

# Increasing Psychological Well-Being and Resilience by Psychotherapeutic Methods

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**ABSTRACT** A specific psychotherapeutic strategy for increasing psychological well-being and resilience, well-being therapy, has been developed and validated in a number of randomized controlled trials. The findings indicate that flourishing and resilience can be promoted by specific interventions 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. A decreased vulnerability to depression and anxiety has been demonstrated after well-being therapy in high-risk populations. There are important implications for the state/trait dichotomy in psychological well-being and for the concept of recovery in mood and anxiety disorders.

The concept of resilience stems from the observation that many children are able to achieve a positive developmental outcome despite adverse experiences (Yates & Masten, 2004). This resilience framework offered important implications for the design, implementation, and evaluation of intervention efforts aiming to enhance the asset base and to reduce the adversity exposure of children at high risk. Studies of resilient children have underscored the importance of both internal factors (character strengths) and environmental elements (such as family cohesion and warmth) vis-à-vis the difficulties of poverty and troubled environments (Kumpfer, 1999; Yates & Masten, 2004). Research now has progressed to include the study of resilience in early, middle, and late adulthood. Staudinger, Marsiske, and Baltes (1995) have proposed connections between the develop-

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mental psychopathological approach to resilience and ideas of “reserve capacity,” a construct from life span developmental theory, referring to an individual’s potential for change, especially continued growth. In their work examining aging adults, Ryff, Singer, Dienberg Love, and Essex (1998) defined resilience as the capacity to maintain or recover high well-being in the face of life adversity. Looking for the presence of wellness following adversity comprises a more demanding and rigorous conception of resilience than the avoidance of illness or negative behavioral outcomes, the usual gold standards. Examples are provided by life histories of women regaining high well-being following depression (Singer & Ryff, 1999) and the ability to sustain psychological well-being during serious or chronic illness (Folkman & Greer, 2000).

Ryff and Singer (1996) remarked that, historically, mental health research is dramatically weighted on the side of psychological dysfunction and that health is equated with the absence of illness rather than the presence of wellness. They 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). 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.

From a clinical perspective, there are major advantages to applying the Ryff et al. (1998) conceptualization of resilience. First, health is not viewed simply as the absence of disease but as the presence of wellness in a biopsychosocial perspective (Fava & Sonino, 2008). Further, resilience is conceptualized as a longitudinal and dynamic process, which is related to the concept of flourishing (Ryff & Singer, 2000b). Issues such as leading a meaningful and purposeful life as well as having quality ties to others affect the physiological substrates of health. Such a formulation brings physical health into the concept of resilience, underscoring a joint emphasis on the mind and the body in understanding positive functioning (Ryff et al., 1998). Finally, the focus on psychological well-being and its modifications

throughout the life cycle allows us to identify possible strengths and vulnerabilities in psychological functioning over the life course, with considerable clinical implications.

In this review, we refer to *resilience* as a set of attributes and resources that prevent illness following adverse environmental circumstances in the general population and prevent relapse after symptomatic remission in a clinical population. Frank and Frank (1991) clarified how “certain types of therapy rely primarily on the healer’s ability to mobilize healing forces in the sufferer by psychological means. These forms of treatment may be generically termed psychotherapy” (p. 1). *Flourishing* is here defined as the personal growth that may result from the psychotherapeutic process in the setting of illness. It shares many similarities with the concept of post-traumatic growth (Buchi et al., 2007).

We describe the key features of well-being therapy, the validation studies, and the implications of these findings for the conceptualization of resilience and well-being, with special reference to stable individual differences and social contexts. We also outline a novel definition and assessment of recovery in mood and anxiety disorders that result from this renewed conceptualization.

### Conceptual Framework of Well-Being Therapy

The development of well-being therapy stems from three converging developments. First there is a growing body of literature on residual symptoms after apparently successful treatment in mood and anxiety disorders. Such symptoms may include anhedonia and impaired functional capacity. Most residual symptoms also occur in the prodromal phase of illness and may progress to become prodromes 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 the long-term outcome of major depressive disorders (Fava, Ruini, & Rafanelli, 2005).

Second, 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—as measured by the Psychological Well Being Scales (Ryff, 1989)—compared to healthy control subjects (Rafanelli

et al., 2000). The question then arose as to whether such impairment is also amenable to amelioration with 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, Tomba, & Grandi, 2007). Major clinical trials have underscored the fact that full remission occurs in a minority of patients. The need to advance intervention strategies and programs by including psychological well-being has become pressing. These intervention strategies are crucial in clinical populations at high risk for relapse, such as in major depression. A theory-based resilient approach differs from other approaches to treatment in that it includes emphasis on positive emotional health rather than focusing on decreasing negative affective symptoms. Therefore an intervention that targets the positive may address an aspect of functioning and health that is typically left unaddressed in conventional treatments. The model also postulates that deficits in well-being are due to inattention to positive experiences and lack of capacity to sustain states of well-being due to automatic thoughts.

This section describes how deficits in psychological well-being may be manifested by patients.

The focus of treatment in well-being therapy follows Ryff's conceptual framework (Ryff & 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, depicted in Table 1 (Fava, 1999; Fava & Ruini, 2003).

*Environmental mastery.* This is the most frequent impairment that emerges. 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. Environmental mastery is a key mediator or moderator of stressful life experiences. 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 & Singer, 1998).

**Table 1**  
**Modification of the Six Dimensions of Psychological Well-being**  
**According to Ryff's (1989) Model**

Dimensions	Impaired Level	Optimal Level
Environmental mastery	The subject has or feels difficulties in managing everyday affairs; feels unable to change or improve surrounding context; is unaware of surrounding opportunities; lacks sense of control over external world.	The subject has a sense of mastery and competence in managing the environment; controls external activities; makes effective use of surrounding opportunities; able to create or choose contexts suitable to personal needs and values.
Personal growth	The subject has a sense of personal stagnation; lacks 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 sense of realizing own potential; sees improvement in self and behavior over time.
Purpose in life	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 purpose; has aims and objectives for living.
Autonomy	The subject is overconcerned with the expectations and evaluation 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; able to resist social pressures; regulates behavior from within; evaluates self by personal standards.
Self-acceptance	The subject feels dissatisfied with self; is disappointed with	The subject has a positive attitude toward the self;

*(Continued)*

Table 1 (Cont.)

Dimensions	Impaired Level	Optimal Level
	what has occurred in past life; is troubled about certain personal qualities; wishes to be different than what he or she is.	accepts his other good and bad qualities; feels positive about past life.
Positive relations with others	The subject has few close, trusting relationships with others; finds difficult to be open and is isolated and frustrated in interpersonal relationship; 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; capable of strong empathy, affection, and intimacy; understands give-and-take of human relationships.

*Personal growth.* 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), which also underlies resilience. 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 common contents and methodological similarities between the exams 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. In the case of treatments that emphasize self-help, such as cognitive-behavioral treatments, therapy itself offers a sense of direction and hence a short-term goal. However, this goal directedness often does not persist when acute symptoms abate or premorbid functioning is suboptimal, or both. 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.

*Autonomy.* 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, because 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 ensue result in chronic dissatisfaction and frustration.

*Self-acceptance.* Patients may maintain unrealistically high standards and expectations, driven by perfectionistic attitudes (that reflect lack of self-acceptance) or endorsement of external instead of personal standards (that reflect lack of autonomy), or both. As a result, any instance of well-being is neutralized by a chronic dissatisfaction with oneself. A person may set unrealistic standards for his or her performance. For instance, it is a frequent clinical observation that patients with social phobia tend to aspire to outstanding social performances (being sharp, humorous, etc.) and are not satisfied with average performances. (Interestingly, average performance keeps them from being in the spotlight, which could be seen as their apparent goal.)

*Positive relations with others.* Interpersonal relationships may be influenced by strongly held attitudes of which the patient may be unaware and that may be dysfunctional. For instance, a young woman who recently got married may have set unrealistic standards for her marital relationship and find herself frequently disappointed. At the same time, she may avoid pursuing social plans that involve other people and may lack sources of appreciation of what could be realistic expectations from and to other people in marital relationships and life tasks. Impairments in self-acceptance (with the resulting belief that one is unlovable and may be rejected) may also

undermine positive relations with others. There is a large body of literature (Uchino, Caciotto, & Kiecolt-Glaser, 1996) on the buffering effects of social integration, social network properties, and perceived support against life stressors. Family relationships and family life have also been extensively studied for their health consequences, even though the focus often has been on the negative (e.g., divorce, separation) and how they compromise health (Facchinetti, Ottolini, Fazziò, Rigatelli, & Volpe, 2007; Faravelli, Catena, Scarpato, & Ricca, 2007; Fava & Sonino, 2008), with much less attention given to the ways in which family life contributes to human flourishing (Ryff & Singer, 2000b). Improvements in the family functioning may facilitate the recovery process in depression (Fabbri, Fava, Rafanelli, & Tomba, 2007).

A question that may arise is what differentiates well-being therapy from standard cognitive therapies, which may also involve positive thinking. MacLeod and Moore (2000) argue that positive cognition has been viewed with suspicion within cognitive therapy because it raises the possibility of creating illusory rather than accurate thinking. The rationale behind cognitive therapy is that psychological disorders arise out of inaccurate, negative thinking that needs to be corrected, and positive cognitions may ensue when such detrimental thinking is removed (MacLeod & Moore, 2000). The rationale behind well-being therapy is that criteria can be established to distinguish valid and helpful positive thinking from unrealistic expectations and that promotion of psychological well-being may result in decrease of distress and higher levels of resilience to environmental circumstances. A main difference between standard cognitive therapies and well-being therapy is thus the focus, which in well-being therapy is on instances of emotional well-being, whereas in cognitive therapy it 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 psychological well-being along Ryff's (1989) dimensions (see Table 1).

A final distinction is that, unlike cognitive behavioral frameworks, well-being therapy refrains from explaining from the outset to the patient its rationale and strategies but relies on his or her progressive appraisals of positive self. The patient who struggles against anxiety, for instance, may be helped to view anxiety as an unavoidable element of everyday life that can be counteracted by a progressive

increase in environmental mastery and self-acceptance. Enhancing acceptance (vs. control) of distress and positive resources to keep distress in bounds and fostering a very individualized road to recovery, set by the patient's increasing awareness, is another characteristic of well-being therapy.

The term cognitive behavioral therapy subsumes a number of diverse therapeutic procedures, such as cognitive therapy, problem-solving interventions, and exposure. In a restrictive definition, it indicates psychotherapeutic approaches that explicitly seek to produce changes in cognition as a means of influencing the phenomena of interest, such as affect or behavior (Fava, 2007). Such a definition excludes specific behavioral interventions, such as exposure, that may work through cognitive mediation but that are not primarily intended to produce change by influencing thinking.

A broader definition stems from the growing awareness of the importance of self-therapy (self-observation and homework assignments) in producing change through the most diverse cognitive or behavioral elements, or both (Fava, 2007). Well-being therapy may be placed within this broad definition of cognitive behavioral therapy.

### **The Structure of Well-Being Therapy**

Well-being therapy is based on Ryff's cognitive model of psychological well-being (Ryff, 1989). This model was selected on the basis of its easy applicability to clinical populations (Fava et al., 2001; Rafanelli et al., 2000). Well-being therapy is structured, directive, oriented on current problems and states, and based on an educational model (Fava, 1999; Fava & Ruini, 2003). Well-being therapy is a short-term psychotherapeutic strategy that extends over 8–12 sessions and that may take place every week or every other week. It is an individual approach that emphasizes self-observation (Emmelkamp, 1974), with the use of a structured diary, and interaction between patients and therapists. It is structured so that early treatment emphasizes developing skills and capacity to sustain attention to aspects of daily experience or emotions that are positive, and subsequent sessions emphasize the promotion of psychological well-being. The duration of each session may range from 30 to 50 min. The development of sessions is as follows.

*Initial Sessions*

Early sessions of treatment are simply concerned with identifying episodes of well-being and setting them into a situational context, no matter how short-lived they are. 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.

The rationale for an early emphasis on identifying positive experiences derives from both early formulations of and empirical data highlighting the value of ameliorating hedonic deficits. Meehl (1975) 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). There has been confirmation of Meehl’s observations in two controlled trials (Burton & King, 2004; Emmons & McCullogh, 2003), where attention to positive daily experiences resulted in improving the levels of psychological well-being (Emmons & McCullogh, 2003) or health center visits for illness (Burton & King, 2004). Further, patients are encouraged to monitor the quality of experience people associate with daily situations (work, leisure, etc.). 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 & Csikszentmihalyi, 1998). Optimal experience is characterized by the perception of high environmental challenge and environmental mastery, deep concentration, involvement, enjoyment, control of the situation, clear-cut feedback on the control on the course of activity, and intrinsic motivation (Deci & Ryan, 1985). Cross-cultural studies have demonstrated that optimal experience can occur in any daily context, such as work and leisure (Delle Fave & Massimini, 2003; Massimini & Delle Fave, 2000). Patients are thus asked to report whether 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 effect any homework assignment, such as resistance and compliance. Identification of instances of well-being and of optimal experiences and reporting them in the diary would be the indicators that the individual is ready to move to the next phase, which aims to target the obstacles to sustained psychological well-being.

### *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 (1982) Rational-Emotive Therapy 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 because 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 and optimal experiences (e.g., 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. The focus of this phase of well-being therapy is always on self-monitoring of moments and feelings of well-being and graded task assignments. The therapist refrains from suggesting conceptual and technical alternatives (e.g., different interpretations), unless a satisfactory degree of self-observation (including irrational or automatic thoughts) has been achieved. Attention is paid to the ratings assigned by the patient to moments of well-being associated with carrying out the assignment. If the ratings are consistently low (e.g., 30 out of 100), the therapist

asks the patient to describe circumstances that would potentially represent a rating of 70 or 80. This is done to avoid having the patient focus exclusively on circumstances associated with lower levels of hedonia.

This intermediate phase may extend over two or three sessions, depending on the patient's motivation and ability, and it paves the way for the specific well-being enhancing strategies. Identification of automatic thoughts in the diary indicates readiness to move to the next phase, which is aimed at offering alternative interpretations to automatic thoughts.

### *Final Sessions*

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), and to pursue optimal experiences. Meeting the challenge that optimal experiences may entail is emphasized (e.g., their pursuing may involve the risk of failure or may seem to be selfish to the patient). 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 & Singer, 2007), which may be administered before therapy starts. Ryff's six dimensions of psychological well-being are progressively introduced to the patients, as long as the material that 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.

As noted earlier, the techniques in WBT that are used in overcoming the impairments in psychological well-being may include cognitive restructuring (modification of automatic or irrational thoughts), scheduling of activities (mastery, pleasure, and graded task assignments), assertiveness training, and problem solving (Beck et al., 1979; Ellis & Becker, 1982; Pava, Fava, & Levenson, 1994; Weissman & Markowitz, 1994), in addition to self-observation of

positive experiences (Burton & King, 2004; Emmons & McCullough, 2003). The goal of the therapist is to lead the patient through the transitions outlined in Table 1. 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 structured diary. However, it is only when such insights about these impairments in well-being dimensions are translated into behavioral terms that a significant improvement has been made.

For example, a patient after his third recurrent episode of major depression learned how his lack of autonomy led his workmates to consistently take advantage of him. This situation resulted in a workload that, because of its diverse nature, undermined his environmental mastery and constituted a significant stress, also in terms of working hours. The situation was accepted by virtue of a low degree of self-acceptance: The patient claimed that this was the way he was but at the same time was dissatisfied with self and chronically irritable. When he learned to say no to his colleagues (assertive training) and consistently endorsed this attitude, a significant degree of distress ensued, linked to perceived disapproval by others. However, as time went by, his tolerance for self-disapproval gradually increased, and, in the last session, he was able to make the following remark: “Now my workmates 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 6-year follow-up, while being drug free.

This clinical picture illustrates how an initial feeling of well-being (being helpful to others), which 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, leading to increased resilience.

Cognitive restructuring in well-being therapy follows Ryff's conceptual framework (Ryff & Singer, 1996).

### Validation Studies

Well-being therapy, according to the format previously outlined, has been employed in several clinical studies. Other studies are currently in progress. In some cases WBT has been used alone. In other cases, it has been added to cognitive therapy using a sequential combination (first psychotherapy addressed the abatement psychological distress and subsequently the promotion of well-being). In some other cases it has been added to pharmacotherapy or behavioral treatment based on exposure. It is quite difficult to apply WBT in an acutely ill patient (e.g., in a major depressive episode) because the amount of negative thoughts may be at that stage overwhelming. WBT appears to be more suitable for addressing psychological issues that other therapies have left unexplored. However, these conclusions are, at present, tentative and may be modified by further studies and clinical experience. In the same vein, all studies that are presented have involved individual WBT. Group format WBT is, however, conceivable and may be a future line of development of this strategy.

### Residual Phase of Mood and Anxiety Disorders

The effectiveness of well-being therapy in the residual phase of affective disorders has been tested in a small controlled investigation (Fava, Rafanelli, Cazzaro, Conti, & Grandi, 1998a). 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 either a 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; Paykel, 1985), and in PWB well-being. However, when the residual symptoms of the two groups were compared immediately after treatment, a significant advantage of well-being therapy over cognitive behavioral strategies was observed. Well-being therapy was also associated with a significant increase in

PWB well-being, particularly in the Personal Growth scale. 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 affect (Fava, Rafanelli, Cazzaro 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)—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 substantial changes, but in the residual phase further reduction of symptoms by pharmacological or other standard psychotherapeutic approaches may be associated with limited benefits, whereas promotion of psychological well-being may be more effective in decreasing negative affects.

#### *Treatment of Generalized Anxiety Disorder*

Well-being therapy has recently been applied to the treatment of generalized anxiety disorder (GAD; Fava, Ruini, Rafanelli, Finos et al., 2005). Twenty patients with DSM-IV GAD were randomly assigned to eight sessions of cognitive behavioral therapy (CBT) or the sequential administration of four sessions of CBT followed by another 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, in terms of both 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 for 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 (Beck & Emery, 1985) and may thus result in a more effective cognitive restructuring.

These results lend support to a sequential use of treatment components for achieving a more sustained recovery.

### *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), defined as the occurrence of three 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. This package also included cognitive behavioral treatment 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 plus well-being therapy had a significantly lower level of residual symptoms after drug discontinuation in comparison with the clinical management group. Cognitive behavioral plus well-being therapy 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, Ruini, Rafanelli, Finos, et al., 2004), the relapse rate was 40% in the former group and 90% in the latter. Further, the group treated with CBT had a significantly lower number of recurrences when multiple relapses were taken into account. Unfortunately, in this investigation well-being measurements were not performed, and we thus do not know the course of psychological well-being during the treatment phases.

### *Loss of Clinical Effect During Drug Treatment*

The return of depressive symptoms during maintenance antidepressant treatment is a common and vexing clinical phenomenon (Baldessarini, Ghaemi, & Viguera, 2002; Bockting et al., 2008; Papakostas, Perlis, Seifert, & Fava, 2007). A number of pharmacological strategies have been suggested for addressing loss of antidepressant efficacy, but they have had limited success (Chouinard & Chouinard, 2008; Schmidt et al., 2002). To examine whether an intervention that included well-being therapy might improve mainte-

nance of medication effects, a small clinical trial was carried out. 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 with continuation of antidepressant drugs at the same dosage (Fava, Ruini, Rafanelli, & Grandi, 2002). Four out of five patients in the group treated only with antidepressant responded to a larger dose of medication, 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 by 1-year follow-up. The data suggest that application of combined cognitive behavioral and well-being therapy may counteract loss of clinical effect during long-term antidepressant treatment. The specific contribution of WBT, however, cannot be discerned from this type of study. Tolerance to antidepressant treatment has been associated with activation of the hypothalamic-pituitary-adrenal (HPA) axis (Fava, 2003). In a single case report, well-being therapy induced a normalization of the HPA axis (Sonino & Fava, 2003). It is thus conceivable that well-being therapy may, through this mechanism, restore and maintain remission with antidepressant drugs when response fails or is about to fail.

### *Posttraumatic Disorder*

Treatment of posttraumatic stress disorder is still a major challenge from a psychotherapeutic viewpoint (Cottraux et al., 2008; Schnyder, 2005; Van Emmerik, Kamphuis, & Emmelkamp, 2008), and research aimed at ameliorating trauma-related psychiatric disorder is of the utmost importance (Schnyder, 2005). Two cases were reported (Belaise, Fava, & Marks, 2005) in which patients improved with well-being therapy, even though their central trauma was discussed only in the initial history-taking session. They are briefly outlined here.

*Case 1.* Y was a priest aged 58 working in a mission in the developing world. One night two burglars broke into the mission and stabbed him once. He was about to be stabbed again, probably lethally, when an outside noise made them flee. Y developed full-blown PTSD with vivid, repeated images by day and night of the man who was going to kill him. He returned to Italy due to his PTSD and sought help there 6 months after the stabbing as his symptoms prevented him from resuming work. He was afraid of being stabbed

again whenever he went out, which severely restricted his mobility. Y was advised to do homework exposure to situations he avoided even in Italy (e.g., going out at night, taking a bus), which he completed. He improved greatly after four twice-weekly sessions but still felt unable to resume priestly activities such as celebrating mass and taking confessions. WBT then began. Y monitored and recorded periods when he felt well, thoughts which interrupted these, and cognitive restructuring of those thoughts (Table 2). The patient wrote down interpretations as a potential "observer." After four sessions over 8 weeks of WBT, Y resumed work as a priest in a parish in Italy and showed no more general anxiety, insomnia, vivid imagery, or obvious avoidance apart from not returning to the developing world. He was repeatedly confronted with the latter, but he said he would function less well in a mission there than in Italy. Two years after treatment, he visited his former mission and stayed there for 2 weeks. At 1-year follow-up, he felt much better than before the stabbing, especially in his role of confessor. "I learned," he said, "that one's psychological well-being is the key: If you feel well, you transmit wellness; if you feel distressed, you transmit the gloomy view of religion which many of my colleagues have." He remained well at an 8-year follow-up.

*Case 2.* Z was a 28-year-old bank clerk who had 6 months earlier witnessed a bank robbery at her place of work. Although she had not been personally threatened then, she soon developed interrupted

**Table 2**  
Self-Observation of Episode of Well-Being

Situation	Feeling of Well-Being	Interrupting Automatic Thoughts	Patient's Interpretation of Thoughts as an "Observer"
I'm walking in the city. It's a beautiful morning.	I eventually feel well. No more fears or anxiety.	I don't deserve this. I'm having a good time here while my colleagues must deal with difficult problems.	There are many ways to help others. The time has come for me to change my life.

sleep, nightmares, general anxiety, difficulty concentrating, and fear of a new robbery. As she had no avoidance, she had WBT over eight twice-weekly sessions. She revealed in diary entries difficulties in managing everyday affairs such as dealing with nonroutine problems in her job, a fear of any unexpected event, and lack of progress and development in her work and other aspects of life. By the end of therapy, she gained a sense of mastery in dealing successfully with difficult problems at work and seeing similarities between past work difficulties and most future problems likely to arise at work (transfer of experiences). She thought it was just luck that she had not screamed or acted dangerously during the robbery (Table 3). Z had been scared of any unexpected event (even a problem with a client), not just of a potential new robbery. Gaining mastery and a sense of personal growth (becoming aware that she had acquired sufficient skills to deal with unexpected problems) helped her lose her fear of a new robbery. Table 3 illustrates how she could act as an observer of her own interrupting automatic thoughts and develop alternative interpretations of them. Full remission continued at a 6-year follow-up.

The findings from these two cases should of course be interpreted with caution (the patients may have remitted spontaneously), but they are of interest because they are indicative of an alternative route

**Table 3**  
Self-Observation of Episode of Well-Being

Situation	Feeling of Well-Being	Interrupting Automatic Thoughts	Patient's Interpretation of Thoughts as an "Observer"
Leaving the bank at the end of the day.	Everything went smoothly today. I was almost relaxed.	This was a lucky day. But luck cannot last. Anything can disclose my inadequacies.	Whenever there was an unexpected problem at work you coped with it. You've been working for 5 years now and there has been no complaint.

to overcoming trauma and developing resilience. A randomized controlled trial is now in order.

### *School Interventions*

Nowadays schools are conceived of as the ideal setting not only for focusing on more traditional learning activities but also for building skills that promote resilience and psychological well-being early in the lifecourse (Caffo, Belaise, & Forresi, 2008). We have recently begun a new line of work to examine the value of efforts to build resilience resources through school-based interventions. In a pilot study of a very brief treatment (i.e., four class sessions lasting several hours), a sample of 111 middle school students were randomly assigned to either a protocol using theories and techniques derived from cognitive behavioral therapy or a protocol derived from WBT. Classes had been randomly selected from the school and there were no specific problems or targets that needed to be addressed. Both school-based interventions resulted in a comparable improvement in symptoms and psychological well-being (Ruini, Belaise, Brombin, Caffo, & Fava, 2006). This pilot investigation suggested that well-being enhancing strategies could play an important role in the prevention of psychological distress and the promotion of optimal human functioning among children. However, the number of sessions was low (four) and the first two sessions were shared by both treatments. It was thus impossible to differentiate specific contributions of each strategy. Other studies are currently in progress for developing a more fine-grained evaluation of the specific intervention effects.

### **Well-Being Therapy and the Mechanisms of Resilience**

Well-being therapy's effectiveness in promoting recovery and preventing relapse in individuals with mood and anxiety disorders may be based on two distinct yet ostensibly related clinical phenomena. The first has to do with the fact that an increase in psychological well-being may have protective effect in terms of vulnerability to chronic and acute life stresses (Ryff & Singer, 2000a). The second has to do with the complex balance of positive and negative affects. There is extensive research—reviewed in detail elsewhere (Rafanelli et al., 2000; Ruini et al., 2003)—that indicates a certain degree of inverse correlation between positive and negative affects. As a result, changes in well-being may induce a decrease in distress and vice versa. In the

acute phase of illness, removal of symptoms may yield the most substantial changes, but the reverse may be true in its residual phase. An increase in psychological well-being may decrease residual symptoms that direct strategies that target distress (whether cognitive behavioral or pharmacological) would be unlikely to affect.

Further, it has been suggested that cognitive behavioral psychotherapy may work at the molecular level to alter stress-related gene expression and protein synthesis or influence mechanisms implicated in learning and memory acquisition in neuronal structures (Goddard & Charney, 1997). For instance, in one study, sadness and happiness affected different brain regions: Sadness activated limbic and paralimbic structures, whereas happiness was associated with temporal parietal decreases in cortical activity (George et al., 1995). Such effects were not merely opposite activity in identical brain regions. Research on the neurobiological correlates of resilience has disclosed how different neural circuits (reward, fear conditioning and extinction, social behavior) may involve the same brain structures, and particularly the amygdala, the nucleus accumbens, and the medial prefrontal cortex (Charney, 2004). Reconsolidation is a process in which old, reactivated memories undergo consolidation: Each time a traumatic memory is retrieved, it is integrated into an ongoing perceptual and emotional experience, which involves NMDA and beta-adrenergic receptors and requires cAMP response-element binding protein induction (Charney, 2004). Singer, Friedman, Seeman, Fava, and Ryff (2005), on the basis of preclinical evidence, suggested that WBT may stimulate dendrite networks in the hippocampus and induce spine retraction in the basolateral amygdala (a site of storage for memories of fearful or stressful experiences), leading to a weakening of distress and traumatic memories. The pathophysiological substrates of well-being therapy may thus be different compared to symptom-oriented cognitive behavioral strategies, reflecting that well-being and distress are not merely opposites (Rafanelli et al., 2000).

#### **Implications For The State/Trait Dimension In Psychological Well-Being and Resilience**

Cloninger (2006) attributes the clinical changes related to well-being therapy and mindfulness-based cognitive therapy (Ma & Teasdale, 2004; Teasdale et al., 2000) to modifications in three character traits, defined as self-directness (i.e., responsible, purposeful and resource-

ful), cooperativeness (i.e., tolerant, helpful, compassionate), and self-transcendence (i.e., intuitive, judicious, spiritual). Individuals with high levels of all these character traits have frequent positive emotions (i.e., happy, joyful, satisfied, optimistic) and infrequent negative emotions (i.e., anxious, sad, angry, pessimistic). The lack of development in any one of the three factors leaves a person vulnerable to the emergence of conflicts that can lead to anxiety and depression (Cloninger, 2006). These character traits can be exercised and developed by interventions that encourage a sense of hope and mastery for self-directedness. Indeed, in a study performed in the general population (Ruini et al., 2003), several PWB scales displayed significant correlations with Cloninger's (1987) Tridimensional Personality Questionnaire. Further, in a controlled psychotherapeutic trial (Rafanelli et al., 2000), most of the PWB scales were more sensitive to changes upon psychotherapeutic treatment than the symptom and well-being scales of the Symptom Questionnaire (SQ; Kellner, 1987), which had been found to be an extremely sensitive instrument in other studies. The correlations between PWB and SQ were different in patients and controls (Rafanelli et al., 2000). This may be explained by the influence of the course of the illness in determining the state (likelihood to change) and trait (likely to persist) dimensions of a measurement (Fava, Ruini, & Rafanelli, 2004).

New insights have recently occurred in studying subsyndromal symptomatology in the course of mood and anxiety disorders (Fava, Rafanelli, Tossani, & Grandi, 2008; Fava, Ruini, et al., 2007; Howland et al., 2008; Wittchen et al., 2008). When the illness remits, either upon treatment or spontaneously, it often progressively recapitulates in a process sometimes referred to as "the roll-back" phenomenon. Individuals experience many of the stages and symptoms that they did during the time the symptoms first developed. This means that certain symptoms (e.g., those that occur in the prodromal phase of illness) may be stable and persistent and yet amenable to specific treatment (such as WBT in the residual phase of mood and anxiety disorders). These symptoms, which have a defined onset in the patient's life, when tested in the course of time, may be misunderstood as a trait dimensions. In the same vein, pathological personality traits, whose clinical onset generally occurs during adolescence, may have an episodic course, in what has been recently defined as episodic personality dysfunction (Reich, 2007). The state/trait dichotomy may be feasible in studying general populations over

the course of time but does not apply so readily to clinical studies because of the influence of the roll-back phenomenon and the episodic manifestations of personality dysfunction. As a result, psychological constructs traditionally conceived as trait dimensions may surprisingly display sensitivity to change in a specific clinical situation, whereas constructs viewed as state dimensions may display unexpected stability throughout the longitudinal development of the disorder. This conceptualization has profound impact on assessment of psychological well-being in relation to therapeutic interventions such as WBT.

Ryan and Deci (2001) have summarized research on psychological well-being as falling in two general groups: The hedonic viewpoint focuses on subjective well-being, happiness, pain avoidance, and life satisfaction (Diener, Suh, Lucas, & Smith, 1999; Fredrickson, 2002; Neugarten, Havinghurst, & Tobin, 1961), whereas the eudaimonic viewpoint focuses on meaning and self-realization and defines well-being in terms of degree to which a person is fully functioning (Ryff, 1989) or as a set of wellness variables such as self-actualization and vitality (Ryan & Deci, 2001). This classification has achieved wide currency in research concerned with psychological well-being and resilience. The findings on WBT indicate that the two viewpoints are inextricably linked in clinical situations, and the extent, amount, and circumstances of changes in well-being induced by treatments may matter more than a priori distinctions.

### Resilience and Recovery

The long-term outcome of mood and anxiety disorders has been bleak (De Fruyt & Demyttenaere, 2007; Fava, Ruini, et al., 2007; Ghaemi & Baldessarini, 2007). Various follow-up studies, in fact, have documented relapses and recurrence in affective disorders (Fava, Ruini, et al., 2007). As a result, the challenge of treatment of mood and anxiety disorders today appears to be the prevention of relapse more than the attainment of recovery (Fava, Tomba, et al., 2007). Here we have offered an overview of a program of research suggesting that attention to bolstering well-being is central for both achieving recovery and preventing relapse. The controlled trials of well-being therapy that we have discussed indicate that psychological well-being may be increased by specific psychotherapeutic methods and that these changes are closely related to decrease in distress and

improvement in contentment, friendliness, relaxation, and physical well-being (Fava et al., 2002; Fava, Rafanelli, Cazzaro, et al., 1999a; Fava, Ruini, Rafanelli, Finos, et al., 2004, 2005; Ruini et al., 2006). Unlike nonspecific interventions aimed at increasing control or social activity, which yield short-lived improvements in subjective well-being (Okun, Olding, & Cohn, 1990), changes induced by WBT tend to persist at follow-up (Fava et al., 2002; Fava, Ruini, Rafanelli, Finos, et al., 2004, 2005), underlie increased resilience, and entail less relapse in the face of current events.

Efforts to direct clinical attention to promoting well-being in the treatment of mood and anxiety disorders may be furthered by delineating markers of recovery. Has the patient gained, after the illness episode, a degree of resilience that may predict a favorable long-term outcome, particularly when active treatment is discontinued? Fava, Ruini, et al. (2007) have outlined a definition of recovery from major depression that encompasses psychological well-being and resilience. In Table 4 we report on a novel approach to the assessment of recovery in psychiatric patients, based on a semistructured interview concerned with psychological well-being and resilience, derived from PWB items (Ryff, 1989). The fact that the patient reports psychological well-being in at least one of the six areas outlined in Table 4, his or her persistence of remission despite discontinuation of treatment (whether pharmacological or psychotherapeutic), and lack of residual symptoms that interfere with everyday life and social functioning are the new targets for developing therapeutic strategies of enduring quality.

### **Well-Being Therapy and Individual Differences**

An issue that is often neglected is the fact that randomized controlled trials, when transferred from their origin in agricultural research into clinical medicine and psychology, were not intended to answer questions about treatment of individual patients (Fava, 2006). WBT was originally developed as a strategy for promoting psychological well-being that was still impaired after standard pharmacological or psychotherapeutic treatments. 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. This individualized approach characterizes the treatment protocol and requires careful

**Table 4**

Interview for Assessing Psychological Well-Being According to Ryff's (1989) Dimensions in Clinical Populations, With Each Question to Be Answered Yes or No

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Environmental mastery

- A. The subject has a sense of mastery and competence in managing the environment:  
In general, do you feel that you are in charge of the situation in which you live?
- B. The subject makes effective use of surrounding opportunities:  
Today do you feel that you are capable of making the most of the opportunities in your life (at work, in the relationships, in the community, etc.) to obtain the best possible results?
- C. The subject is able to create or choose contexts suitable to personal needs and values:  
Do you believe you are able to fit in with people and the community around you, such as choosing people and contexts suitable to your personal needs and values?

Personal growth

- A. The subject has a feeling of continued development:  
In your opinion, has your life been a continuous process of learning, changing and growth?
- B. The subject has a sense of realizing his or her own potential:  
So far in your life, do you feel that you have been realizing your potential?
- C. The subject sees improvements in self and behavior over time:  
Do you have the sense that you have developed and matured a lot as a person over the years?

Purpose in life

- A. The subject has goals in life and a sense of direction:  
Do you enjoy making plans for the future and working to make them a reality? In doing this do you get a sense of direction in your life?
- B. The subject feels there is meaning to present and past life:  
Do you feel good when you think of what you have done in the past and what you hope to do in the future?
- C. The subject holds beliefs that give life purpose:  
Sometimes, do you feel as if you have done all there is to do in life?

Autonomy

- A. The subject is self-determining and independent:  
Is it more important for you to stand alone on your own principles than to fit in with others?
- 

*(Continued)*

**Table 4 (Cont.)**


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B.	The subject is able to resist social pressures: Do you have confidence in your opinions, even though they are contrary to general consensus?
C.	The subject evaluates self by personal standards: Do you evaluate yourself by what you think is important rather than values of others?
Self-acceptance	
A.	The subject has a positive attitude toward the self: In general, do you feel confident and positive about yourself?
B.	The subject accepts his or her good and bad qualities: Do you like most aspects of your personality even in its weaknesses?
C.	The subject feels positive about his or her past: When you look at the story of your life, are you pleased with how things have turned out?
Positive relations with others	
A.	The subject has warm and trusting relationships with others: Do you have many people who want to listen when you need to talk and share your concerns, that is, do you feel that you get a lot out of your friendships?
B.	The subject is capable of strong empathy, affection, and intimacy: Do you enjoy personal and mutual conversations with family and friends, sympathizing with each other's problems?
C.	The subject understands the give-and-take of human relationships: Would people describe you as a giving person, willing to share your time with others, and do you find it easy to really open up when you talk with others?

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self-monitoring before any cognitive restructuring takes place. Unlike standard cognitive therapy, which is based on specific assumptions (e.g., the cognitive triad in depression), WBT develops on the basis of findings from self-observation in the diary. 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 a pharmacological and psychological nature. The model is realistic, instead of idealistic, but more in line with the emerging evidence on the unsatisfactory degree of remission that one course of treatment entails and the need for addressing several areas of concern in the treatment of patients with mood and anxiety disorders (Fava, Tomba, et al., 2007).

### Conclusions

Engel (1960) defined etiological factors as “factors which either place a burden on or limit the capacity of systems concerned with growth, development or adaptation” (p.73). Well-being therapy attempts to address these etiological factors and to lead patients to an increased level of recovery and resilience. The findings from the studies we have presented indeed suggest that psychological distress and vulnerability to life events may be counteracted, and even prevented, by increasing levels of well-being. Longitudinal evaluation of psychological well-being and resilience in clinical populations may yield important insights into their characteristics and conceptualization. Further, the entire area of rehabilitation in medicine (Sonino & Fava, 2007) needs to take the promotion of well-being and resilience as a primary target of intervention.

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