Chapter 2
The Individualized and Cross-Cultural Roots of Well-being Therapy

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2.1 Introduction

In 1948 the World Health Organization defined health as a "state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (WHO 1948). Further early experts in psychosomatics, such as Kissen (1963), Engel (1960, 1967), and Lipowski (1977) suggested the importance of evaluating the complexity of clinical phenomena in the equilibrium between health and disease (Fava and Sonino 2010). Kissen (1963) clarified that the relative weight of psychosocial factors may vary considerably from one individual to another within the same illness. Engel developed a biopsychosocial model of illness (1977) where the study of the diseases must include the individual, his/her body and his/her surrounding environment as essential components of the total system. In the same vein, Lipowski (1977) underlined the importance of studying the relationships of biological, psychological and social determinants of health and disease. Thus, researchers recognized the need for multiple indicators in evaluating well-being and treatment outcomes (Fava and Sonino 2010; Rafanelli and Ruini 2012).

Nevertheless, in almost all Western countries, a negativity bias that drives researchers and clinicians to attend to and be more affected by the negativity, such as symptoms and dysfunctions, has prevailed (Haizlip et al. 2012). This "negativity bias" is constantly reinforced starting from the educational background provided to clinicians and to students in medical schools, where many teaching methods and clinical reasoning are focused on a "negative approach" (Haizlip et al. 2012). Haizlip et al. (2012) suggested that this negativity bias is strictly linked to our Western culture that inadvertently emphasizes the tendency to recognize, to remember and to pay

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attention to the negative aspects in human life. Thus, the negatively biased medical model embraced clinical practice, clinical research and general approach to illnesses and disease in Europe and North America.

Conversely, in Eastern countries, such as India, China and Japan, the traditional clinical models always involved a holistic approach to the individuals, their illnesses and other factors, such as energies, nature elements and spirituality (Hao et al. 2011). Even though they could be very differentiated, all eastern clinical models emphasize mind-body connections (Chan and Chow 2001) and are mainly focused on mobilizing human's capacity for self-adjustment and self-rehabilitation.

These concepts, however, also found some consideration in Western psychology and psychotherapy. For instance, since its early stages, clinical psychology research emphasized issues such as Jung's concept of individuation (1933), Frankl conceptualization of resilience and meaning (1959), and Jahoda criteria for positive mental health (1958). Similarly, humanistic psychology suggested concepts such as self-realization and self-actualization as final therapeutic goal (Maslow 1968; Rogers 1961). In 1954, Parloff, Kelman & Frank suggested that the goals of psychotherapy were increased personal comfort and effectiveness. For a long time these latter achievements were viewed only as by-products of the reduction of symptoms or as a luxury that clinical investigators could not afford. 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 and 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 psychiatry and 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 prodromes of relapse (Fava et al. 2007a). 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 et al. 2005a).

Further, 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 et al. 2000). The question then arose as to whether also such impairment was amenable to amelioration upon psychological treatment.

Finally, 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 et al. 2007b). The need to develop intervention strategies and programs by including psychological well-being has then become manifest.

Seligman (2002) proposed a definition and operationalization of positive mental health, by taking into account the variables and dimensions addressed by positive

psychology. Similarly, the crucial conceptualization of flourishing vs. languishing developed by Keyes (2002) brought the difference between presence of mental health and absence of mental illness into focus. Maddux (2008) claimed the necessity to overcome the illness ideology, deeply rooted in the biomedical model, which is still dominant in clinical psychology. This process requires a systematic overhaul of the basic assumptions underlying classification of disorders and treatment models (Delle Fave and Fava 2011).

However, a basic problem to be addressed is the consensus on a definition of well-being, that may be used to plan interventions and set treatment outcomes.

2.2 The Concept of Psychological Well-being and Its Clinical Implications

Until now, well-being research has been grounded in the Western tradition, with its individualistic features shared by a minority of nations (Triandis 1995). For instance, research showed that the higher levels of subjective well-being (SWB) reported by European Americans compared with Eastern Asians are clearly grounded in cultural expectations and conceptualizations (Kitayama et al. 2000, 2004). However, all human cultures are concerned with well-being (Oishi 2000). A broader, less culture-bound interpretation frame could promote a better understanding of the cross-cultural variations in definition, operationalization and evaluation of the related constructs (Delle Fave and Fava 2011).

2.2.1 The Concept of Well-being in Philosophy

A seminal review by Ryan and Deci (2001) examined the concept of well-being and described two main approaches, the hedonic and the eudaimonic one. According to the former, well-being consists of subjective happiness, pleasure and pain avoidance. Thus, the concept of well-being is equated with the experience of positive emotions versus negative emotions and with satisfaction in various domains of one's life. According to the eudaimonic perspective, well-being 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. Both concepts of well-being have specific philosophical background deriving from Greek traditions: the eudaimonic is certainly more linked to Aristotelian approach, whereas the hedonic is more linked to Aristippus and Epicurus theories (Ryff and Singer 2008). Thus, the interest in positivity and well-being is intrinsically grounded in European/Western culture. Nevertheless the negativity based medical model has guided mental health research so far.

Recently, with the diffusion of positive psychology movement, these two approaches have lead to different areas of research, but they complement each other

in defining the construct of well-being (Ryan and Deci 2001). Some Authors have also suggested that they can compensate each other; thus individuals may have profiles of high eudamonic 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 et al. 2002) However, in this investigations, 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.

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 solipsistic and individualistic to leave no room for human connection and the social good; or it could be so focused on responsibilities and duties outside the self that personal talents and capacities are neither recognized or developed (Ryff and Singer 2008). Other body of literature from the Greek tradition provided similar definitions of harmony, as in the Stoics' ideal of evenness of judgment and detachment, in Plato's description of the just man – which relies on the balance between reason, spirit and appetites – and in Epicure's concept of ataraxia – freedom from worries or anxiety through the ability of maintaining balance and serenity in both enjoyable and challenging times (Chenyang 2008).

Cross-cultural data collected in seven Western cultures by an international team (Delle Fave et al. 2010) confirmed the importance of harmony/balance as a component of well-being. The term "harmony" reflects more specifically the perception of inner peace, self-acceptance, serenity, a condition of balance and evenness that was best formalized by philosophical traditions in Asian cultures. In the Chinese language, the term used for harmony includes such meanings as "gentle", "mild", "peace", "quiet in mind and peaceful in disposition". Yan Ying (fourth century BC, quoted by Chenyang 2008) additionally refers to harmony as mixing different things and balancing opposite elements into a whole, as in cooking and making music.

Several converging philosophical conceptualizations (Ryff and Singer 2008; Chenyang 2008) thus value the concept of balance, both as a theoretical guide and as an empirical reality that scholars of well-being need to appreciate.

2.2.2 The Concept of Well-being in Clinical Psychology

In clinical psychology the eudaimonic view has found much more feasibility, compared to the hedonic approach, because it concerns human potential and personal strength (Ryff and Singer 1996, 2008). Ryff's model of psychological well-being, encompassing autonomy, personal growth, environmental mastery, purpose in life, positive relations and self-acceptance (see Chap. 1 of this book) has been found to fit specific impairments of patients with affective disorders (Rafanelli et al. 2000, 2002; Fava et al. 2001; Ruini et al. 2002). Further, the absence of psychological well-being was found to be a risk factor for depression

(Wood and Joseph 2010). Thunedborg et al. (1995) observed that quality of life measurement, and not symptomatic ratings, could predict recurrence of depression. An increase in psychological well-being may thus protect against relapse and recurrence (Wood and 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.

Even though there is overwhelming evidence of major cross-cultural differences in the definition and evaluation of both well-being and psychopathology (Massimini and Delle Fave 2000; Marsella and Yamada 2007), Ryff and Singer (1996) suggested that the route to enduring recovery lies not exclusively in alleviating the negative, but in engendering the positive. Certainly cultures shape individuals' behavior and conception of what a good life is, both providing a meaning-making system for daily events and interactions, and fostering/limiting opportunities for goal setting, personal growth and self-expression (Ryan and Deci 2001; Uchida et al. 2004). In any case Ryff and Singer (1996) underlined that interventions that bring the person out of the negative functioning are one form of success, but facilitating progression toward the restoration of positive is quite another. Early pioneer works in this research domain, can be considered Ellis and Becker's (1982) guide to personal happiness, Fordyce's (1983) program to increase happiness, Padesky's (1994) work on schema change processes, Frisch's (1998, 2006) quality of life therapy, and Horowitz and Kaltreider's (1979) work on positive states of mind. Again, by a cultural point of view, psychotherapeutic interventions addressed to positivity shared common Western cultural tradition.

2.2.3 The Concept of Well-being in Psychosomatics

Recently, many investigations in psychosomatic research provided confirmation to the protective role of well-being, both for mental and physical health. Positive emotions and well-being, with the contribution of other factors, can influence the healing process of various diseases and longevity (Chida and Steptoe 2008; Fava and Sonino 2010). Some Authors, such as Seeman et al. (2002), have investigated the role of social support and interpersonal relationships in psychosomatics. They concluded that the presence of positive relationships is associated with lower levels of allostatic load, which reflects the cumulative effects of stressful experiences in daily life (Fava et al. 2010; McEwen and Stellar 1993). As conditions of psychosocial distress and mental illness have been found to be associated with specific alterations of certain biological indicators of allostatic load (McEwen and Stellar 1993), Ryff and Singer (1996, 1998) therefore suggested that the presence of psychological well-being is a protective factor, that could be associated with variations in the same biological parameters of allostatic load. In the same line, research has indeed suggested the important role of positive affectivity (Fredrickson and Joiner 2002) in promoting resilience and growth.

Specific dimensions of positive functioning, namely autonomy and independence, have resulted to be related to increased level of noradrenaline (Seeman et al. 2002) and seem thus to be associated to in increased stress response. Similarly, excessively elevated levels of positive emotions can become detrimental and are more connected with mental disorders and impaired functioning (Fredrickson and Losada 2005). In 1991 Garamoni et al. 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 the optimal balance.

Positive interventions, thus, should not be simply aimed to increase happiness and well-being, but should consider the complex balance between psychological well-being and distress (MacLeod and Moore 2000) and be targeted to specific and individualized needs. Wood and Tarrier (2010) emphasize that positive characteristics such as gratitude and autonomy often exist on a continuum. They are neither "negative" or "positive": their impact depends on the specific situation and on the interaction with concurrent distress and other psychological attitudes. All these elements should be taken into account in the psychotherapy process. The promotion of well-being should comprise the cultural competence of the patients, that is their optimal functioning contextualized in their daily cultural environment (Leong and Wong 2003).

An example of psychotherapeutic intervention that takes into consideration the above concepts for in achieving a balanced and individualized path to optimal functioning is Well-being Therapy (WBT) (Ruini and Fava 2012).

2.3 The Structure of Well-being Therapy

Well-being therapy is a short-term psychotherapeutic strategy, that extends over 8–12 sessions, which may take place every week or every other week (Fava 1999; Fava and Ruini 2003; Ruini and Fava 2012). The duration of each session may range from 30 to 50 min. 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), encompassing six dimensions of positive functioning and eudaimonic well-being: autonomy, environmental mastery, personal growth, purpose in life, self-acceptance and positive interpersonal relationships. The development of sessions is as follows.

2.3.1 Initial Sessions

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.

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). This is 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 (Deci and Ryan 1985). Cross-sectional studies have demonstrated that optimal experience can occur in any daily context, such as work and leisure (Delle Fave and 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.

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

2.3.2 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. 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 and Emery 1985; Beck et al. 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 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 (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.

This intermediate phase may extend over 2 or 3 sessions, depending on the patient's motivation and ability, and it paves the way for the specific well-being enhancing strategies.

2.3.3 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 Psychological Well-being (PWB), an 84-item self-rating inventory (Ryff 1989). 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.

2.4 Well-being Therapy: Clinical Framework

Cognitive restructuring in well-being therapy follows Ryff's conceptual framework (Ryff and Singer 1996). The goal of the therapist is to lead the patient from an impaired level to an optimal level in the six dimensions of psychological well-being. This means that patients are not simply encouraged pursing 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 cultural and social contexts (Ruini et al. 2003; Ruini and Fava 2012).

The various dimensions of positive functioning can compensate each other (some being more interpersonally-oriented, some more personal/cognitive) and the aim of WBT, such as other positive interventions, should be the promotion of an optimal-balanced functioning between these dimensions, in order to facilitate individual flourishing (Keyes 2002). This means that sometimes patients should be encouraged to decrease their level of positive functioning in certain domains. Without this clinical framework, the risk is to lead patients at having too high levels of self-confidence, with unrealistic expectations that may become dysfunctional and/or stressful to individuals, as described in Table 2.1.

Environmental mastery (Table 2.1)

This is the most frequent impairment that emerges, that is felt by patients as a lack of sense of control. This leads the patients to miss surrounding opportunities, with

Table 2.1 Modifications of Well-being dimensions to achieve a balanced, optimal functioning

Dimensions	Low level	Balanced-functional level	High level
Environmental Mastery *Wisdom,* *Self determination* *Optimal experience*	The person feels difficulties in managing everyday affairs; feels unable to improve surrounding context; is unaware of surrounding opportunities; and lacks sense of control over external world.	The person has a sense of mastery and competence in managing the environment; makes effective use of surrounding opportunities; is able to choose contexts suitable to personal needs.	The person is unable to savoring positive emotions and hedonic pleasure.
Personal growth *Meaning* *Post-traumatic growth* *Benefit finding* *Intrinsic motivation*	The person has a sense of personal stagnation; lacks sense of improvement over time; feels bored and uninterested with life.	The person has a sense of continued development; sees self as growing and improving; is open to new experiences; has sense of realizing own potential.	The person is unable to process negativity, does not give enough emphasis to past negative experiences, cultivates benign illusions that do not fit with reality, sets unrealistic standards for overcoming adversities.
Purpose in life *Goals* *Hope* *Passion* *Optimism*	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; has aims and objectives for living.	The person has obsessional passions, is unable to admit failures. He/she manifests persistence and rigidity. Excessive hope is paralyzing and hampers facing negativity and failures.
Autonomy *Leadership,* *Locus of controls* *Self determination* *Bravery*	The person is overconcerned with the expectations and evaluation of others; relies on judgment of others to make important decisions.	The person is independent; able to resist to social pressures; regulates behavior from within; evaluates self by personal standards.	The person is unable to get along with other people, to work in team, to learn from others. Relies only on himself/herself for solving problems, and is unable to ask for advice or help.
Self-acceptance *Self-esteem* *Positive reframing*	The person feels dissatisfied with self; is disappointed with what has occurred in past life; wishes to be different than what he or she is.	The person has a positive attitude toward the self; accepts his/her good and bad qualities; feels positive about past life.	Narcissism, egocentrism, difficulties in admitting owns mistakes, rigidity
Positive relations *Empathy* *Generosity,* *Altruism* *Forgiveness* *Gratitude*	The person has few close, trusting relationships with others; finds difficult to be open and is isolated and frustrated in interpersonal relationship.	The person has warm and trusting relationships with others; is concerned about the welfare of others; capable of strong empathy affection, and intimacy; understands give and take of human relationships.	Due to exaggerated empathy, the person feels pain and distress of others. He/she sacrifices his/her needs and well-being for those of others. His/her extreme capacity to forgive and be grateful toward others could mask low self esteem and sense of wothlessness.

the possibility of subsequent regret over them. On the other hand, sometimes patients may require help because they are unable to enjoy and savoring daily life, as they are too engaged in work or family activities. Their abilities of planning and solving problems may lead others to constantly ask for their help, with the resulting feeling of being exploited and overwhelmed by requests. These extremely high levels of environmental mastery thus become a source of stress and allostatic load to the individual. Environmental mastery can be considered a key mediator or moderator of stressful life experiences (Fava et al. 2010). A positive characterization of protective factors converges with efforts to portray the individual as a psychological activist, capable of proactive and effective problem- solving, rather than passively buffeted by external forces (Ryff and Singer 1998), but also capable of finding time for rest and relaxing in daily life.

Personal growth (Table 2.1)

Patients often tend to emphasize their distance from expected goals much more than the progress that has been made toward goal achievement. 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). On the other hand people with levels of personal growth that are too high tend to forget on do not give enough emphasis to past experiences because they are exclusively future-oriented. Negative or traumatic experiences could particularly be under-estimated (Held 2002; Norem and Chang 2002), as a sort of extreme defense mechanism (denial), i.e., "I just need to get over this situation and go on with my life". Dysfunctional high personal growth is similar to a cognitive benign illusion, or wishful thinking, which hinders the integration of past (negative) experiences and their related learning process.

Purpose in life (Table 2.1)

Patients may perceive a lack of sense of direction and may devalue their function in life. This particularly occurs when environmental mastery and sense of personal growth are impaired. On the other hand, many other conditions worthy of clinical attention may arise from too high levels of purpose in life. First of all individuals with a strong determination in realizing one (or more) life goal(s) could dedicate themselves fully to their activity, thereby allowing them to persist, even in the face of obstacles, and to eventually reach excellence. This again could have a cost in terms of allostatic load and stress. Further, Vallerand et al. (2003) have proposed the concept of obsessive passion for describing an activity or goal that becomes a central feature of one's identity and serves to define the person. Individuals with an obsessive passion come to develop ego-invested self-structures (Hodgins and Knee 2002) and, eventually, display a rigid persistence toward the activity thereby leading to less than optimal functioning. Such persistence is rigid because it not only occurs in the absence of positive emotions and sometimes of positive feedbacks, but even in the face of important personal costs such as damaged relationships, failed commitments and conflicts with other activities in the person's life (Vallerand et al. 2007). The individual

engagement for a certain goal could thus become a form of psychological inflexibility (Kashdan and Rottenberg 2010) which is more connected with psychopathology, than well-being. Some individuals, in fact, remains attached to their goals even when these seem to be unattainable, and keep believing that they would be happy pending the achievement of these goals. These mechanisms are associated with hopelessness (MacLeod and Conway 2007; Hadley and Macleod 2010) and parasuicidal behaviors (Vincent et al. 2004). Further, this confirms the idea that hope, another future-oriented positive emotion, can become paralyzing and hampers facing and accepting negativity and failures (Bohart 2002; Geraghty et al. 2010).

Autonomy (Table 2.1)

It is a frequent clinical observation that patients may exhibit a pattern whereby a perceived lack of self-worth leads to unassertive behavior. For instance, patients may hide their opinions or preferences, go along with a situation that is not in their best interests, or consistently put their needs behind the needs of others. This pattern undermines environmental mastery and purpose in life and these, in turn, may affect autonomy, since these dimensions are highly correlated in clinical populations. Such attitudes may not be obvious to the patients, who hide their 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 result in chronic dissatisfaction and frustration. On the other hand, in Western countries particularly, individuals are culturally encouraged to be autonomous and independent. Certain individuals develop the idea that they should rely only on themselves for solving problems and difficulties, and are thus unable to ask for advice or help. Also in this case, an unbalanced high autonomy can become detrimental for social/interpersonal functioning (Seeman et al. 2002). Some patients complain they are not able to get along with other people, or work in team, or maintain intimate relationships, because they are constantly fighting for their opinions and independence.

Self-acceptance (Table 2.1)

Patients may maintain unrealistically high standards and expectations, 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. A person may set unrealistic standards for her performance. On the other hand, an inflated self-esteem may be a source of distress and clash with reality, as was found to be the case in cyclothymia and bipolar disorder (Garland et al. 2010; Fava et al. 2011).

Positive relations with others (Table 2.1)

Interpersonal relationships may be influenced by strongly held attitudes of perfectionism which the patient may be unaware and which may be dysfunctional. Impairments in self-acceptance (with the resulting belief of being rejectable and unlovable, or others being inferior and unlovable) may also undermine positive

relations with others. There is a large body of literature (Uchino et al. 1996) on the buffering effects of social integration, social network properties, and perceived support. On the other hand, little research has been done on the possible negative consequences of an exaggerated social functioning. Characteristics such as empathy, altruism and generosity are usually considered universally positive. However, in clinical practice, patients often report sense of guilt for not being able to help someone, or to forgive an offence. An individual with a strong pro-social attitude can sacrifice his/her needs and well-being for those of others, and this in the long time becomes detrimental and sometimes disappointing. This individual can also become over-concerned and overwhelmed by others' problems and distress and be at risk for burn-out syndrome. Finally a generalized tendency to forgive others and be grateful toward benefactors could mask low self-esteem and low sense of personal worth.

2.5 WBT Validation Studies

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

2.5.1 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 who had been successfully treated by behavioral (anxiety disorders) or pharmacological (mood disorders) methods, were randomly assigned to either a well-being therapy or cognitive behavioral treatment (CBT) 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) (Guidi et al. 2011; Paykel 1985), and in PWB well-being. However, when the residual symptoms of the two groups were compared after treatment, a significant advantage of well-being therapy over cognitive behavioral strategies was observed with the CID. 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 and 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.

2.5.2 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 et al. 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.

2.5.3 Loss of Clinical Effect During Drug Treatment

The return of depressive symptoms during maintenance antidepressant treatment is a common and vexing clinical phenomenon (Fava and Offidani 2011). 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 et al. 2002). Four out of five patients responded to a larger dose, but all relapsed again on that dose by 1 year follow-up. Four out of the five patients responded to psychotherapy and only one relapsed. The data suggest that application of well-being therapy may counteract loss of clinical effect during long-term antidepressant treatment.

2.5.4 Treatment of Generalized Anxiety Disorder

Well-being Therapy has been applied for the treatment of generalized anxiety disorder (Fava et al. 2005b; Ruini and Fava 2009). Twenty patients with DSM-IV GAD were randomly assigned to eight sessions of CBT or the sequential administration of four sessions of CBT followed by other four sessions of WBT. Both treatments were associated with a significant reduction of anxiety. However, significant advantages of

the WBT-CBT sequential combination over CBT were observed, both in terms of symptom reduction and psychological well-being improvement. These preliminary results suggest the feasibility and 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 that entailed by the customary monitoring of episodes of distress in cognitive therapy (Ruini and Fava 2009).

2.5.5 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 reported (Belaise et al. 2005) in which patients improved with WBT, even though their central trauma was discussed only in the initial history-taking session. The findings from these two cases should of course 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 and Tomba 2009).

2.5.6 Cyclothymic Disorder

Well-being therapy was recently applied (Fava et al. 2011) in sequential combination with CBT for the treatment of cyclothymic disorder, that involves mild or moderate fluctuations of mood, thought, and behaviour without meeting formal diagnostic criteria for either major depressive disorder or mania (Baldessarini et al. 2011). Sixty-two patients with DSM-IV cyclothymic disorder were randomly assigned to CBT/WBT (n=31) or clinical management (CM) (n=31). An independent blind evaluator assessed the patients before treatment, after therapy, and at 1- and 2-year follow-ups. At post treatment, significant differences were found in all outcome measures, with greater improvements after treatment in the CBT/WBT group compared to the CM group. Therapeutic gains 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.

2.6 Conclusions

WBT was originally developed as a strategy for promoting psychological well-being which was still impaired after standard pharmacological or psychotherapeutic treatments in clinical populations. It was based on the assumption that these

impairments may vary from one illness to another, from patient to patient and even from one episode to another of the same illness in the same patient. These impairments represent a vulnerability factor for adversities and relapses (Fava and Tomba 2009; Ryff and Singer 1996; Wood and Joseph 2010).

Recently, other new psychotherapeutic strategies, summarized under the umbrella of third wave psychotherapies (Hofmann and Asmundson 2008), have been validated, enlarging their scopes to the improvement of patients' well-being. Their novelty consists of introducing Eastern techniques such as mindfulness meditation, love and kind meditation (Cohn and Fredrickson 2010) or Buddhist philosophy (see Chap. 3 of this book for a more complete review) combined with traditional CBT approach. It remains unclear if Western patients could fully understand and internalize their Eastern theoretical background, so different from their culture (Kohl et al. 2012). By a clinical point of view, the question is whether these new psychotherapies could really lead to patient's improvement and growth over time, or rather they constitute a series of good daily practices with positive effects on their quality of life and positive emotions (Cohn and Fredrickson 2010; Kohl et al. 2012).

WBT does not combine culturally different techniques, but unlike standard cognitive therapy which is based on rigid specific assumptions (e.g., the cognitive triad in depression), it is characterized by flexibility (Kashdan and 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. We suggest that such functioning could be reached in some cases by diminishing some hedonic and eudaimonic dimensions when they impede flourishing (Keyes 2002). Individuals may be helped to move up form impaired low levels to optimal, but also to move down from high-dysfunctional to optimal-balanced levels. This diverse feasibility and flexibility of WBT is in line with the positive clinical psychology approach, which calls for a number of different interventions to be selected based on individual specific needs (Wood and Tarrier 2010).

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