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Well-being therapy. A novel psychotherapeutic approach for residual symptoms of affective disorders

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ABSTRACT

Background. There is increasing awareness of the prognostic value of residual symptomatology in affective disorders and of the need for specific therapeutic strategies in this phase of illness. The aims of the study were to apply a novel, short-term psychotherapeutic approach for increasing well-being, based on Ryff's conceptual model, to remitted patients with affective disorders and to compare the results with those obtained with symptom-oriented cognitive behavioural strategies.

Methods. 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 behavioural or pharmacological methods were randomly assigned to a well-being enhancing therapeutic strategy (well-being therapy) or cognitive–behavioural treatment of residual symptoms.

Results. Both well-being and cognitive–behavioural therapies were associated with a significant reduction of residual symptoms. However, a significant advantage of well-being therapy over cognitive–behavioural strategies was observed with observer-rated methods.

Discussion. These preliminary results suggest the feasibility of well-being therapy in the residual stage of affective disorders. Further research should determine its value as a relapse-preventive strategy in specific mood and anxiety disorders.

INTRODUCTION

A substantial proportion of patients with mood and anxiety disorders still display residual symptoms upon successful treatment of their illness (Fava, 1996). Such symptoms were found to entail prognostic value in the entire range of affective disorders, from depression to social phobia, from panic disorder to obsessive–compulsive disturbances (Fava, 1996). Treatment of residual symptoms of primary unipolar major depression by cognitive–behavioural methods (Fava *et al.* 1994) resulted in a significantly lower relapse rate at a 4 year follow-up (Fava *et al.* 1996*a*).

Ryff & Singer (1996) remark 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 suggest that the absence of well-being creates conditions of vulnerability to possible future adversities and that the route of recovery lies not exclusively in alleviating the negative, but in engendering the positive (Ryff & Singer, 1996). In the same vein, more than four decades ago, Parloff and colleagues (1954) suggested that the goals of psychotherapy were not necessarily the reduction of symptoms, but increased personal effectiveness. The aims of this preliminary report were: (*a*) to apply a novel psychotherapeutic approach for increasing well-being based on Ryff's conceptual model (1989) to the treatment of residual symptoms of affective disorders

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(major depression, panic disorder with agoraphobia, social phobia, generalized anxiety disorder, obsessive–compulsive disorder); and (*b*) to compare the effectiveness of this approach against symptom orientated cognitive–behavioural methods.

METHOD

Twenty-three consecutive out-patients satisfying the criteria described below, who had been referred to and treated in the Affective Disorders Program of the University of Bologna School of Medicine in Italy, were enrolled in this study. The patients' diagnoses were established by the consensus of a psychiatrist (G.A.F.) and a clinical psychologist (C.R.) independently using the Schedule for Affective Disorders and Schizophrenia (Endicott & Spitzer, 1978). Subjects had to meet the following criteria: (1) a current DSM-IV (American Psychiatric Association, 1994) diagnosis of major depressive disorder, or panic disorder with agoraphobia, or social phobia, or generalized anxiety disorder, or obsessive–compulsive disorder; (2) no history of active drug or alcohol abuse or dependence or of personality disorder according to DSM-IV criteria; (3) no history of bipolar illness or antecedent dysthymia; (4) no active medical illness; and (5) successful response to treatment administered by two psychiatrists (S.G. and S.C.) according to standardized protocols (Fava *et al.* 1989, 1994, 1995, 1996*b*). These protocols involved the use of antidepressant drugs in the setting of major depressive illness (Fava *et al.* 1994) and behavioural psychotherapy based on exposure (Fava *et al.* 1989, 1995, 1996*b*) in anxiety disorders. Duration of treatment of mood and anxiety disorders ranged between 3 and 5 months. After treatment, all patients were assessed by the same clinical psychologist who had evaluated them on intake, but who did not take part in the treatment. Only the patients rated as 'better' or 'much better' according to Kellner's global scale of improvement (Kellner, 1972) were included in the study. These 23 patients were screened from a sample of 31 patients initially evaluated.

The clinical psychologist then administered a modified version of the Paykel's Clinical Interview for Depression (Paykel, 1985). This interview covered 21 symptom areas, with a total score potentially ranging from 21 to 147, as described in detail elsewhere (Fava *et al.* 1994). It has been found to be a suitable instrument for evaluating both prodromal and residual symptoms in affective disorders (Fava & Kellner, 1991; Fava, 1996). In the current protocol a residual symptom was scored as present when a rating of at least 3 on the 7-point scales of the interview was assigned. Only three of the 23 patients screened had no residual symptoms according to this method of rating, and they were excluded from further participation in the study.

In addition to the Clinical Interview for Depression (CID), two self-rating scales were administered to the remaining 20 patients. One was Ryff's Scales of Psychological Well-Being (PWB) (Ryff, 1989), an 84-item inventory that covers six areas of well-being: autonomy, environmental mastery, personal growth, positive relations with others, purpose in life, self-acceptance. Subjects respond with a six-point format ranging from strongly disagree to strongly agree. Responses to negatively scored items are reversed in the final scoring procedure so that high scores indicate high self-rating on the dimension assessed. Each scale score may range from 0 to 14. The other instrument was Kellner's Symptom Questionnaire (SQ) (Fava *et al.* 1983; Kellner, 1987), a 92-item self-rating scale that yields four scales of distress (anxiety, depression, somatization and hostility–irritability) and four scales of well-being (relaxation, contentment, physical well-being and friendliness). Each symptom scale score may range from 0 to 17; each well-being scale score from 0 to 6.

The 20 patients were then randomly assigned to one of two treatment groups: (1) well-being therapy; or (2) cognitive–behavioural treatment of residual symptoms. In both cases treatment consisted of eight 40 min sessions once every other week. The same psychiatrist (G.A.F.) was involved in both treatment groups.

In well-being therapy patients were asked to report only the episodes of well-being, rated on a 0–100 scale, in a diary. The initial two sessions were simply concerned with identifying and setting into a situational context such episodes, no matter how short lived they were. Subsequent

work (3rd to 5th sessions) – using techniques derived from both Ellis & Harper rational–emotive therapy (1961) and cognitive therapy (Beck *et al.* 1979) – was aimed to identifying automatic thoughts and beliefs leading to premature interruption of well-being. In the final sessions (6th to 8th), patients were assessed according to Ryff's dimensions of well-being (Ryff, 1989; Ryff & Singer, 1996) and specific impairments were focus of attention. For instance, low scorers on the dimension of personal growth have a sense of personal stagnation; lack sense of improvement or expansion over time; feel bored and uninterested with life; and feel unable to develop new attitudes or behaviours. High scorers, on the contrary, have a feeling of continued development; see themselves as growing and expanding; are open to new experiences; have a sense of realizing their potential; and see improvement in themselves and their behaviour over time (Ryff & Singer, 1996). The goal of the therapist then becomes to guide the patient through this transition. Furthermore, in behavioural terms, mastery and pleasure tasks as well as exposure to feared situations, were encouraged.

Such behavioural techniques were used also in patients treated with cognitive–behavioural treatment of residual symptoms. Cognitive therapy was conducted as described by Beck *et al.* (1979; Beck & Emery, 1985). Its focus, however, was on psychological distress, and identifying and modifying negative automatic thoughts and beliefs underlying it. Ten patients were assigned to each treatment group. The patients assigned to well-being therapy (WBT) had a mean age of 31·3 (S.D. = 7·0) years. There were four males and six females. Four patients were married. Eight belonged to the middle-upper social class and two to the working class, according to Goldthorpe & Hope's (1974) occupational classification. All patients had completed at least 13 years of education. Psychiatric diagnoses were as follows: major depressive disorder (2 patients), panic disorder associated with agoraphobia (4), social phobia (2), generalized anxiety disorder (1), obsessive–compulsive disorder (1). Their mean duration of illness was 14·7 (S.D. = 14·3) months.

The 10 patients assigned to cognitive–behavioural therapy (CBT) had a mean age of 25·5 (S.D. = 6·1) years. Five were women and three were married. Seven patients belonged to the middle-upper social class and nine had completed at least 13 years education. Psychiatric diagnoses were as follows: major depressive disorder (1 patient), panic disorder associated with agoraphobia (3), social phobia (4), generalized anxiety disorder (1) and obsessive–compulsive disorder (1). Their mean duration of illness was 15·0 (S.D. = 12·4) months. At the time of the first assessment, the three depressed patients were taking antidepressant drugs (amitriptyline 200 mg daily in two cases and fluoxetine 20 mg daily in one case). Furthermore, five of the 17 patients with anxiety disorders were taking benzodiazepines (lorazepam or clonazepam at low doses). All patients with anxiety disorders had received behavioural psychotherapy based on exposure; in obsessive–-compulsive disorder exposure was associated with response prevention. The patients with major depression and panic disorder were in stage 3 of their illness (Fava & Kellner, 1993). Psychotropic drugs were successfully tapered and discontinued in the course of treatment, except for the two patients taking lorazepam (one per each group).

Treatment integrity was checked by taping eight randomly selected sessions, four involving well-being therapy and four cognitive–-behavioural treatment of residual symptoms. Two independent assessors were asked to identify the type of therapy that was performed (WBT or CBT). Both assessors correctly identified all sessions.

The 20 subjects were reassessed with the CID, the SQ and PWB after treatment by the same clinical psychologist who had performed the previous evaluations and who was blind as to treatment assignment.

A non-parametric method, the permutation test, adapted by Pesarin (1990), was used to evaluate differences between groups. This test is analogue of two-tailed Student's t test and parametric analysis of variance and covariance, without, however, being conditioned by normal distribution hypotheses. The method is based on a simulation or resampling procedure, conditional on the data, which provides a simulated estimate of the permutation distribution of any statistic. It is particularly suitable for multi-

dimensional (multivariate and/or multiparametric) cases, since it allows a combination procedure to control for multiple testing (Pesarin, 1990).

RESULTS

Both treatments (well-being therapy and cognitive–behavioural therapy) were associated with decrease in residual symptoms as measured by the Clinical Interview for Depression (Table 1). When the residual symptoms at the second assessment (after well-being therapy and cognitive–behavioural treatment) of the two groups were compared, with the initial measurements as covariates, a significant effect of well-being therapy ($t = 5{\cdot}58$; df = 18; $P < 0{\cdot}001$) was found.

Interpretation of self-rated data is hindered by the considerable number (14) of subscales of the PWB and SQ. However, the non-parametric combination method for dependent permutation tests allows to consider the two instruments by a global viewpoint. Well-being therapy was associated with a significant ($P < 0{\cdot}05$) increase in PWB well-being and a significant ($P < 0{\cdot}05$) decrease in SQ distress. The individual subscales which displayed significant changes were PWB personal growth, SQ anxiety and SQ contentment (Table 1).

Cognitive–behavioural treatment was associated with a significant ($P < 0{\cdot}01$) increase in PWB well-being, but was not significantly ($P < 0{\cdot}161$) related to an improvement in the SQ dimensions. The individual scales which displayed significant changes were PWB purpose in life and self-acceptance and SQ depression (Table 1).

There were no significant differences between the two treatments with analysis of covariance in PWB and SQ, using the combined differences. Only one individual scale (SQ friendliness) attained statistical significance ($t = 2{\cdot}88$; df = 18; $P < 0{\cdot}05$).

DISCUSSION

This study has obvious limitations due to its preliminary nature. First, it involved a small number of patients. Secondly, the diagnostic characteristics of the sample were rather heterogeneous. Finally, it had a semi-naturalistic design, since patients were initially treated with the use of different, even though standardized,

Table 1. *Changes in patients with affective disorders treated with well-being therapy (WBT) and cognitive–behavioural therapy (CBT)*

	WBT ($N = 10$)			CBT ($N = 10$)		
	Pre-therapy	Post-therapy		Pre-therapy	Post-therapy	
Scale	Mean (S.D.)	Mean (S.D.)	t (df = 9)	Mean (S.D.)	Mean (S.D.)	t (df = 9)
Clinical Interview for Depression	42·6 (4·5)	28·8 (3·5)	14·86***	40·0 (4·4)	33·8 (4·4)	6·21***
PWB						
Autonomy	7·2 (4·6)	8·6 (3·2)	1·35	7·8 (3·6)	7·8 (3·4)	0·01
Environmental mastery	5·6 (4·2)	6·8 (4·3)	1·45	3·8 (3·5)	5·2 (3·3)	1·56
Personal growth	9·4 (2·9)	11·4 (2·8)	4·47**	8·8 (3·3)	10·0 (3·4)	1·28
Positive relations	8·0 (4·0)	9·5 (4·0)	1·48	7·3 (2·9)	8·0 (2·4)	1·35
Purpose in life	7·7 (4·1)	8·0 (4·3)	0·33	5·5 (3·5)	7·9 (3·2)	3·03*
Self-acceptance	5·5 (3·7)	6·7 (4·9)	0·98	3·2 (3·6)	5·1 (4·0)	3·14*
SQ						
Anxiety	10·4 (3·9)	7·0 (4·1)	2·78*	8·6 (5·4)	7·4 (3·8)	0·73
Depression	8·9 (4·5)	6·0 (6·0)	1·50	10·0 (4·8)	6·4 (4·2)	2·86*
Somatization	9·3 (4·1)	5·8 (4·2)	2·62	6·4 (6·6)	4·5 (4·0)	1·36
Hostility	6·4 (5·1)	4·1 (5·2)	1·82	7·2 (4·4)	5·4 (3·4)	1·39
Relaxation	1·9 (1·9)	2·9 (2·2)	2·02	1·6 (1·2)	2·0 (1·4)	0·80
Contentment	2·2 (2·3)	3·9 (2·6)	2·49*	3·2 (1·2)	3·2 (1·4)	0·00
Physical well-being	1·8 (2·3)	2·6 (1·6)	1·81	2·7 (1·1)	3·1 (1·2)	0·51
Friendliness	1·9 (2·9)	4·2 (2·0)	1·41	3·6 (1·2)	2·1 (1·2)	0·71

PWB, Psychological Well-Being scale; SQ, Symptom Questionnaire.
* $P < 0{\cdot}05$; ** $P < 0{\cdot}01$; *** $P < 0{\cdot}001$.

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methods (antidepressant drugs or behavioural therapy). Nonetheless, the study provides important clinical insights.

A novel, specific, psychotherapeutic technique specifically addressed to increasing well-being was found to be significantly associated with a decrease in residual symptoms in patients with mood and anxiety disorders.

A significant advantage of well-being therapy over traditional cognitive–behavioural methods was disclosed by the Clinical Interview for Depression. However, the small number of subjects suggests caution in interpreting this difference, which was not supported by self-rated methods. This suggests the need for further studies with larger samples of patients with specific affective disorders.

Well-being therapy was based on self-monitoring of episodes of well-being by patients in a diary, including reasons (thoughts or beliefs) leading to interruption of well-being. The technique is aimed to changing beliefs and attitudes detrimental to well-being, to stimulating awareness of personal growth and recovery from affective illness, and to reinforcement of well-being promoting behaviour. It is based on Ryff's conceptual model of well-being as the result of self-acceptance, positive relations with others, autonomy, environmental mastery, purpose in life and personal growth (Ryff, 1989; Ryff & Singer, 1996). Such conceptual model has been extensively validated in non-clinical populations (Ryff & Singer, 1996). The technique is intended to be used mainly in the residual stage of affective illness (Fava & Kellner, 1993). Its effectiveness may be explained on the basis of several distinct yet converging issues.

In a naive conceptualization, yet the one implicitly endorsed by DSM-III and DSM-IV, well-being and distress may be seen as mutually exclusive (i.e. well-being is lack of distress). According to this model, well-being should result from removal of distress. Yet, there is evidence, both in psychiatric (Fava, 1982, 1996; Fava *et al.* 1986) and psychosomatic (Fava, 1992; Bech *et al.* 1996) research, to call such views in question. In particular, a balance of positive and negative affects was described in major depression (Garamoni *et al.* 1991) and was found to be affected by cognitive–behavioural therapy (Nofzinger *et al.* 1994). 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 also changes in well-being may affect the balance of positive and negative affects. In this sense, the higher degree of symptomatic improvement that was observed with well-being therapy in this study is not surprising: in the acute phase of affective illness, removal of symptoms may yield the most substantial changes, but the reverse may be true in its residual phase.

It should also be noted that interventions that bring the person out of negative functioning (e.g. exposure treatment in panic disorder with agoraphobia) are one form of success, but facilitating progression toward restoration of the positive is quite another (Ryff & Singer, 1996) and may require specific help. Meehl (1975) described how low hedonic capacity may affect interpersonal functioning (e.g. inducing shame and guilt) and how people with low hedonic capacities should pay greater attention to the 'hedonic bookkeeping' of their activities than would be necessary for people located midway or high on the hedonic capacity continuum. There has been little exploration, outside of psychodynamic realm, of psychological factors affecting progression to full recovery in affective illness. Well-being therapy may act upon those neglected factors.

It has been suggested that treatments that are effective in the acute phase of mood and anxiety disorders may not be the most suitable for their residual stage or for preventive purposes (Fava, 1996). Modifications of current cognitive behavioral strategies have been suggested in major depression (Fava *et al.* 1994, 1997*a*; Pava *et al.* 1994; Teasdale *et al.* 1995) and anxiety disorders (Astin, 1997; Fava *et al.* 1997*b*). Further research should verify whether well-being therapy may have a place as a relapse prevention strategy in specific disorders, either as a specific form of treatment or as a technique to be incorporated in a more complex, individualized treatment package. Such preventive action may be displayed either by affecting the progression from residual symptoms upon remission to prodromes of relapse (Fava *et al.* 1994, 1996*a*), or by decreasing vulnerability to stress (Ryff & Singer, 1996), or both. A recent study found that quality of life measurement, and not

symptomatic ratings, could predict recurrence of depression (Thunedborg *et al.* 1995). Even though well-being therapy was developed as a specific post-acute therapeutic strategy, it is also conceivable that it may be of value in selected cases of affective disorders, particularly if refractory to standard treatments. Since most of the patients in this study (all 17 with anxiety disorders) had received behavioural psychotherapy, it is also conceivable that the combination of behaviour therapy and well-being therapy may yield better results than the one with joint behavioural and cognitive strategies.

All of these issues warrant further investigation.

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