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Well-Being Therapy: Conceptual and Technical Issues

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Psychological well-being · Well-being therapy ·
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Abstract

Well-being therapy is a short-term, well-being-enhancing psychotherapeutic strategy. It is based on Carol D. Ryff's multidimensional model of psychological well-being, encompassing environmental mastery, personal growth, purpose in life, autonomy, self-acceptance and positive relations with others. Its conceptual and technical issues are described. It may be applied as a relapse-preventive strategy in the residual phase of affective (mood and anxiety) disorders, as an additional ingredient of cognitive behavioral packages, in patients with affective disorders who failed to respond to standard pharmacological and psychotherapeutic treatments, in body image disorders and in psychosomatic medicine. The first validation studies appeared to be promising. The technique is in its preliminary stage of development and may undergo major changes in the next years. It is hoped it may herald a new trend of psychotherapy research and practice in the current symptom-oriented settings.

In 1954, Parloff et al. [1] suggested that the goals of psychotherapy were not necessarily the reduction of symptoms but increased personal comfort and effectiveness. However, specific techniques for engendering the positive were not developed in subsequent years. A notable exception was Ellis' and Becker's *Guide to Personal Happiness* [2], a modification of rational-emotive therapy for removing the main blocks to personal happiness (shyness, feeling of inadequacy, feeling of guilt etc.). However, this approach did not seem to affect clinical practice. In the same way, work on a positive state of mind [3] was advocated but remained marginal to psychotherapeutic practice. Not surprisingly, in Bergin's and Garfield's *Handbook of Psychotherapy and Behavior Change* [4], the words 'well-being' or 'happiness' do not appear in the subject index. There were three main reasons for this missing development. First of all – as Ryff and Singer [5] remark – historically mental health research is dramatically weighted on the side of psychological dysfunction and health is equated with the absence of illness rather than the presence of wellness. In a naive conceptualization, yet the one implicitly endorsed by the DSM, well-being and distress may be seen as mutually exclusive (i.e. well-being is lack of distress). According to this model, well-being should result from removal of distress. Yet, there is evidence both in psychiatric [6] and psychosomatic [7] research to call such views in question. A second reason is

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concerned with the conceptual model a psychotherapeutic approach should refer to. Before Carol D. Ryff developed her multidimensional model of well-being in the late eighties [8], no model was available to satisfactorily describe the variations in psychological well-being which may occur in a clinical setting. The concept of salutogenesis developed by the medical sociologist Aaron Antonovsky [9] was an important, yet partial, element. In particular, his concept of coherence, as a global orientation that expresses the confidence of meeting environmental challenges [10], had considerable clinical implications, as shown by recent psychosomatic research [11]. Finally, until recently, it was unclear what types of clinical applications might be feasible for a well-being-enhancing psychotherapy. This was because therapeutic efforts were aimed only at the acute phase of psychiatric disorders and subclinical symptomatology was viewed as devoid of substantial clinical interest [6]. The last decade, however, has substantiated how the majority of patients with mood and anxiety disorders still display residual symptoms upon successful treatment of their illness [12]. Such symptoms were found to entail prognostic value in the entire range of affective disorders, from depression to social phobia, from panic disorder to obsessive-compulsive disturbances [6, 13]. The need of developing specific psychotherapeutic strategies aimed at the residual stage of psychiatric illness [14] then became manifest [6].

This clinical and conceptual framework was thus instrumental in developing a well-being enhancing psychotherapeutic strategy, defined as well-being therapy [15]. The main characteristics and technical features of well-being therapy, its potential clinical applications and its preliminary validation studies will be described.

Structure of Well-Being Therapy

Well-being therapy is a short-term well-being-enhancing psychotherapeutic strategy, that extends over 8 sessions, which may take place every week or every other week. The latter interval is the one which was preferred in initial studies. The duration of each session may range from 30 to 50 min. It is a technique which emphasizes self-observation [16], 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 (PWB) [8]. It is structured, directive, problem oriented and based on an educational model.

The development of sessions is as follows.

Initial Sessions

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

Meehl [17] described 'how people with low hedonic capacity should pay greater attention to the "hedonic book keeping" of their activities than would be necessary for people located midway or high on the hedonic capacity continuum. That is, it matters more to someone cursed with an inborn hedonic defect whether he is efficient and sagacious in selecting friends, jobs, cities, tasks, hobbies and activities in general' [p. 305].

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

Intermediate Sessions

Once the instances of well-being are properly recognized, the patient is encouraged to identify thoughts and beliefs leading to premature interruption of well-being. For instance, in the example reported in table 1, the patients added 'it is just because I brought two presents'. The similarities with the search for irrational, tension-evoking thoughts in Ellis and Becker rational-emotive therapy [2] and automatic thoughts in cognitive therapy [18] 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 realize which areas of PWB are unaffected by irrational or automatic thoughts and which are flooded 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?' [18]. Or he/she may 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 [18]. However, the focus is always on self-monitoring. The therapist refrains from

suggesting conceptual and technical alternatives, unless a satisfactory degree of self-observation (including irrational or automatic thoughts) has been achieved. This intermediate phase may extend over 2 or 3 sessions, depending on the patient's motivation and ability, and paves the way for the specific well-being-enhancing strategies.

Final Sessions

The monitoring of the course of episodes of well-being allows the therapist to realize specific impairments in well-being dimensions according to Ryff's conceptual framework. An additional source of information may be provided by Ryff's scales of PWB, an 84-item self-rating inventory [8]. In the original validation study [15], however, PWB results were not available to the therapist, who just worked on the patient's diary. Ryff's 6 dimensions of PWB are progressively introduced to the patients, as long as the material which is recorded lends itself to it. Errors in thinking and alternative interpretations (which may become the source of another column – observer's interpretation – to be added to that concerned with irrational or automatic thoughts) are then discussed, along the specific guidelines.

Key Concepts in Therapy

Cognitive restructuring in well-being therapy follows Ryff's conceptual framework [8]:

Environmental Mastery

This is a most frequent impairment that emerges (table 2). It was expressed by a patient as follows: 'I have got a filter that nullifies any positive achievement (I was just lucky) and amplifies any negative outcome, no matter how much expected (this once more confirms I am a failure).' This lack of sense of control leads the patient to miss surrounding opportunities, with the possibility of subsequent regret over them.

Personal Growth

Patients often tend to emphasize their distance from expected goals much more than the progress that has been made (table 3). A basic impairment that emerges is the inability to identify the similarities between events and situations that were handled successfully in the past and those that are about to come (transfer of experiences). Impairments in perception of personal growth and environmental mastery thus tend to interact in a dysfunctional way. A university student who is unable to realize the

Table 1. Self-observation of episodes of well-being

Situation	Feeling of well-being	Intensity (0–100)
I went to visit my nephews and they greeted me with great enthusiasm and joy	They like me and care for me	40

Table 2. Modification of environmental mastery according to Ryff's model [8]

Impaired level	Optimal level
The subject has or feels difficulties in managing everyday affairs; feels unable to change or improve the surrounding context; is unaware of surrounding opportunities; lacks a sense of control over the external world	The subject has a sense of mastery and competence in managing the environment; controls external activities; makes effective use of surrounding opportunities; is able to create or choose contexts suitable to personal needs and values

Table 3. Modification of personal growth according to Ryff's model [8]

Impaired level	Optimal level
The subject has a sense of personal stagnation; lacks a sense of improvement or expansion over time; feels bored and uninterested with life; feels unable to develop new attitudes or behaviors	The subject has a feeling of continued development; sees self as growing and expanding; is open to new experiences; has a sense of realizing his/her own potential; sees improvement in self and behavior over time

common contents and methodological similarities between the examinations he or she successfully passed and the ones that are to be given shows impairments in both environmental mastery and personal growth.

Purpose in Life

An underlying assumption of psychological therapies (whether pharmacological or psychotherapeutic) is to restore premorbid functioning (table 4). In case of treatments which emphasize self-help such as cognitive-behav-

Table 4. Modification of purpose in life according to Ryff's model [8]

Impaired level	Optimal level
The subject lacks a sense of meaning in life; has few goals or aims, lacks sense of direction, does not see purpose in past life; has no outlooks or beliefs that give life meaning	The subject has goals in life and a sense of directedness; feels there is meaning to present and past life; holds beliefs that give life a purpose; has aims and objectives for living

Table 5. Modification of autonomy according to Ryff's model [8]

Impaired level	Optimal level
The subject is overconcerned with the expectations and evaluations of others; relies on judgment of others to make important decisions; conforms to social pressures to think or act in certain ways	The subject is self-determining and independent; is able to resist social pressures; regulates behavior from within; evaluates self by personal standards

Table 6. Modification of self-acceptance according to Ryff's model [8]

Impaired level	Optimal level
The subject feels dissatisfied with self; is disappointed with what has occurred in past life; is troubled about certain personal qualities; wishes to be different from what he or she is	The subject has a positive attitude toward the self; accepts his/her good and bad qualities; feels positive about his/her past life

Table 7. Modification of positive relations with others according to Ryff's model [8]

Impaired level	Optimal level
The subject has few close, trusting relationships with others; finds it difficult to be open and is isolated and frustrated in interpersonal relationship; is not willing to make compromises to sustain important ties with others	The subject has warm and trusting relationships with others; is concerned about the welfare of others; is capable of strong empathy, affection and intimacy; understands give and take of human relationships

ioral ones, therapy itself offers a sense of direction and hence a short-term goal. However, this does not persist when acute symptoms abate and/or premorbid functioning is much less than optimal. The patient may perceive a lack of sense of direction and may devalue his/her function in life. This particularly occurs when environmental mastery and sense of personal growth are impaired. Debits [19] has provided evidence for the clinical relevance and predictive power of the concept of meaning in life in psychotherapy. Her results challenge the notion among clinicians that meaningfulness and meaninglessness are nothing more than philosophical concepts that can easily be neglected [19].

Autonomy

It is a frequent clinical observation that patients may exhibit a pattern (table 5) whereby a perceived lack of self-worth leads to unassertive behavior (hiding their opinions or preferences, going along with situations that are not in their best interests, consistently putting their needs behind the needs of others etc.). This pattern undermines environmental mastery and purpose in life and these, in turn, may affect autonomy. Such attitudes may not be obvious to the patients. They hide a considerable need for social approval. A patient who tries to please everyone is likely to fail to achieve this goal and the unavoidable conflicts that may ensue result in chronic dissatisfaction and frustration.

Self-Acceptance

Patients may maintain unrealistically high standards and expectations (table 6), which may be driven by perfectionistic attitudes (that reflect lack of self-acceptance) and/or endorsement of external instead of personal standards (that reflect lack of autonomy). As a result, any instance of well-being is neutralized by a chronic dissatisfaction with oneself.

Positive Relations with Others

Also interpersonal relationships (table 7), may be influenced by strongly held attitudes of which the patient may be unaware and which may be dysfunctional. For instance, a young woman who recently got married may have set unrealistic standards for her marital relationship and find herself as often disappointed. At the same time she may avoid pursuing social plans which involve other people and may lack sources of comparison. Impairments in self-acceptance (with the resulting belief of being rejectable and unlovable) may also undermine positive relations with others.

Technical Aspects

In a controlled investigation [20], 20 remitted patients with mood or anxiety disorders displayed significantly lower levels in all 6 dimensions of well-being according to the 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. It is also to be expected that there is a fair degree of overlap and correlations between the single dimensions of well-being [8, 20].

The techniques that may be used in overcoming these impairments may include [2, 18, 21, 22]:

- (a) cognitive restructuring (modification of automatic or irrational thoughts);
- (b) scheduling of activities (mastery, pleasure, and graded task assignments);
- (c) assertiveness training;
- (d) problem solving.

The goal of the therapist is to lead the patient through the transitions outlined in tables 2–7. As happens with symptom-oriented cognitive behavioral therapy, at times the simple discovery of untested standards and assumptions for well-being may lead to challenge and growth. Other times, modification of these patterns may be time consuming and require working on repeated instances through the diary. It is only when such insights, however, are translated into behavioral terms that a significant improvement has been made. For instance, a patient after his third recurrent episode of major depression learns how his lack of autonomy leads his work-mates to consistently take advantage of him. This results in work loads that, because of their diverse nature, undermine his environmental mastery and constitute a significant stress, also in terms of working hours. The situation is accepted by virtue of a low degree of self-acceptance: the patient claims that this is the way he is, but at the same time is dissatisfied with self and chronically irritable. When he learns to say no to his colleagues (assertive training) and consistently endorses this attitude, a significant degree of distress ensues, linked to perceived disapproval by others. However, as time goes by, his tolerance to disapproval gradually increases and in the last session he is able to make the following remark: ‘Now my work-mates say that I am changed and have become a bastard. In a way I am sorry, since I always tried to be helpful and kind to people. But in another way I am happy, because this means that – for the first time in my life – I have been able to protect myself.’ The

patient had no further relapse at a 4-year follow-up, while being drug free.

This clinical picture illustrates how an initial feeling of well-being (being helpful to others) that was identified in the diary was likely to lead to an overwhelming distress. Its appraisal and the resulting change in behavior initially led to more distress, but then yielded a lasting remission. The example clarifies that a similar behavioral change might have been achieved by distress-oriented psychotherapeutic strategies (indeed, the approach that was used to tackle this specific problem was no different). However, these changes would have not been supported by specific modifications of well-being dimensions.

The standard format that has been outlined involves 8 sessions; however, the number of sessions may vary according to the patient’s needs and collaboration with therapy. In certain cases, 12–16 sessions may be necessary; in other cases (when, for instance, the patient has already undergone a traditional, symptom-oriented cognitive behavioral therapy and is thus familiar with daily homework and the diary), the number of sessions may be shortened.

Examples of Potential Clinical Applications

Well-being therapy was originally designed as a specific psychotherapeutic strategy in the residual phase of affective disorders [15]. The application of this therapy to acutely ill patients, whose life is dominated by mental pain and suffering, indeed appeared to be difficult. While this remains its most important clinical application, there are several other areas that may potentially benefit from it.

Residual Phase of Affective Disorder

Relapse and recurrence are vexing problems in mood and anxiety disorders [12, 23, 24]. Treatment of residual symptoms by cognitive behavioral methods in unipolar depression resulted in a significantly lower relapse rate at a 4-year follow-up [25, 26]. Such preventive action was explained by affecting the progression from residual symptoms upon remission to prodromes of relapse. Similar considerations may apply to bipolar disorder [27]. Ryff and Singer [5], however, 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 a negative functioning (e.g. exposure

treatment in panic disorder with agoraphobia) are one form of success, but facilitating progression toward the restoration of the positive is quite another [5]. As a result, well-being therapy, by increasing levels of PWB, may potentially decrease vulnerability to stress in remitted patients with affective disorders.

Cognitive Behavioral Treatment Packages

Well-being therapy may not be necessarily used on its own; it may become a part of a more complex, symptom-oriented cognitive behavioral strategy. By adding monitoring of episodes of well-being, it may provide a more comprehensive coverage of automatic thoughts and dysfunctional schemas. This hypothesis needs to be tested in controlled studies comparing cognitive behavioral therapy alone and with well-being therapy.

Treatment Refractoriness in Affective Disorders

There is increasing awareness of the high proportion of patients with affective disorders who fail to respond to standard pharmacological and psychotherapeutic treatments [28]. For instance, drug-resistant depression is a clinical problem that occurs in about 20% of depressive episodes [29] and is amenable to cognitive behavioral treatment [30]. Resistance to exposure in panic disorder was found to be associated with lower compliance with regard to exposure homework [31]. Compliance, particularly in cognitive behavioral settings, requires endurance and motivation. It is thus conceivable that well-being therapy may either complete the degree of improvement afforded by symptom-oriented treatments or increase compliance or both. There has been little exploration, outside of the psychodynamic realm, of psychological factors affecting progression to full recovery in affective illness [32]. Yet, clinical phenomena, such as refusal to comply with a basic request, are common observations in this setting. The strategies for handling psychological resistances derive from psychodynamic psychotherapy. It is possible that Ryff's conceptual framework and well-being therapy may provide an empirically based approach to the understanding and treatment of these clinical phenomena.

Body Image Disorders

Even though there is little specific investigation in this area, psychological dimensions related to well-being may be related to body image disorders, with particular reference to body dysmorphic disorder. Current treatment of body image disorder appears to be largely unsatisfactory [33]. Well-being-therapy may have a therapeutic potential in this area.

Psychosomatic Medicine

Ryff and Singer [34] discussed the contours of positive human health, and how it is rooted in a biopsychosocial consideration of the patient [35]. An extensive body of evidence suggests the influence of PWB in altering individual vulnerability to disease [34] or quality of life [11, 36–39]. It is thus conceivable that well-being therapy may yield clinical benefits in improving quality of life, coping style and social support in chronic and life-threatening illnesses, as was shown for cognitive behavioral strategies [40]. The disorders related to somatization [41, 42] – defined as tendency to experience and communicate psychological distress in the form of physical symptoms and to seek medical help for them [43] – may also derive some benefit from well-being-enhancing strategies.

Obsessive-Compulsive Disorder

Intrusive anxiety-provoking thoughts are a core feature of obsessive-compulsive disorder [44]. Recent research [45] suggests that obsessive patients use punishment, worry, reappraisal and social control as a technique of thought control more frequently than healthy subjects. Punishment appears to be the strongest discriminator [45]. Clinical observation suggests that anxiety-provoking thoughts may often be preceded by instances of well-being in obsessive-compulsive disorder. These patients may thus have a low threshold for well-being-related anxiety. This hypothesis needs to be tested in controlled studies.

Preliminary Validation Studies

Well-being therapy, according to the format previously outlined, has been employed in some clinical studies.

Residual Phase of Affective Disorders

The effectiveness of well-being therapy in the residual phase of affective disorders has been tested in a small controlled investigation [15]. Twenty patients with affective disorders (major depression, panic disorder with agoraphobia, social phobia, generalized anxiety disorder, obsessive compulsive disorder) who had been successfully treated by behavioral (anxiety disorders) or pharmacological (mood disorders) methods, were randomly assigned to well-being therapy or cognitive behavioral treatment of residual symptoms. Both well-being and cognitive behavioral therapies were associated with a significant reduction of residual symptoms, as measured by the Clinical Interview for Depression (CID) [46], and an increase in PWB. However, a significant advantage of well-being

therapy over cognitive behavioral strategies was observed with the CID. The small number of subjects suggests caution in interpreting this difference and the need for further studies with larger samples of patients with specific affective disorders. However, these preliminary results point to the feasibility of well-being therapy in the residual stage of affective disorders. The improvement in residual symptoms may be explained on the basis of the balance between positive and negative affects [15]. 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 [47] –, it is conceivable that also changes in well-being may affect the balance of positive and negative affects. 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 part of a cognitive behavioral package that was applied to recurrent depression [48], 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 [49]. This package included also cognitive behavioral treatment of residual symptoms [25, 26] and lifestyle modification [48]. Forty patients with recurrent major depression, who had been treated successfully with antidepressant drugs, were randomly assigned to either this cognitive behavioral package including well-being therapy or clinical management. In both groups, antidepressant drugs were tapered and discontinued. The group that received cognitive behavioral therapy had a significantly lower level of residual symptoms after drug discontinuation in comparison with the clinical management group. Cognitive behavioral therapy also resulted in a significantly lower relapse rate (25%) at a 2-year follow-up than did the control (80%). Since well-being therapy was associated with two other main ingredients (cognitive behavioral treatment of residual symptoms and lifestyle modification), it is not possible to know from this study whether it yielded a significant contribution.

Resistance to Exposure in Panic Disorder with Agoraphobia

Behavioral treatment based on exposure in vivo has emerged as a major therapeutic tool in panic disorder

with agoraphobia [24]. Unlike drug treatment, it has been found to provide lasting relief to the majority of patients [50]. However, there are also patients who fail to benefit sufficiently from a standard course of individual behavioral treatment based on exposure in vivo [31]. In a controlled trial, with a cross-over design, three treatment modalities, namely exposure alone, exposure associated with imipramine and cognitive therapy supplementing exposure, were compared in a sample of 21 patients with DSM-IV panic disorder and agoraphobia who did not respond to exposure [31]. Twelve of the 21 patients achieved remission (panic-free status) during the trial. In 8 cases this occurred after exposure alone and in 2 cases each after the other treatments. Three patients dropped out of treatment. The 6 patients who completed treatment but still suffered from panic attacks were offered a course of well-being therapy. Three patients accepted. After well-being therapy they were assessed with the same instruments that were used in the trial, namely a modified version of the CID [46] and the agoraphobia subscale of the Fear Questionnaire [51]. Well-being therapy was associated with the prolongation of exposure in vivo homework. Two of the 3 patients achieved a panic-free status. It is obviously very difficult to draw conclusions from this very small trial, which involved only half of the patients who still suffered from panic disorder. A placebo (nonspecific) effect is possible, even though unlikely from patients who had unsuccessfully undergone three consecutive trials. Since the controlled trial had disclosed a significant effect of the time factor [31], the results might have been simply due to prolongation of exposure. However, it is also possible that well-being therapy helped the 2 patients undergoing exposure and increased their compliance as to exposure homework. This, indeed, appeared to have been improved according to the therapist's ratings.

Conclusions

Well-being therapy is obviously at a very preliminary stage. Adequate validation studies should elucidate its specific role in psychiatry and psychosomatic medicine. Unlike several psychotherapeutic techniques that have been affected by orthodoxy, it is hoped that its current format may undergo major changes in the next few years, according to research evidence as well as the clinical experience of practicing clinicians [52]. It is also hoped that it may contribute to changing outcome definition in psychiatric disorders [12, 53–55].

The goal of well-being therapy may appear to be ambitious. As the Latin philosopher Seneca warns in *De vita beata*, the more we look for happiness, the less likely we are to achieve it. Happiness is not everything – as Carol Ryff demonstrated about 19 centuries later [8] – and what is required is ‘felicitationis intellectus’, the awareness of well-being:

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

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