WELL-BEING THERAPY IN DEPRESSION

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DISCLOSURE OF CONFLICT OF INTEREST

Neither I or my spouse has a relevant financial relationship with a commercial interest to disclose. I have written a book on WBT, for which I receive no royalties.

- Residual symptoms, despite successful response to therapy, appeared to be the rule after completion of drug or psychotherapeutic treatment in both mood and anxiety disorders.

- The presence of residual symptoms was correlated with poor long-term outcome.

(Fava GA & Kellner R, *Am J Psychiatry* 1991)

These findings led to the hypothesis that residual symptoms upon recovery may progress to become prodromal symptoms of relapse and that treatment directed toward residual symptoms may yield long-term benefits.

(Fava GA & Kellner R, *Am J Psychiatry* 1991)

STAGES OF A PSYCHIATRIC DISORDER

STAGE 1: prodromal phase
STAGE 2: acute manifestations
STAGE 3: residual phase
STAGE 4: chronic (in attenuated or persistent form)

(Fava GA & Kellner R, *Acta Psychiatr Scand* 1993)

SEQUENTIAL TREATMENT

- Use of antidepressant drugs for the treatment of the acute episode.

- Use of psychotherapeutic strategies for the residual symptoms of depression, while antidepressant drugs are tapered and discontinued or continued.

(Fava GA et al., *Am J Psychiatry* 1994)

SEQUENTIAL MODEL

Treatment which potentially aims to different effects (e.g., pharmacotherapy and psychotherapy) may be used in a sequential order.

One type of treatment (e.g., psychotherapy) may be employed to improve symptoms which the other type of treatment (e.g., pharmacotherapy) was unable to affect.

(Fava GA et al., *Am J Psychiatry* 1994)

Another line of evidence potentially supporting the sequential model in affective disorders is the increasing awareness of the role of comorbidity.

In major depression, two-thirds of the patients meet the criteria for another Axis I disorder (particularly anxiety disorders) and one third has 2 or more disorders.

(Zimmerman M et al., *J Clin Psychiatry* 2002)

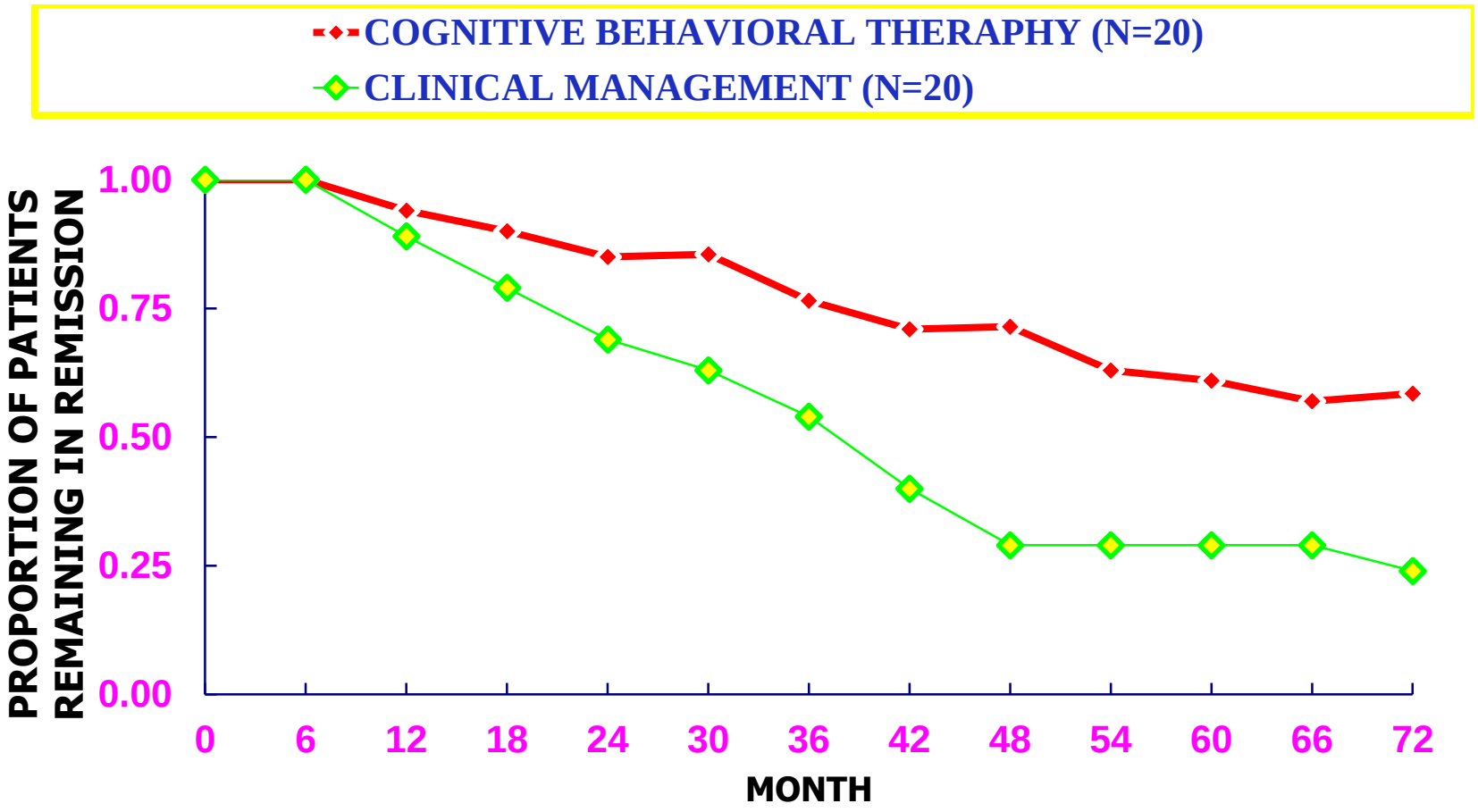
It is thus unlikely that monotherapy may entail solution to such complex disturbances, also since some forms of comorbidity may be covered by the acute manifestations of the disorder and become evident only when the most severe symptoms have abated.

(Fava GA, *Psychol Med* 1999)

In a controlled trial, 40 patients with major depressive disorder, who had been successfully treated with antidepressant drugs, were randomly assigned to either cognitive behavioral treatment or clinical management of residual symptoms. In both groups antidepressant drugs were tapered and discontinued.

(Fava GA et al., *Am J Psychiatry* 1994)

PROPORTIONS OF DEPRESSED PATIENTS WHO REMAINED IN REMISSION 6 YEARS AFTER COGNITIVE BEHAVIORAL THERAPY OR CLINICAL MANAGEMENT FOR RESIDUAL SYMPTOMS



RYFF'S PSYCHOLOGICAL WELL-BEING SCALES

Autonomy

Environmental mastery

Interpersonal relationships

Personal growth

Purpose in life

Self-acceptance

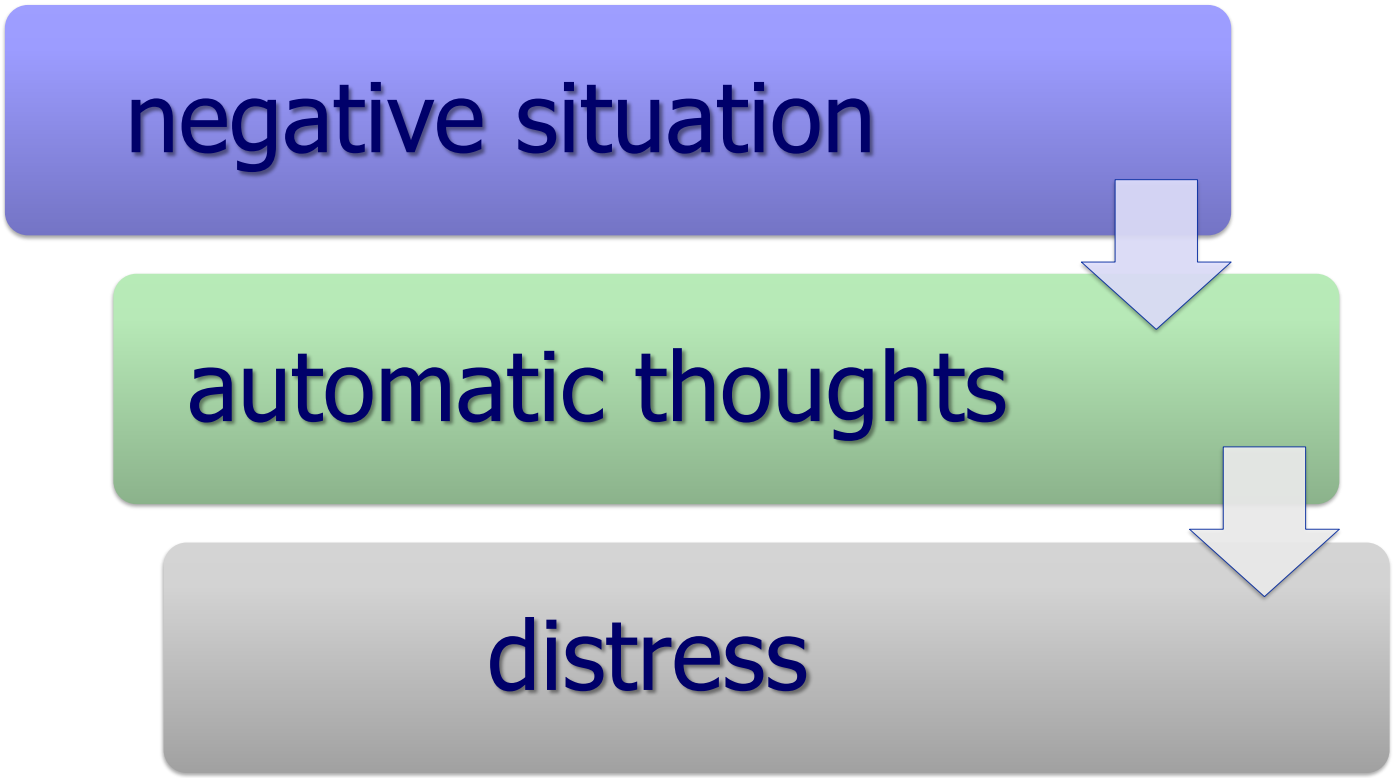
(Ryff CD, *J Consult Clin Psychol* 1989)

PSYCHOMETRIC CHARACTERISTICS OF REMITTED PATIENTS WITH AFFECTIVE DISORDERS (n=20) AND HEALTHY CONTROL SUBJECTS

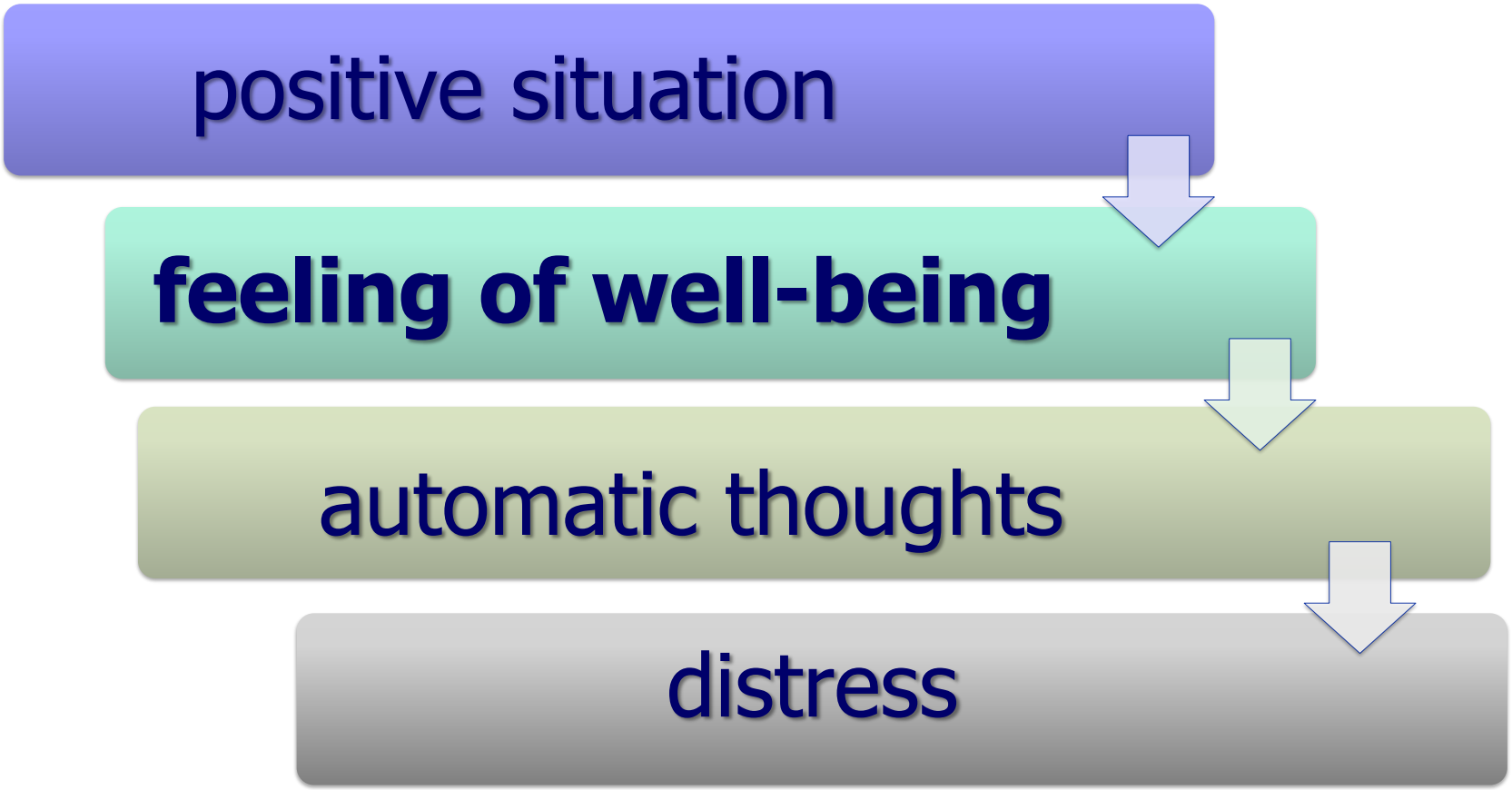
SCALE	PATIENTS MEAN (SD)	CONTROLS MEAN (SD)	t VALUE (df=18)
CLINICAL INTERVIEW FOR DEPRESSION (CID)	41.3 (4.6)	28.8 (4.2)	8.29***
PWB AUTONOMY	7.5 (4.1)	10.8 (2.2)	3.20**
PWB ENVIRONMENTAL MASTERY	4.7 (3.9)	9.8 (2.8)	4.76***
PWB PERSONAL GROWTH	9.1 (3.0)	11.7 (1.6)	3.47**
PWB POSITIVE RELATIONS	7.6 (3.5)	11.7 (2.2)	4.51***
PWB PURPOSE IN LIFE	6.6 (3.9)	10.2 (2.7)	3.44**
PWB SELF ACCEPTANCE	4.3 (3.7)	10.9 (2.7)	6.42***

**p<.01 ***p<.001

COGNITIVE THERAPY



WELL-BEING THERAPY



PRINCIPLES OF WELL-BEING THERAPY

- It is a structured, manualized, problem oriented technique, that extends over 8-16 sessions. The number of sessions can be abridged if it is preceded by CBT.

- It emphasizes self-observation of well-being, with the use of a structured diary, and homework.

(Fava GA, *Psychother Psychosom* 1999;

Fava GA, *Well-Being Therapy*. Basel, Karger, 2016)

http://www.well-being-therapy.com

WELL-BEING THERAPY

Initial sessions

check up and self-monitoring of episodes of well-being, mastery and pleasure tasks (optimal experiences)

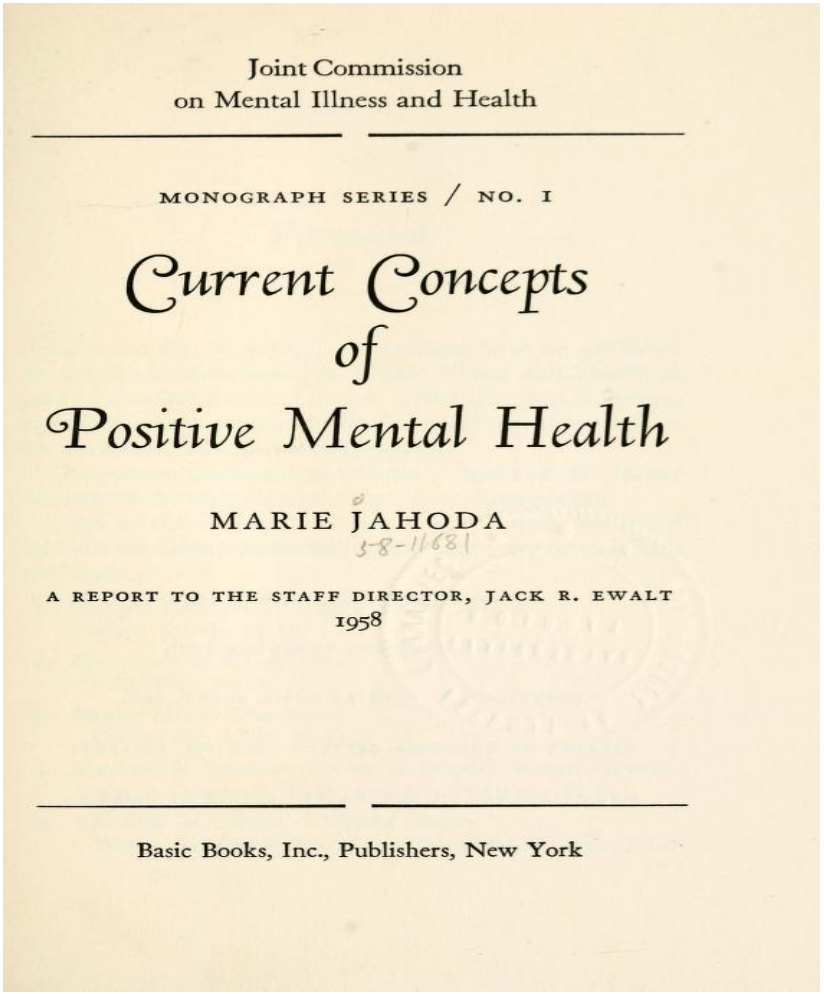
Intermediate sessions

identification of thoughts and beliefs leading to premature interruption of well-being

Final sessions

discussion and modification of dysfunctional beliefs according to well-being dimensions

http://www.well-being-therapy.com



Joint Commission
on Mental Illness and Health

MONOGRAPH SERIES / NO. I

Current Concepts of Positive Mental Health

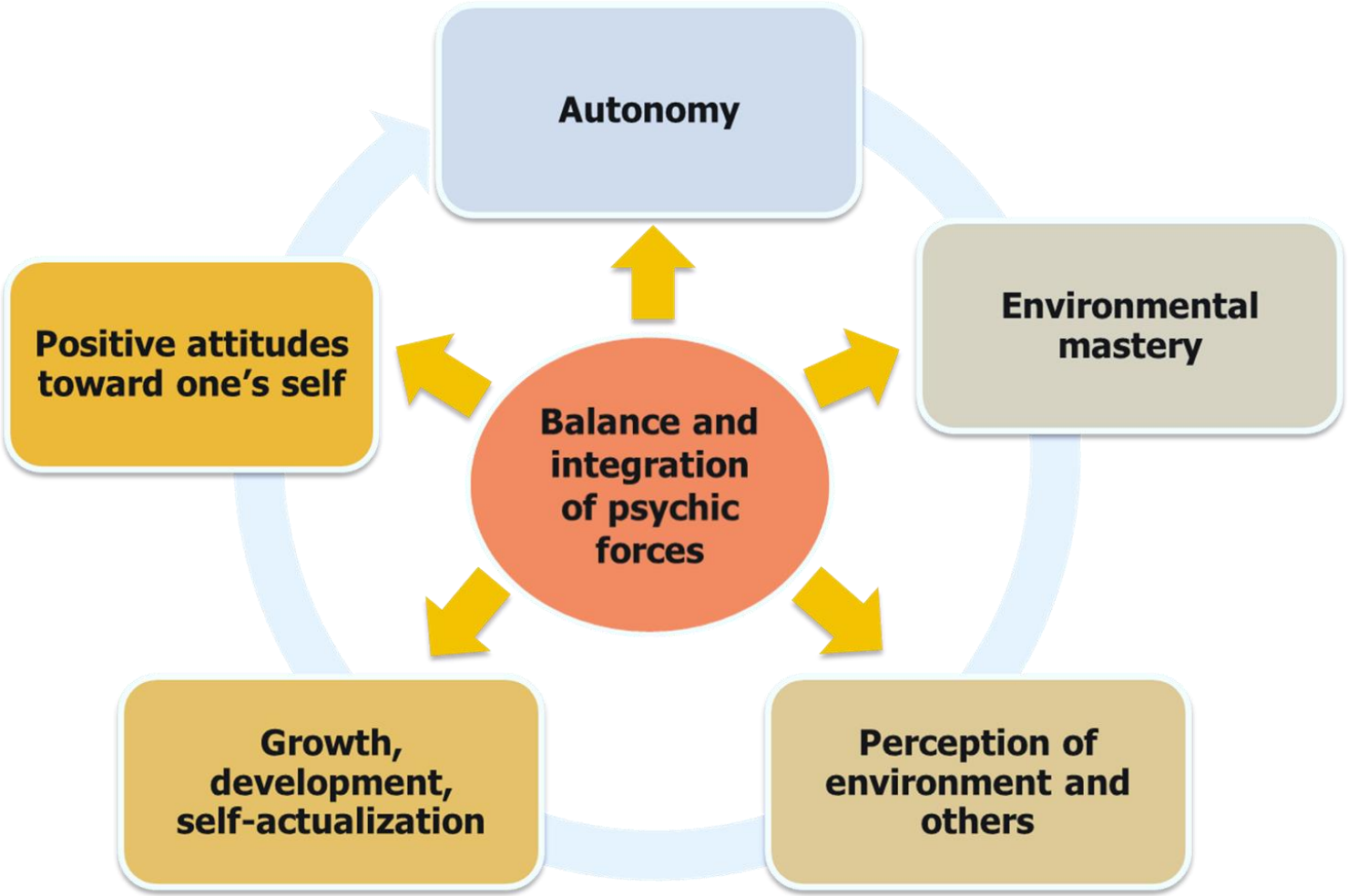
MARIE JAHODA

3-8-11681

A REPORT TO THE STAFF DIRECTOR, JACK R. EWALT
1958

Basic Books, Inc., Publishers, New York

JAHODA'S MODEL OF PSYCHOLOGICAL WELL-BEING



DIRECTIONS OF CHANGE: ENVIRONMENTAL MASTERY

LOW	BALANCED-FUNCTIONAL LEVEL	EXCESSIVE
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.	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.	Is unable to savoring positive emotions and hedonic pleasure. He/she is unable to relax.

(Fava GA, *Well-Being Therapy*. Basel, Karger, 2016)

DIRECTIONS OF CHANGE: PERSONAL GROWTH

LOW	BALANCED-FUNCTIONAL LEVEL	EXCESSIVE
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.	Has 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.	Is unable to process negativity, forgets or does not give enough emphasis to past negative experiences, cultivates benign illusions that do not fit with reality, sets unrealistic standards for overcoming adversities.

(Fava GA, *Well-Being Therapy*. Basel, Karger, 2016)

DIRECTIONS OF CHANGE: PURPOSE IN LIFE

LOW	BALANCED-FUNCTIONAL LEVEL	EXCESSIVE
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.	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.	Has obsessional passions, is unable to admit failures; manifests persistence and rigidity and is unable to change perspectives and goals; excessive hope hampers facing negativity and failures.

(Fava GA, *Well-Being Therapy*. Basel, Karger, 2016)

DIRECTIONS OF CHANGE: AUTONOMY

LOW	BALANCED-FUNCTIONAL LEVEL	EXCESSIVE
Is over-concerned 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.	Is self-determining and independent; able to resist to social pressures; regulates behavior from within; evaluates self by personal standards.	Is unable to get along with other people, to work in team, to learn from others; spends time and energy for fighting for his/her opinions and rights; relies only on himself/herself for solving problems, and is unable to ask for advice or help.

(Fava GA, *Well-Being Therapy*. Basel, Karger, 2016)

DIRECTIONS OF CHANGE: SELF-ACCEPTANCE

LOW	BALANCED-FUNCTIONAL LEVEL	EXCESSIVE
Feels dissatisfied with self; is disappointed with what has occurred in past life; is troubled about certain personal qualities; wishes to be different than what he/she is.	Has a positive attitude toward the self; accepts his/her good and bad qualities; feels positive about past life.	Narcissism, egocentrism, difficulties in admitting own mistakes, rigidity.

(Fava GA, *Well-Being Therapy*. Basel, Karger, 2016)

DIRECTIONS OF CHANGE: POSITIVE RELATIONS WITH OTHERS

LOW	BALANCED-FUNCTIONAL LEVEL	EXCESSIVE
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.	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; his/her generosity and altruism have a cost in terms of allostatic load; sacrifices his/her needs and well-being for those of others.

(Fava GA, *Well-Being Therapy*. Basel, Karger, 2016)

20 patients with mood and anxiety disorders

successfully treated by pharmacological or behavioral methods

Well-Being Therapy (WBT)

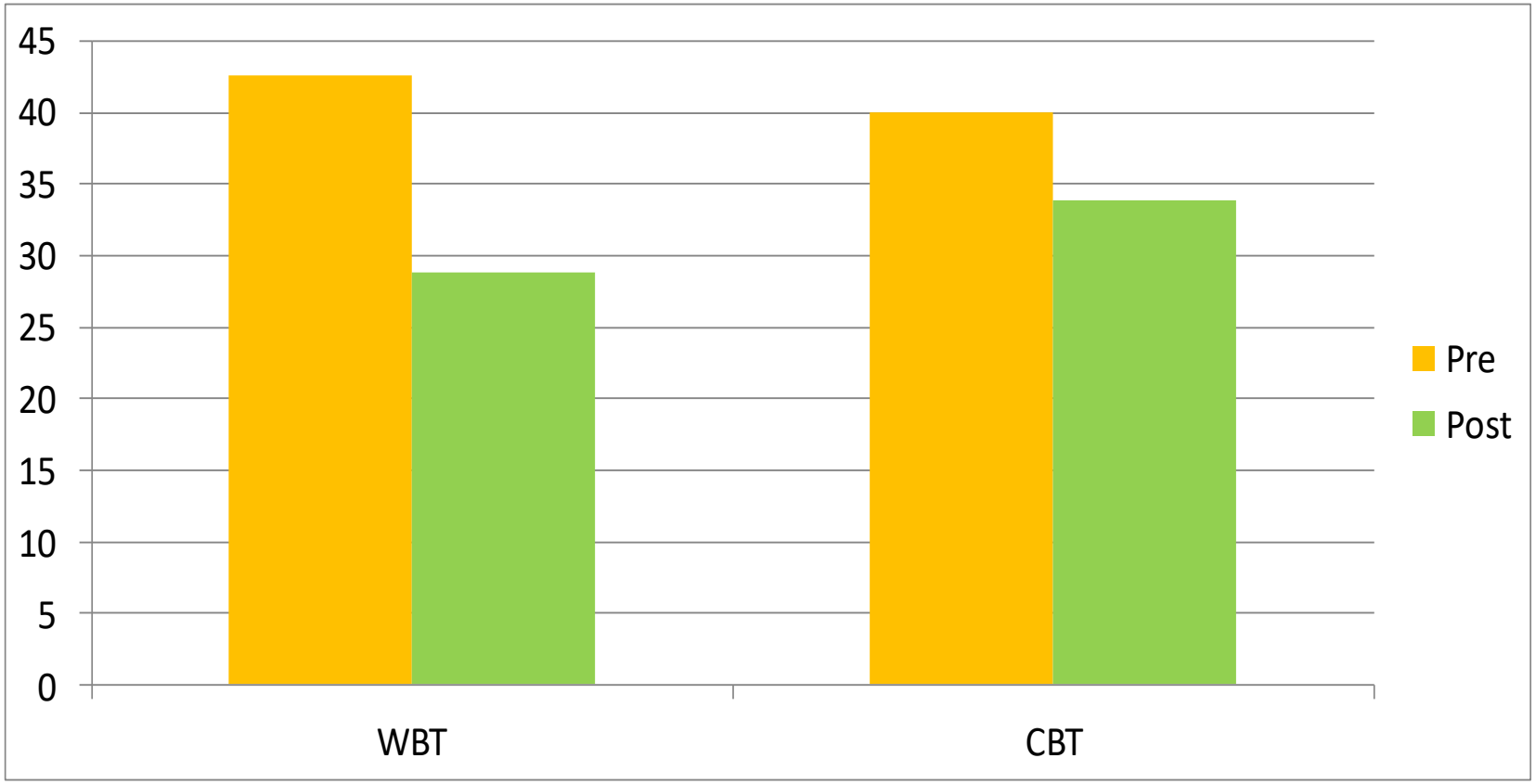
CBT of residual symptoms

(Fava GA et al., *Psychol Med* 1998)

Both well-being and cognitive behavioral therapies resulted in a significant reduction of residual symptoms. However, well-being therapy was found to be significantly more effective than cognitive-behavioral strategies.

(Fava GA et al., *Psychol Med* 1998)

WELL-BEING THERAPY FOR RESIDUAL DEPRESSION: CID SCORES



p<.001

(Fava GA et al., *Psychol Med* 1998)

40 patients with recurrent major depressive disorder

successfully treated with ADs

sequential combination of CBT and WBT

Clinical Management (CM)

(Fava GA et al., *Arch Gen Psychiatry* 1998)

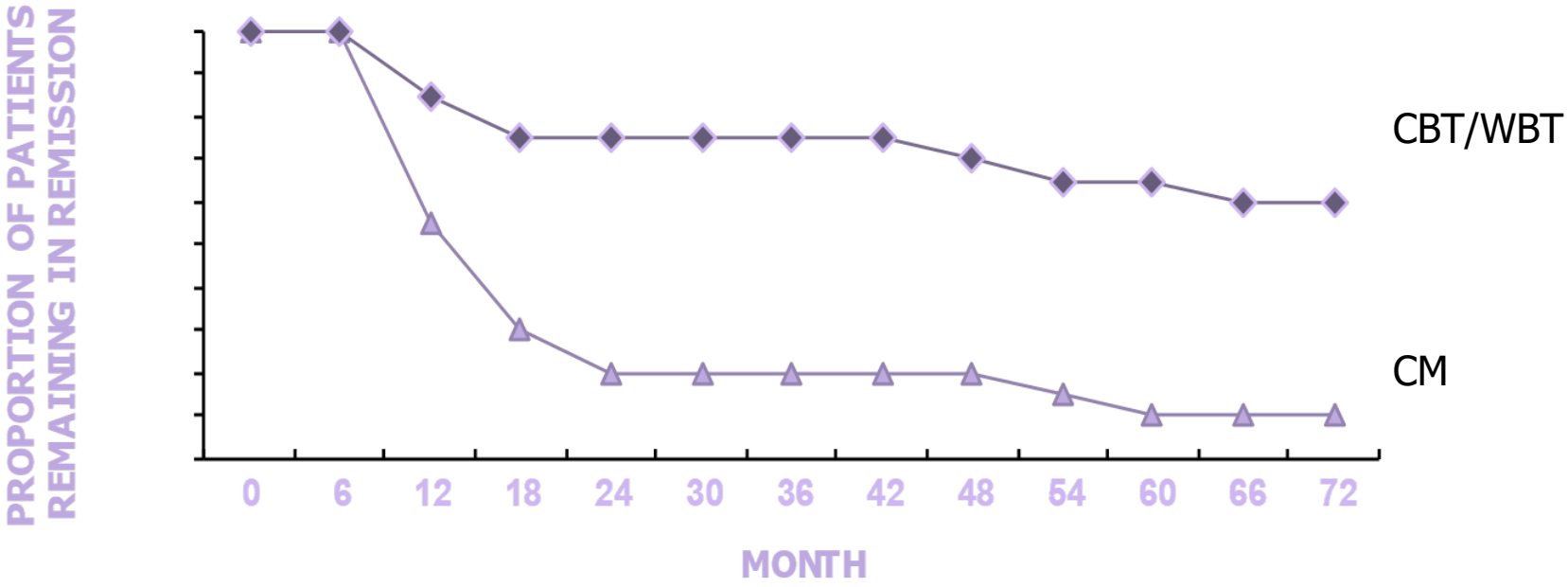
In both groups, during the 20 week experimental period, antidepressant drugs were tapered and discontinued. A 6-year follow-up was undertaken. During this period, no antidepressant drugs were used unless a relapse ensued.

Well-Being Therapy, associated with cognitive-behavioral treatment of residual symptoms, was significantly more effective than clinical management in preventing relapse in recurrent depression.

(Fava GA et al., *Arch Gen Psychiatry* 1998;

Fava GA et al., *Am J Psychiatry* 2004)

SIX-YEAR OUTCOME



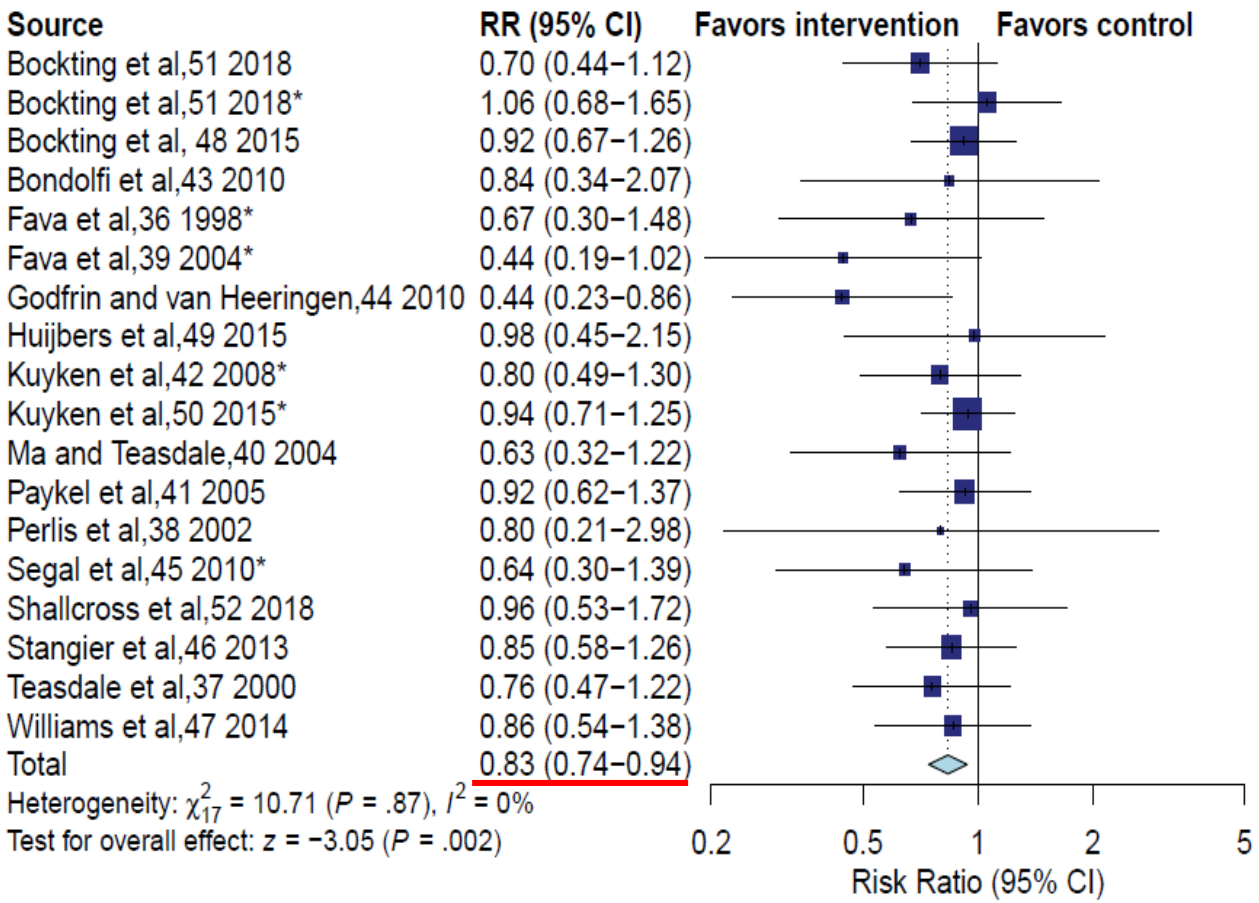
The results were replicated in Germany by Stangier et al. (*Am J Psychiatry* 2013), who added WBT and Mindfulness to CBT in adult patients and Kennard et al. in the US (*Am J Psychiatry* 2014) who applied the combination of WBT and CBT to pediatric depression.

Elements of WBT have also been employed by Farb et al. (*J Consult Clin Psychol* 2018) in Canada and Bockting et al. (*Lancet Psychiatry* 2018) in the Netherlands.

META-ANALYSIS BY GUIDI J & FAVA GA, *JAMA PSYCHIATRY* 2021

The sequential integration of psychotherapy following response to acute-phase pharmacotherapy, alone or combined with ADM, may be protective against relapse and recurrence in MDD.

META-ANALYSIS OF 17 RCTS INVOLVING THE SEQUENTIAL MODEL IN MDD



20 patients with generalized anxiety disorder

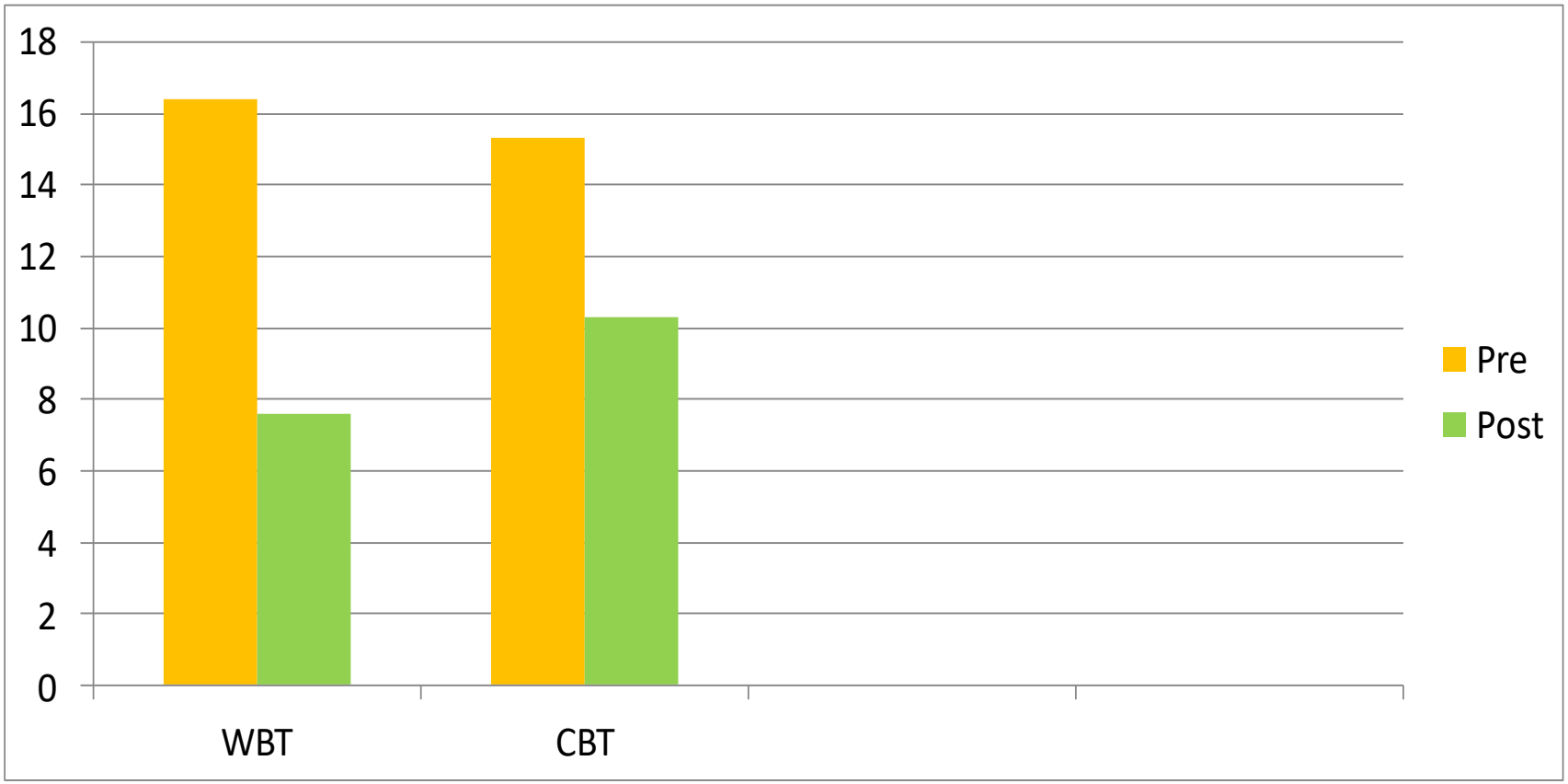
8 sessions of cognitive behavioral treatment

4 sessions of CBT, followed by 4 sessions of WBT

(Fava GA et al., *Psychother Psychosom* 2005)

The sequential combination of CBT+WBT was significantly superior to CBT for anxiety, depression and psychological well-being.

WELL-BEING THERAPY FOR GAD: CID ANXIETY SCORES



p<.01

(Fava GA et al., *Psychother Psychosom* 2005)

The results indicate that WBT is a specific and effective ingredient in the sequential combination of CBT and WBT.

THE TREATED-ACS STUDY

Cognitive-behavioral TREATmEnt of Depression in patients with Acute Coronary Syndrome

(Rafanelli C et al., *Psychother Psychosom* 2020)

100 patients meeting DSM-IV criteria for depressive disorders and/or DCPR criteria for demoralization after 1 month from a first episode of myocardial infarction or unstable angina

CBT+WBT+lifestyle modification

Clinical Management (CM)

Twelve 45-minute sessions, once a week

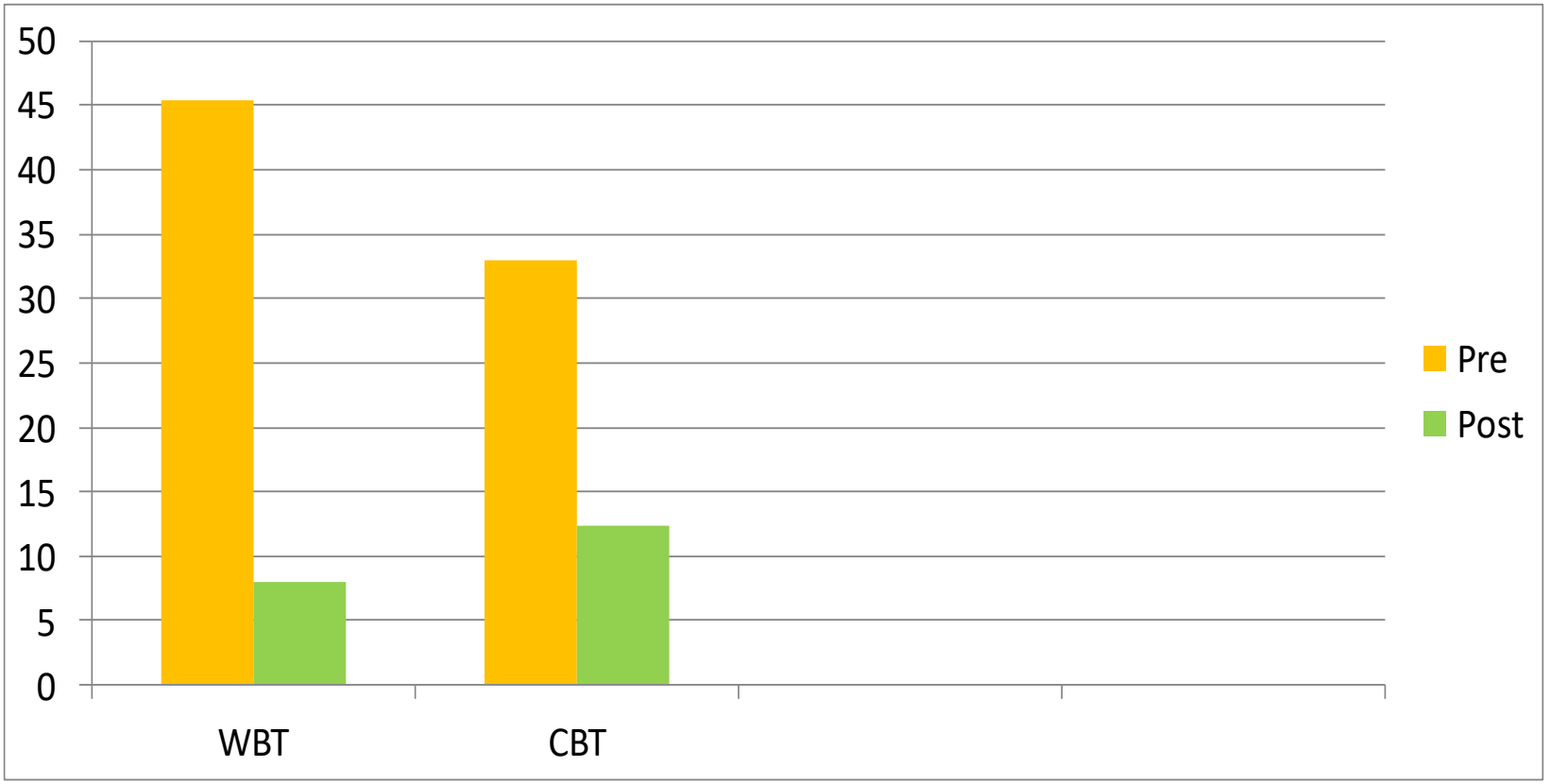
RESULTS

- CBT/WBT sequential combination was associated with a significant improvement in depressive symptoms compared to CM.

- In both groups, the benefits persisted at 30-month follow-up, even though the differences faded.

- Treatment was also related to a significant amelioration of biomarkers (platelet count, HDL, and D-dimer), whereas similar frequencies of adverse cardiac events were observed.

WBT vs CBT FOR DEPRESSION IN IRANIAN UNIVERSITY STUDENTS: BDI SCORES



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(Moeenizadeh M & Salagame KKK, *Int J Psych Studies* 2010)

HOW SHOULD WBT BE APPLIED?

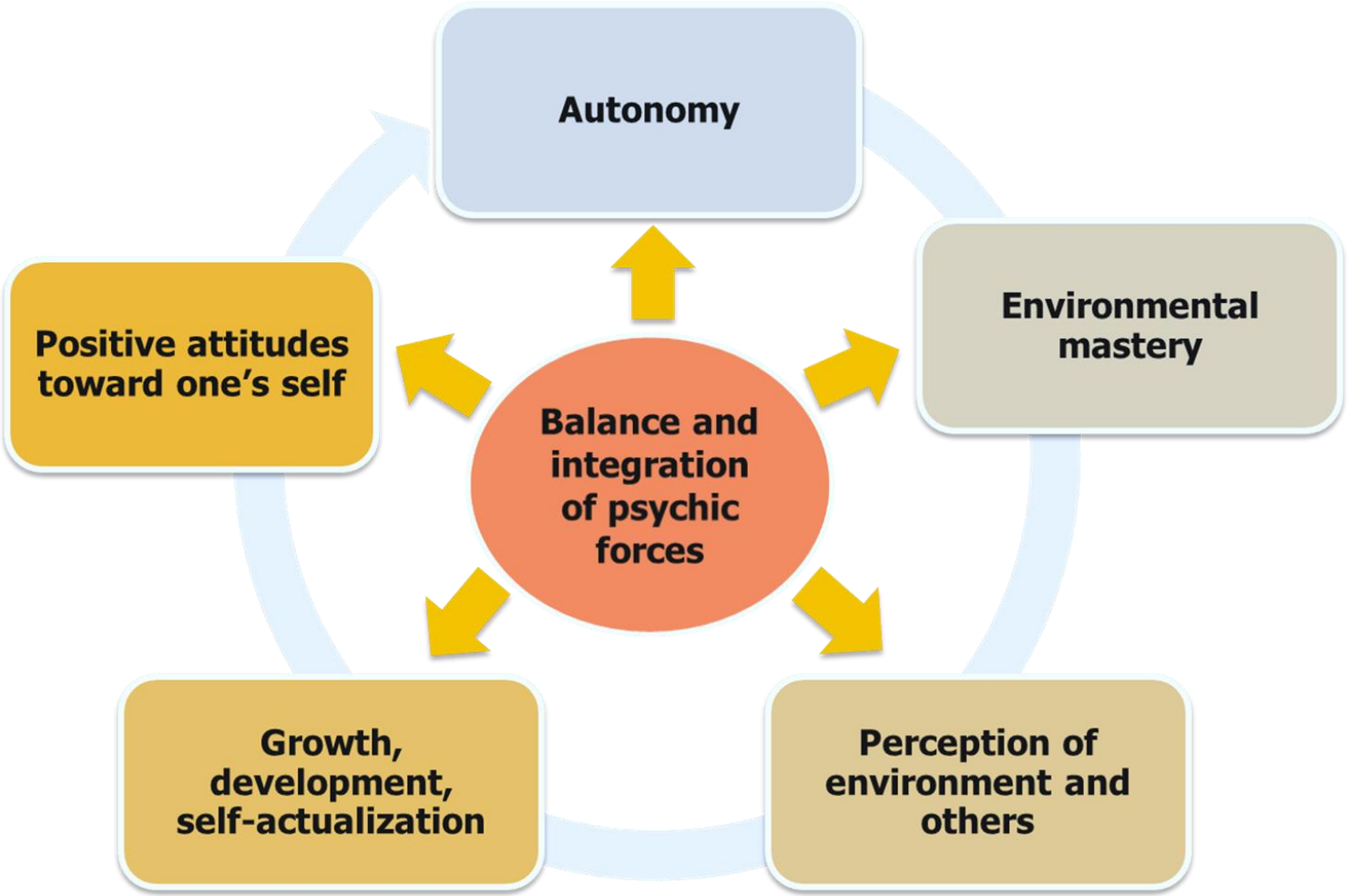
The application departs from the concept of treatment package that is applied to all patients on the basis of a diagnosis. Most of the patients who are seen in clinical practice have complex and chronic disorders.

(Fava GA et al., *J Clin Psychiatry* 2012)

The use of WBT should follow clinical reasoning and case formulation and is based on the concept of euthymia.

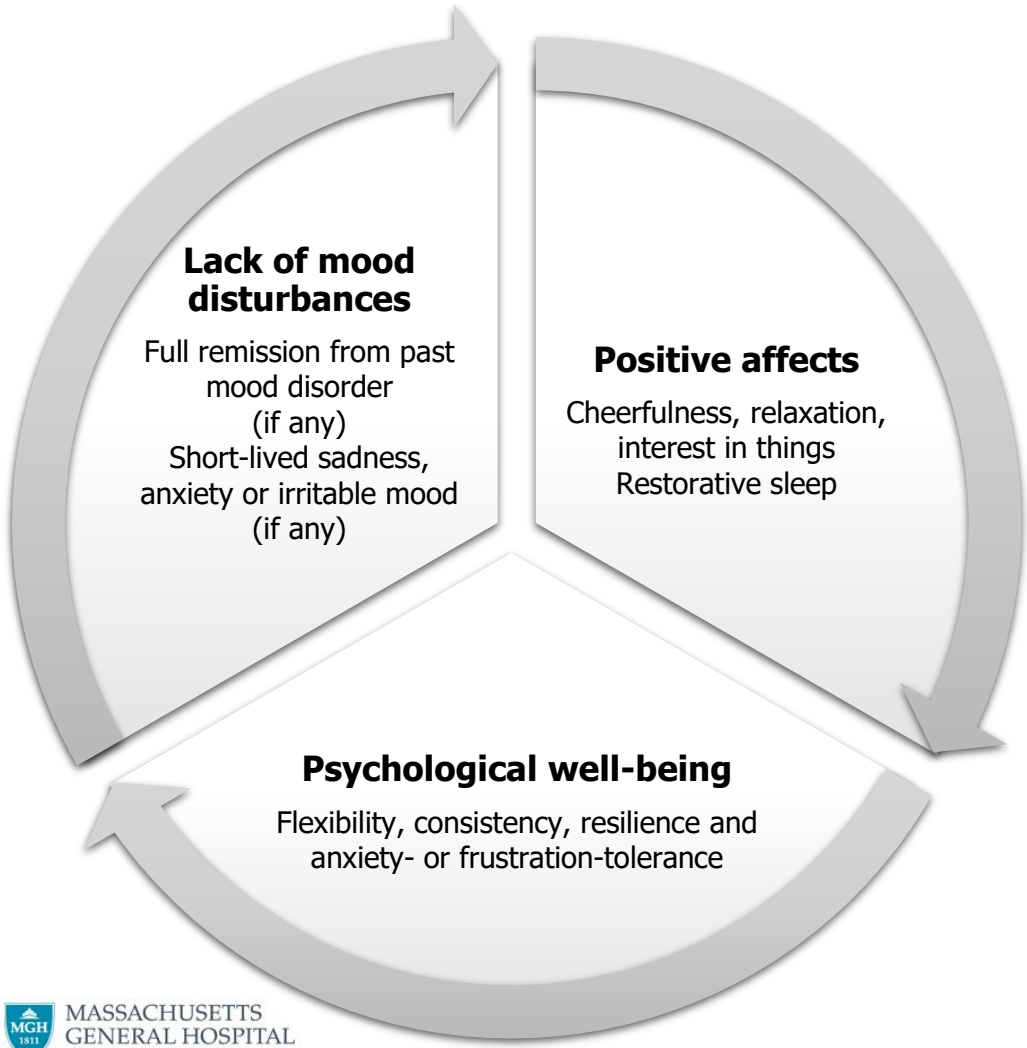
(Fava GA & Guidi J, *World Psychiatry* 2020)

JAHODA'S MODEL OF PSYCHOLOGICAL WELL-BEING



THE CONCEPT Of EUTHYMIA

(Fava GA & Bech P, *Psychother Psychosom* 2016)



a. **Lack of mood disturbances** that can be subsumed under diagnostic rubrics. If the subject has a prior history of mood disorder, he/she should be in full remission. If sadness, anxiety or irritable mood are experienced, they tend to be **short-lived**, related to specific situations, and do not significantly affect everyday life.

b. The subject has **positive affects**, i.e., feels cheerful, calm, active, interested in things, and sleep is refreshing or restorative.

c. The subject manifests **psychological well-being**, i.e., displays balance and integration of psychic forces (**flexibility**), a unifying outlook on life which guides actions and feelings for shaping future accordingly (**consistency**), and resistance to stress (**resilience** and tolerance to anxiety or frustration).

THE EVOLVING SCIENCE OF EUTHYMIA

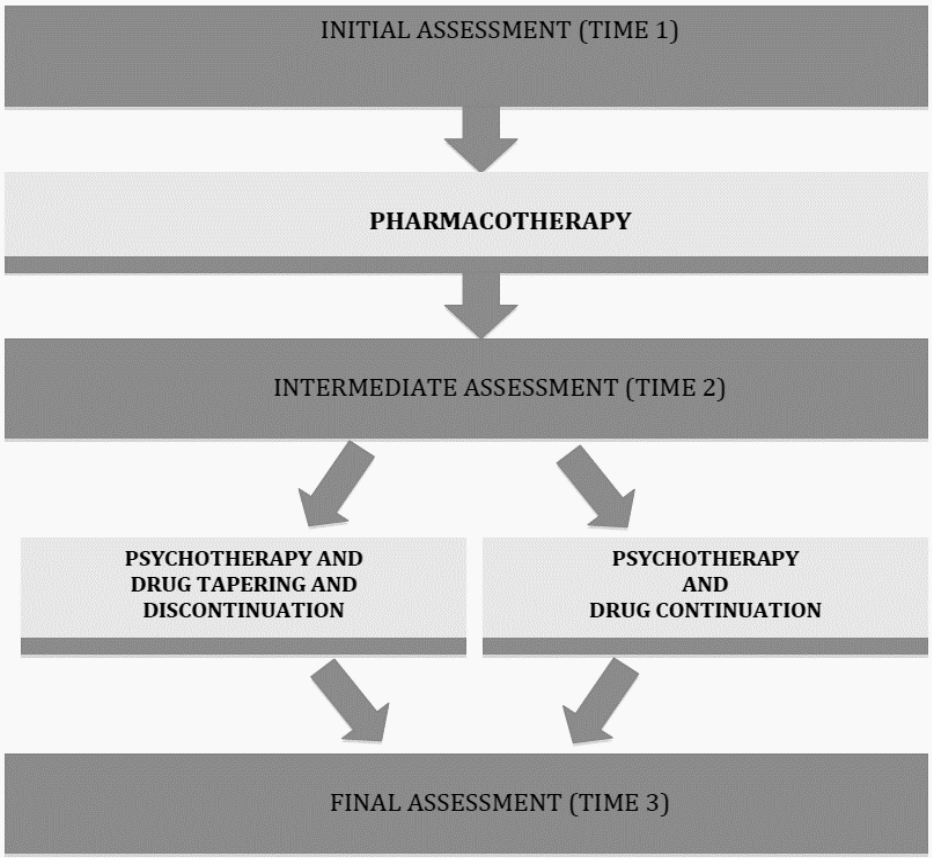
There is increasing evidence that the evaluation of euthymia and its components has major clinical implications. Specific instruments (clinical interview and self-rated questionnaires) may be incorporated in an innovative assessment strategy.

(Fava GA & Guidi J, *World Psychiatry* 2020)

CONCEPTUAL SHIFTS

- **Repeated assessments**

THE SEQUENTIAL INTEGRATION OF PHARMACOTHERAPY AND PSYCHOTHERAPY IN THE TREATMENT OF DEPRESSION



CONCEPTUAL SHIFTS

- Repeated assessments
- **Clinimetric approach**

Macroanalysis establishes a relationship between co-occurring syndromes and problems on the basis of where treatment should begin in the first place.

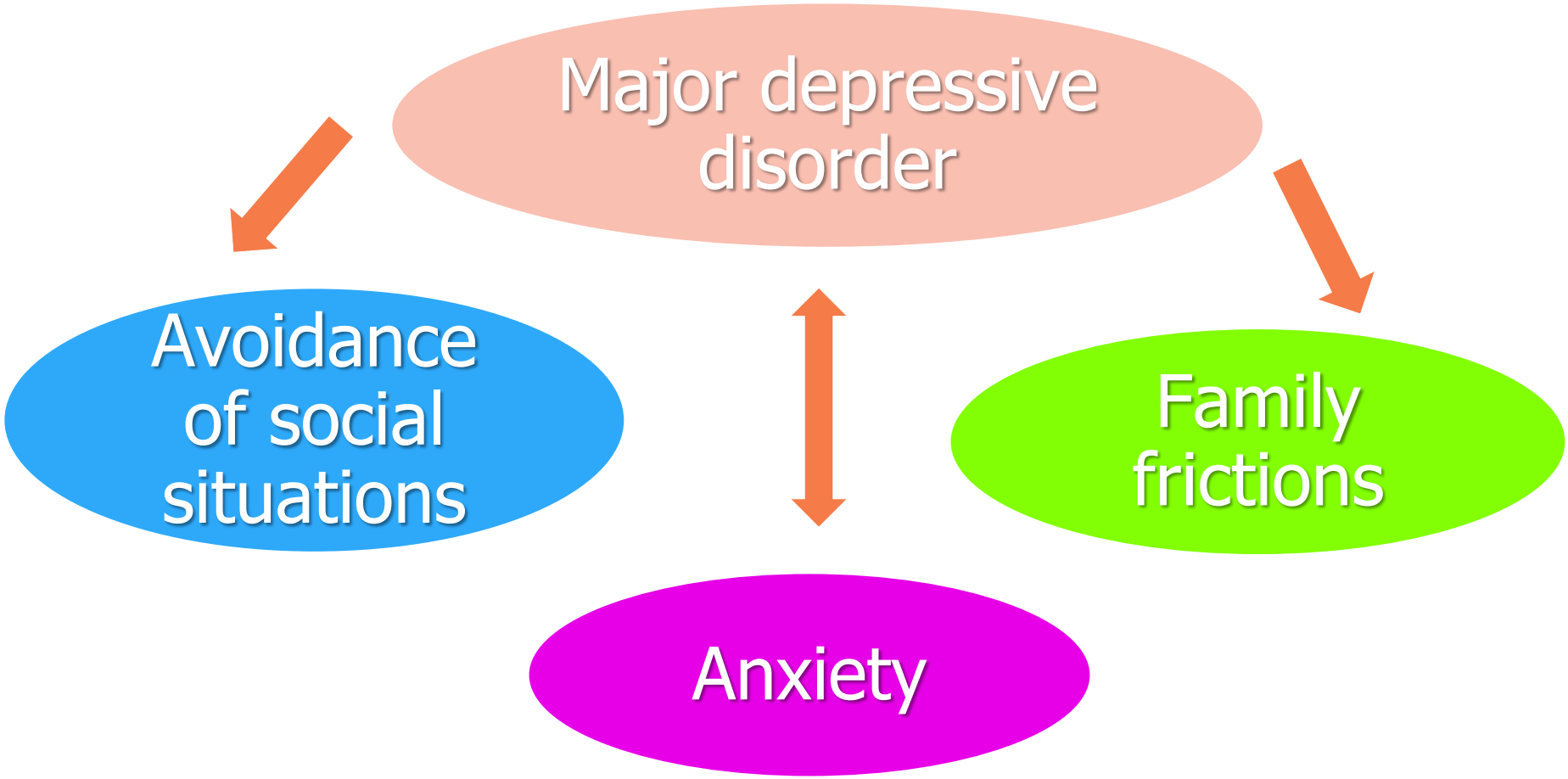
(Emmelkamp PMG et al., *Psychother Psychosom* 2004;

Fava GA et al., *The psychosomatic assessment*. Karger, Basel, 2012)

MACROANALYSIS OF A DEPRESSED PATIENT (1)

Ms A. is a 42 year old woman with a major depressive disorder who, because of loss of interest and irritability, is having problems in the family and withdrawal from social activities. Depression is severe and mixed with anxiety symptoms.

MACROANALYSIS OF A DEPRESSED PATIENT (STAGE 1)

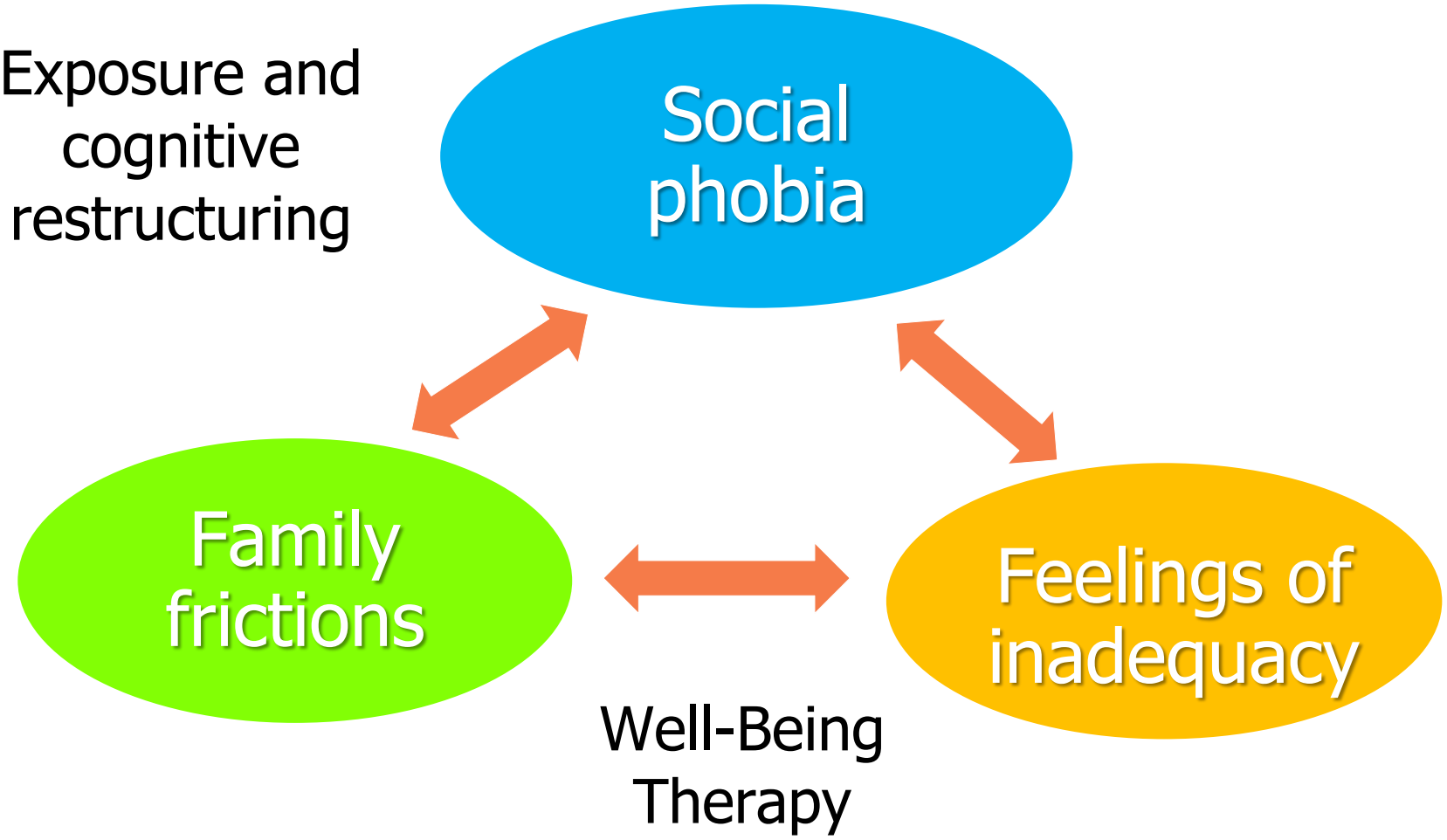


MACROANALYSIS OF A DEPRESSED PATIENT (2)

When a new assessment is performed, after the first line of treatment (pharmacotherapy) has improved the depressive symptomatology, other areas of concern may appear or may modify those already present.

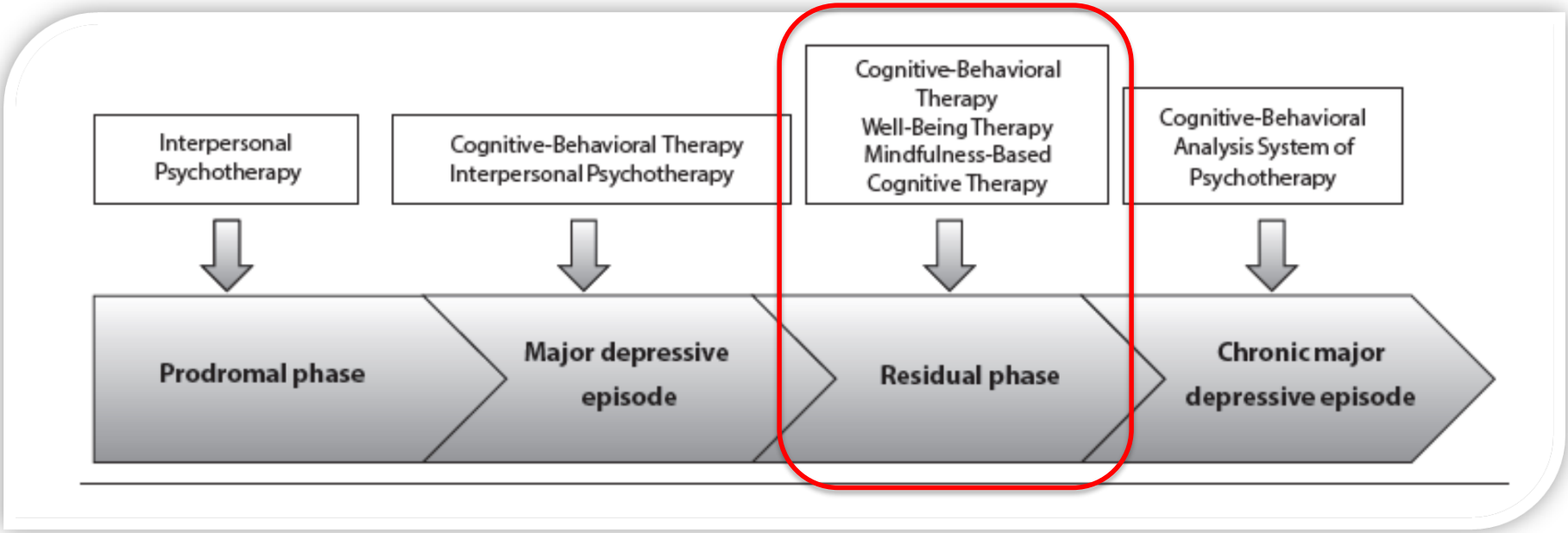
MACROANALYSIS OF A DEPRESSED PATIENT (STAGE 2)

Exposure and cognitive restructuring



CONCEPTUAL SHIFTS

- Repeated assessments
- Clinimetric approach
- **Staging**



(Guidi J et al., *J Clin Psychiatry* 2017)

CONCEPTUAL SHIFTS

- Repeated assessments
- Clinimetric approach
- Staging
- **Individualized treatment**

The sequential model departs from the concept of disease as the primary focus of medical care. Clinical decision making is based on the attainment of individual goals and the identification of all modifiable biological and non biological factors.

CONCEPTUAL SHIFTS

- Repeated assessments
- Clinimetric approach
- Staging
- Individualized treatment
- **The multidisciplinary treatment team**

Fava GA et al. (*World Psychiatry* 2008) have suggested a treatment team encompassing psychiatrists, psychotherapists and internists.

This multidisciplinary team is particularly important with discontinuation of antidepressant drugs.

ADDRESSING TOLERANCE TO ANTIDEPRESSANT DRUGS

- **Loss of clinical effects**

In a small pilot RCT, the sequential combination of CBT/WBT was compared to dose increase in patients who relapsed while taking antidepressants. Most of the patients who had their doses increased responded, but relapsed again within a year. Most of the patients who received psychotherapy responded, and were well at follow-up.

(Fava GA et al., *Am J Psychiatry* 2002)

ADDRESSING TOLERANCE TO ANTIDEPRESSANT DRUGS

- Loss of clinical effects
- **Resistance if the same treatment is reinstituted**

In case reports (e.g., Sonino N and Fava GA, *J Psychiat Res* 2003) resistance to treatment was overcome by sequential use of CBT and WBT.

ADDRESSING TOLERANCE TO ANTIDEPRESSANT DRUGS

- Loss of clinical effects
- Resistance if treatment is reinstituted
- **Withdrawal reactions**

DEPENDENCE AND WITHDRAWAL REACTIONS

Withdrawal reactions are frequent with antidepressant drugs, particularly with SSRI and SNRI, also with slow tapering, and may persist months after discontinuation (**persistent postwithdrawal disorders**).

(Chouinard G et al., *Psychother Psychosom* 2015;

Fava GA et al., *Psychother Psychosom* 2015)

The discontinuation of antidepressant drugs (particularly when they were prescribed at young age in anxiety disorders) constitutes a major clinical challenge. A protocol based on the sequential combination of CBT and WBT has been devised.

(Fava GA, *Discontinuing antidepressant medications*.

Oxford University Press, forthcoming)

Patients are told that they suffer from a **chemical imbalance** in the brain, that is the cause of their illness, that it needs to be fixed by purely chemical means, that psychotherapy is useless, and that personal efforts and responsibility have no part to play in getting better.

(Lipowski ZJ, *Can J Psychiatry* 1989)

The long-term outcomes of depression may be unsatisfactory not because technical interventions are missing, but because our conceptual models and thinking are inadequate.