoring of episodes of distress in cognitive therapy, as observed with single case description (Ruini & Fava, 2009).

Cyclothymic Disorder

Cyclothymic disorder involves mild or moderate fluctuations of mood, thought, and behaviour without meeting formal diagnostic criteria for either major depressive disorder or mania (Baldessarini, Vázquez, & Tondo, 2011). Well-being therapy was recently applied (Fava, Rafanelli, Tomba, Guidi, & Grandi, 2011) in sequential combination with CBT for the treatment of this disorder. Sixty-two patients with DSM-IV cyclothymic disorder were randomly assigned to CBT/WBT or clinical management (CM). An independent blind evaluator assessed the patients before treatment, after therapy, and at 1- and 2-year follow-ups. Significant differences were found in all outcome measures, with greater improvements after treatment in the CBT/WBT group compared to the CM group. That were maintained at 1- and 2-year follow-ups. The results of this investigation suggest that a sequential combination of CBT and WBT, which addresses both polarities of mood swings and comorbid anxiety, was found to yield significant and persistent benefits in cyclothymic disorder.

Post-Traumatic Stress Disorder

The use of WBT for the treatment of traumatized patients has not been tested in controlled investigations, yet. However, two cases were described (Belaise, Fava, & Marks, 2005). Patients improved with WBT, without addressing their central trauma that was discussed only in the initial history-taking session. The findings from these two cases should be interpreted with caution (the patients may have remitted spontaneously), but are of interest because they indicate an alternative route to overcoming trauma and developing resilience and warrant further investigation (Fava & Tomba, 2009).

International Replication Studies

WBT has been recently applied also by other groups of investigators, in different cultural settings. A group of German investigators (Stangier et al., 2013), applied WBT together with CBT and mindfulness as a maintenance therapy for patients with recurrent depression. 180 patients with three or more previous major depressive episodes were randomly assigned to 16 sessions of either CBT or manualized psychoeducation over 8 months and then followed up for 12 months. Even though time to relapse or recurrence of major depression did not differ significantly between treatment conditions, a significant interaction was observed between treatment condition and number of previous episodes (5 or more). Within the subsample of patients with five or more previous episodes, CBT was significantly superior to manualized psychoeducation.

The role of WBT in the treatment of severe depression has been confirmed by a clinical trial performed by a group of Iranian investigators (Moeenizadeh & Salagame, 2010). They randomly assigned 40 patients with major depression to a protocol of CBT or a protocol of WBT. Differences in depressive symptoms (measured with Beck Depressive Inventory-BDI) from pre to post intervention were compared in the two groups. The findings show that all the patients who underwent WBT and CBT improved significantly. However, effect sizes of interventions show that patients who were treated with WBT had greater symptom reduction compared to the other group. The Authors suggest that also in this cultural context, WBT not only enhances the sense of well-being but can also significantly decrease depressive symptoms.

Conclusions

WBT has been originally developed as a strategy for promoting psychological well-being in patients with affective disorders who presented impairments after standard pharmacological or psychotherapeutic treatments. These impairments may vary from one illness to another, from patient to patient and even from episode to another of the same illness in the same patient. It was observed that these impairments represent a vulnerability factor for adversities and relapses (Fava & Tomba, 2009; Ryff & Singer, 1996; Wood & Joseph, 2010). By a psychotherapeutic viewpoint, the techniques that are used in WBT derived from traditional CBT package -which may also involve positive thinking (MacLeod & Moore, 2000)- and may include cognitive restructuring (modification of automatic or irrational thoughts), scheduling of activities (mastery, pleasure, and graded task assignments), assertiveness training, and problem solving (Ellis & Becker, 1982; Beck, et al., 1979; Pava, Fava, & Levenson, 1994; Weissman & Markowitz, 1994). What differentiates well-being therapy from standard cognitive therapies is the *focus* (which in well-being therapy is on instances of emotional well-being, whereas in cognitive therapy is on psychological distress). A second important distinction is that in cognitive therapy the *goal* is abatement of distress through automatic thought control or contrast, whereas in well-being therapy the goal is promotion of optimal functioning, along Ryff's (1989) dimensions. WBT, thus, falls under the umbrella of positive interventions developed in clinical psychology. This strategy takes into consideration both well-being and distress in predicting patients' clinical outcomes (Rafanelli & Ruini, 2012). This individualized approach characterizes the treatment protocol which requires careful self-monitoring before any cognitive restructuring takes place. WBT develops on the basis of findings from self-observation in the diary. In some patients the majority of psychological well-being dimensions need reinforcement and growth. In other cases an excessive or distorted levels of some dimensions require adjustment because they may become dysfunctional and impede flourishing.

As a result WBT may be used to address specific areas of concern in the course of treatment, in sequential combination with other approaches of pharmacological and psychological nature. The model is realistic and in line with the emerging evidence on the poor degree of remission that one course of treatment entails (Fava, Tomba, & Grandi, 2007). Unlike standard cognitive therapy which is based on rigid specific assumptions (e.g., the cognitive triad in depression), WBT is characterized by flexibility (Kashdan & Rottenberg, 2010) and by an individualized approach for addressing psychological issues that other therapies have left unexplored, such as the promotion of eudaimonic well-being and optimal human functioning.

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