The Clinical Applications of Happiness Research

by

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DEDICATION

This project is dedicated to all of those who feel misplaced and unfulfilled. If they should read even a sliver of this document they will find that happiness is waiting for everybody.
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ABSTRACT OF THE DOCTORAL PROJECT

This project provides a comprehensive understanding of happiness and subjective well-being. The two constructs are defined and explored while highlighting what factors make happy people happy, and what characteristics are attainable to those looking to become happier. Happiness-boosting activities, their effectiveness and sustainability are identified, described, and discussed. These happiness interventions are also known as positive psychotherapy interventions, and their clinical applicability is explained and discussed. Some experimenters have found ways to apply older, well-established interventions that aim to decrease the negative, to instead, increase the positive. These interventions are also identified, described, and discussed. The effectiveness and the applicability of these interventions is examined, as well as the specifics of how they were implemented to achieve their results. This paper attempts to strengthen the argument that clinicians can and should begin incorporating the increasing of happiness into their practice, and the research on happiness interventions provides strong confirmation that such interventions are effective. This project also discusses what does not work in the pursuit of happiness, and how mental health professionals can guide clients away from poor judgments and misguided assumptions, and hopefully prevent disappointment.

Keywords: Happiness, subjective well-being, life satisfaction, happiness interventions, positive psychotherapy
Statement of Purpose

Many people seek the services of a therapist to alleviate their emotional pain and distress or to treat the symptoms of a psychological disorder. Clinicians are trained in a variety of interventions that are mainly geared towards reducing adverse symptoms, countering cognitive distortions, modifying maladaptive behaviors, and extracting insights. In other words, many therapists are adept at decreasing a client’s depression, anxiety, and other maladies. However, few therapists have the requisite skills, training, and clinical prowess to increase their clients’ happiness.

In the early-mid 20th century, researchers studied happiness primarily as an affective construct. It was not until 1977 that the first comprehensive experiment to increase personal happiness was conducted, by Dr. Michael Fordyce. The importance of this study, as well as all future studies designed to boost personal happiness, and, one’s overall satisfaction with life, are self-evident: Obtaining higher levels of happiness is an important goal for the human race, and being able to provide psychologists, therapists, and other mental health professionals with reliable tools that can increase happiness and life satisfaction would be a coveted and great asset (Fordyce, 1977).

The study of happiness and subjective-well being is often referred to as positive psychology, and in the past decade it has been the subject of many best-selling, self-help books. These books offer insights on what might increase happiness and lead to a more meaningful and satisfying life. Unfortunately, these best-selling, books offer clinicians little, if anything, in terms of concrete and effective treatment interventions that can be readily applied in practice.
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Fortunately, scientists have begun to utilize research about increasing happiness and life satisfaction to design experiments, and test interventions that, if proven effective, could be used as treatment options in clinical settings. According to Fordyce (1977), people are capable of experiencing a higher potential for happiness than they typically attain; and most people’s happiness is accidental, achieved mainly through uninformed and unguided efforts. This clearly implies that there is an opening - an obligation, perhaps - for psychologists to provide clients with the education and directives on how to change their attitudes and behaviors in order to achieve a higher level of happiness and a greater overall satisfaction with their lives. Happiness no longer needs to be attained through a process of assumptions and guesswork. It can now be an evidenced-based practice with valid and reliable techniques.

According to Lichter, Haye, and Kammann (1980), happiness has an inverse relationship with depression. Their study showed that several reliable and valid measures of depression decreased after an intervention was implemented that increased happiness. This indicates that a clinician could potentially treat a client for depression without making the depression, its symptoms, and its causes, the primary focus of the treatment. It seems possible that a clinician could treat a client with interventions designed to increase levels of happiness and, in turn, decrease the client’s depression at the same time.

Numerous experiments have been conducted and the results have been promising, so much so that the notion of interventions aimed at increasing happiness have begun to gain credibility as legitimate intervention options for clinicians. In theory, when a client walks into a therapist’s office and proclaims, “I want to be happier,” a clinician should
honestly be able to answer, “I can help you with that.” In reality, however, it might be difficult, if not impossible, for a modern-day client to find a clinician who knows enough about happiness and happiness-boosting interventions to honestly give that answer. In fact, one would be hard pressed to find psychologists trained in interventions specifically designed to increase happiness. Many mental health professionals may be unaware of the literature and research, and that such interventions are even available to them at all.

According to Sin and Lyubomirsky (2009), no comprehensive literature review has been written on happiness-increasing interventions. This is astounding, considering that a great deal of the research on happiness interventions that have been designed and conducted has shown significant and effective results (Sin & Lyubomirsky, 2009). It seems that the time is now appropriate – and, perhaps for many mental health consumers, even necessary – for clinicians to incorporate the increasing of happiness and life satisfaction as a viable treatment goal and, more importantly, an essential component of how they practice psychotherapy.

**Goals and Objectives**

Knowing what makes a happy (or, happier) person is the first step in being able to competently apply happiness-increasing interventions in clinical practice. The same requirement is necessary in order to help a client increase their satisfaction with life.

The first goal of this project is to provide a comprehensive understanding of happiness and subjective well-being. Only with a comprehensive understanding of what factors make happy people happy, as well as what characteristics are reasonably attainable to those looking to become happier, can clinicians guide their clients in the appropriate directions and towards the most effective happiness-boosting activities and
behaviors. Furthermore, once one succeeds in increasing happiness and life satisfaction, the next step will be assuring that those gains are sustained over a long period of time.

This project will highlight and describe several strategies that have been tested and shown to make gains in happiness long-lasting.

The next goal of this project is to discuss the results, and more importantly, the procedures of happiness-increasing interventions. These interventions are also known as positive psychotherapy interventions, and the terms will be used interchangeably throughout this project. First, specific interventions will be identified and explained; then, their clinical applicability will be discussed.

Some experimenters have found ways to apply older, well-established interventions that aim to decrease the negative, to instead, increasing the positive. Since these therapies have been in practice for a considerable amount of time, many clinicians are already trained in them, and, with a few adjustments and shifts in focus, can be trained to use these established interventions for a new happiness-boosting goal.

Behavioral activation is one example of an intervention that appears to be easily modified and transformed into a happiness-increasing intervention. A primary focus of behavioral activation is to assist clients in exploring and pursuing educational and vocational goals (Jakupcak, Wagner, Paulson, Varra & McFall, 2010), as well as identifying enjoyable activities to engage and participate in (Jakupcak et al., 2006).

Behavioral activation is an intervention that is typically applied to decrease depression and other adverse emotions. One of the main features of behavioral activation and happiness interventions is participating in meaningful and pleasurable activities. Considering that the activation of behavior is frequently embedded in most happiness
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interventions, some researchers have argued that behavioral activation – a well-established intervention – might be easily adjusted to be used as a positive psychotherapy intervention, and, therefore, increase happiness and well-being (Mazzucchelli, Kane, & Rees, 2010). Since behavioral activation interventions are already a prominent clinical practice, research that has found ways to use behavioral activation as a positive psychotherapy intervention will be discussed and illustrated to give clinicians trained in behavioral activation therapy – and who are eager to incorporate happiness-increasing strategies into their practice – a new way to use an old, familiar theory.

Once the happiness-increasing interventions have been described, the effectiveness of these interventions will be examined, as well as how they were implemented to achieve their results. This section will describe the findings of happiness research, highlight the most significant and applicable results, and bolster the argument that clinicians can and should begin incorporating the increasing of happiness into their practice.

The research on happiness interventions provides strong confirmation that such interventions are effective. Incorporating positive psychotherapy as a viable treatment intervention will give clinicians the ability to sincerely tell their clients that they can indeed help make them happier (Rashid, 2009).

It is the overall goal of this project to provide clinicians with a solid foundation in understanding interventions that focus on the positive (i.e. whose primary goal is to increase happiness) and how to apply them. Additionally, this project will discuss what does not work in the pursuit of happiness, and how mental health professionals can guide clients away from poor judgments and misguided assumptions, and hopefully prevent
disappointment. This project will identify several happiness interventions, illustrate how they work, and highlight their effectiveness. The interventions selected for review will be the ones that were designed for individual and group therapy, clinical populations, and nonclinical populations.
Applications of Happiness Research

Chapter II

Literature Review

For far too long, depression, anxiety, and psychological distress have been the primary focus of the field of psychology. The study of happiness and positive emotions has been largely neglected despite the fact that so many people look to psychologists to help them become happier. A survey conducted in 2000 looked at psychological abstracts since 1887 and found that negative emotions exceed positive emotions by a ratio of 14:1 (Myers, 2000). In other words, the field of psychology has done a comprehensive job researching and learning about the negative psychological and emotional experience. The profession's dearth of happiness-centric interest will be evident in this literature review, as the mindful reader will notice that most of the happiness interventions were designed and tested in the last decade.

Experiments have been created and interventions have been tested to increase happiness, many with promising results as the profession begins to shift more of its focus to the positive side of psychological and emotional experience.

The purpose of this paper is to review the literature on happiness and highlight for clinicians: what factors influence happiness; what are the traits of happy people; what are some of the misconceptions of happiness; how, if at all, can happiness be increased, and can those gains in happiness be sustained? Several interventions will be described, and it is the goal of this project that clinicians will use this information to find creative ways to incorporate the key components and ideas of these interventions, and research, into their treatment plans and goals.
Happiness and Subjective Well-Being

A survey of psychological publications provides a broad definition of personal happiness. It characterizes happiness as not just a transient mood but, mainly, a sense of one’s personal well-being and a comprehensive measure of one’s satisfaction with life, coupled with a general and persistent feeling of emotional well-being (Fordyce, 1977). In other words, it is a comprehensive feeling of overall contentment with life and an emotional perception that all is well.

Happiness is the term most often used to describe positive feelings and positive emotional experiences. Although words such as fulfillment, satisfaction, enjoyment, and serenity all carry their own nuances and circumstantial meanings, happiness is the word most typically applied and customarily understood for these various positive emotional states (Fordyce, 1983). A review of the literature on happiness shows that the terms “happiness” and “subjective well-being” are used interchangeably; this paper will do the same. While happiness is considered the colloquial term and subjective well-being is considered the scientific term, different researchers tend to prefer one term over the other.

The study of subjective well-being focuses on why certain factors – such as a person’s cognitive assessments and emotional responses – contribute to experiencing life in a positive manner, and how these various factors work and differ from one person to another. In other words, subjective well-being is concerned with the process that leads people to make positive evaluations of their lives (Diener, 1984). Additionally, there is both a cognitive and an affective component to subjective well-being. The cognitive component is the process of how people evaluate their life and circumstances, and the affective component is the felt emotional experience. People who have high levels of
subjective well-being, on average, have a positive evaluation of their lives, and on average, experience positive affect more of the time than negative affect (Diener and Diener, 1996).

Subjective well-being is essentially the constellation of three major components: low negative affect, high positive affect, and an overall satisfaction with life (Diener, 2000). Life satisfaction is further broken down into two components: 1) Overall satisfaction with life, and 2) Satisfaction with relevant and specific areas of life, such as work or interpersonal relationships (Diener, 2000).

Happy and Unhappy People

Subjective well-being is heavily dependent on how a person evaluates their own experiences. Some people assess a great deal of what happens to them as negative, while others assess what happens to them as positive. This subjective interpretation of objective experiences is one of the most critical factors that separates happy people from unhappy people (Myers & Diener, 1995).

Happiness is what one experiences when the presence of positive emotions is felt more often than not and negative emotions are relatively scarce. It is important to note that the intensity of positive emotions does not have to be strong, and, in fact, can even be very slight. Happy people state that they frequently feel mild to moderate levels of positive emotions throughout the day while engaged in different dimensions of their life, from work to social activities and so on (Diener, 2000).

Happy and unhappy people differ in many areas of well-being. Happy people are less susceptible to illness, less focused on themselves, and less insulting and antagonistic (Myers & Diener, 1995). People with low levels of subjective well-being evaluate the
circumstances and experiences of their life as unpleasant and unwanted, which leads to feeling adverse emotions such as sadness, anger, and worry. People with high levels of subjective well-being feel a prevalence of positive emotions and positive cognitions about life (Myers & Diener, 1995).

Happy people have a comprehensive feeling of satisfaction that flows into several essential areas of life, such as romantic relationships and work. Happy individuals mostly experience positive emotions because they positively evaluate their circumstances and experiences (Myers & Diener, 1995). In other words, people with high subjective well-being are in a good mood most of the time, which leads them to think that most aspects of their lives are also good. According to Myers and Diener (1995), there are three correlated components that create subjective well-being: a feeling of life satisfaction, feeling positive affect, and lack of negative affect, and it is because of these three factors that happiness is felt.

When compared to unhappy people, happy people are friendlier, less self-centered, less abusive, and less susceptible to illness (Myers, 2000). When comparing happy people to less happy people, it was discovered that less happy people do not experience more unhappy events than happy people. However, happy people tend to experience more happy moments than less happy people (Otake, Shimai, Tanaka-Matsumi, Otsui, & Fredrickson, 2006). These happy experiences often include receiving kindness from others, expressing more gratitude to others, and more reflecting on happier recollections. Additionally, when happy people experience happiness-inducing events and moments, their feeling of happiness tends to be of a greater magnitude than that of less happy people. In other words, they experience more happy moments, and the feeling
of happiness itself is stronger when compared to less happy people. Furthermore, it is because happy people are on average friendlier and more efficient that high levels of subjective well-being are beneficial for society (Diener, 2000), making happiness not only a worthwhile goal for individuals but also for entire communities and countries.

Happy people have several traits in common. They tend to be sociable, outgoing, and self-confident; they feel autonomous and are optimistic (Myers & Diener, 1995). One study compared very happy people to very unhappy people with a goal of finding the necessary variable to ensure happiness (Diener & Seligman, 2002). The study found that while there was not a single factor that could promise happiness, strong and satisfying social relationships were a trait of all happy people. In fact, it appears that happiness is not possible without close social relationships. Additionally, the happiest people spent more time socializing and not much time alone. When compared to unhappy people, happy people were more extroverted and more agreeable; had satisfying relationships with friends, family, and significant others; were less neurotic; and scored lower on measures of mental illness. The happiest people also experienced more positive emotions than negative emotions on a regular basis (Diener & Seligman, 2002).

According to Lyubomirsky and Dickehoof (2010), happiness might require a construal approach because it is the result of a cognitive and motivational process. Since health, income, and other life circumstances have only a minimal effect on happiness, it is a series of hedonically relevant psychological processes that determine how those circumstances impact well-being. A construal theory of happiness would require understanding those psychological processes, how they differ from person to person, and how those cognitive and motivational differences sustain or increase long-term happiness.
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and temporary mood states. Hedonically relevant psychological processes include: reducing dissonance; assessing/changing how one compares themselves to others; and assessing/changing how one reflects upon and evaluates oneself. Happy and unhappy people implement these processes differently to construe life events in such a way that perpetuates and encourages their happy or unhappy self-concepts (Lyubomirsky & Dickerhoof, 2010).

Areas of Well-Being

Several broad areas of life have been identified that could lead to gains in happiness. Such areas of life include work, faith, close relationships (i.e. marriage), and focusing on and pursuing reasonable goals that engage one’s skills. Work is an important factor in life satisfaction. It offers people a social environment that contributes to their personal identity and makes them feel like their life has a purpose and their day-to-day labor matters. Unfortunately for some, work can be unpleasant, boring, and unfulfilling. In order to optimize happiness, a person’s work and most of their activities should be challenging enough to captivate one’s interests and equal one’s skill level (Myers & Diener, 1995).

According to Ryff (1989) there are six essential areas of positive psychological functioning: autonomy, personal growth, self-acceptance, environmental mastery, positive relationships, and purpose in life. Ryff (1989) contends that functioning in all these dimensions is prerequisite to experiencing positive levels of well-being, with self-acceptance, purpose in life, and environmental mastery being highly correlated with life satisfaction, self-esteem, and affect balance. If increasing happiness is to be a goal of therapy, then focusing on and improving functioning in these 6 areas will be a necessary
The Perks of Positive Emotions

The benefits of positive emotions cannot be overstated. According to Fredrickson’s (1998) broad-and-build theory, positive emotions can be infinitely beneficial. Positive emotions, such as joy, interest, contentment, and love, have been shown to expand the range of a person’s attention and cognitions, as well as increase a person’s physical, intellectual, and social resources. Experiencing positive emotions encourages people to abandon familiar strategies and behaviors and motivates them to try creative and improvised ideas, thoughts, and actions. For example, if a person is experiencing love, this could foster other positive emotions such as joy or curiosity, which can then lead to savoring current experiences and exploring new experiences.

Because feeling positive emotions expands individuals’ range of ideas, thoughts, and behaviors, this in turn helps people to find and build their resources (Fredrickson, 1998). While emotions themselves are fleeting, personal resources are sustainable and can be drawn upon for future use, in different instances than the ones where they were first implemented, and during different affective experiences. Furthermore, positive emotions can reverse the impact of negative emotions and often have a salubrious effect. In other words, if therapy were geared towards increasing the experience of positive emotions, according to this theory, it would not only reduce negative emotions but it would also help accrete resources that could be used during future negative experiences and personal setbacks. If those seeking psychotherapy have problems, they can develop new strategies to solve those problems through experiencing positive emotions. And, these new strategies can be used again and again for different problems in the future.
One study that sought to test the benefits of positive emotions showed that happy people demonstrated stronger coping abilities (Fredrickson & Joiner, 2002). These coping abilities were enhanced by positive emotions and, in turn, positive emotions were enhanced by strong coping abilities. In other words, positive emotions not only feel good; they also strengthen coping skills, and strong coping skills elicit even more positive emotions (Fredrickson & Joiner, 2002). This indicates that when people are feeling good, they position themselves to think differently about their problems and setbacks and create new approaches to make adaptive changes. Additionally, these new strategies remain in their toolkit and can be used at later times, making future setbacks less distressing and easier to resolve.

Positive emotions also appear to play an important role in psychological resiliency. In the face of adversity, psychological resiliency provides a mechanism to cope and adapt to even the most trying moments. One study showed that those who have strong levels of psychological resiliency also experienced more positive emotions, which led them to evaluate stressful situations as less dangerous (Tugaed & Fredrickson, 2004).

Feeling pleasant emotions can act as a supplement to increase resiliency and one’s ability to regulate emotions. Furthermore, positive emotions have shown a capacity to quicken recovery from the physiological effect of negative feelings. Positive emotions also appear to play a role in “meaning making.” Those who feel positive emotions have a tendency to cope with negative experiences and setbacks by attributing positive meaning to their suffering (Tugaed & Fredrickson, 2004).

Furthermore, happiness/positive emotion is correlated with being imaginative,
efficient, resilient, successful coping, satisfying and closer relationships, greater income, better health, and longer life (Lyubomirsky, 2011). If for no other reason, these correlations make happiness an imperative factor to be added into therapy and various clinical settings.

**Genetics**

Genetics may greatly impact a person’s levels of happiness, but those levels are not intractable and can be altered (Myers, 2000). There is agreement amongst happiness researchers that there exists a genetically determined set-point that accounts for roughly 50% of a person's level of happiness. This set-point implies a range; happiness fluctuates, sometimes at the high end or low end of the range, but overall happiness levels tend to gravitate towards the middle of that range (Lyubormirsky et al., 2005).

When attempting to make a sustainable affect change, one of the most important questions researchers attempt to answer is how much of that level of affect is predetermined by genetics. Do people have a fixed level of happiness? Do they have an adjustable level of happiness? Is it a combination of both? What are the contributions of nature and nurture to a person’s level of happiness?

According to Lykken and Tellegen (1996), people are born with a genetically determined happiness set-point. Life circumstances temporarily increase or decrease a person’s happiness level, but, on average, one’s happiness level cycles around and returns to its innate set-point.

Lykken and Tellegen (1996) measured the subjective well-being of monozygotic and dizygotic twins after 4.5 years and then again after 10 years and were able to show that a person’s average happiness level is largely influenced by genetics and is relatively
stable over time. They posit that life circumstances, income, marital status, faith, and education account for at most 3% of the variance in well-being, while 44%-52% of the variance can be attributed to heredity. They concluded that happiness levels are relatively stable and that this stable component could account for as much as 80% of the variance in happiness. Individual life experiences can account for as much as 20% of the variance in happiness.

Lykken and Tellegen (1996) acknowledge that it is possible for life circumstances and factors other than genetics to account for more of the variance in happiness than 20%; but based on their study, there appears to be a very strong genetic component that instills a happiness set-point and therefore they contend that happiness levels remain relatively stable over time (Lykken & Tellegen, 1996).

In a more recent study using an extremely large sample of twins and their siblings, the genetic influence on subjective well-being accounted for 40-50% of the variance, while the remaining variance was determined by non-shared environmental factors (Bartels & Boomsma, 2009). This study also demonstrated that the cognitive and emotional factors of subjective well-being, quality of life in general, quality of life at present, subjective happiness, and satisfaction with life, loaded on similar gene sets.

Another study set out to determine just how stable this happiness set-point is and how much variation around that set-point is possible (Fujita & Diener, 2005). This longitudinal study examined changes in baseline levels of happiness for a 17-year period of a large sample from Germany. The results showed that a happiness set-point is modestly stable for some individuals and that significant changes were possible for others as well. Twenty-four percent of the subjects showed significant changes in their life
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satisfaction baseline from the first 5 years to the last 5 years of the study, and almost 10% of the participants in the study showed extremely large changes from their previous baseline. In other words, this study indicates that while the genetically influenced set-point is sturdy and stable, it is not fixed and change is possible. This study demonstrated that there are methods, circumstances, and experiences that can have an immediate, mid-range, and prolonged impact on happiness (Fujita & Diener, 2005). In other words, becoming happier is possible.

Happiness having a strong genetically-set range is certainly a challenge for mental health professionals and happiness researchers. However, the general consensus is that genetics are thought to account for roughly 50% of a person’s happiness level, with the potential to account for as much as 80%. This means anywhere from 20%-50% is malleable. Second, even if happiness does fall within a genetically-determined set range, and even if permanently changing this set-range is a daunting challenge, then at the very least, research and current interventions can focus on raising a person’s happiness level so that is gravitates to the highest point of that range (Lyubomirsky, 2001). Again, this indicates that becoming happier is possible.

Considering the data for a strong genetic component to happiness, and happiness levels tend to fluctuate only moderately around a fixed set-point, then being able to achieve and sustain a significant increase in happiness would be a formidable task (Emmons & McCullough, 2003). That said, many of the interventions that will be discussed in this project will show that there are methods that can significantly increase a person’s happiness. It has been demonstrated that people can achieve levels well beyond their innate set-point.
New happiness interventions continue to be developed and tested. Since many of the happiness interventions are less than 10 years old, and even though the gains in happiness from these interventions have been shown to be sustainable, there is still uncertainty as to just how long these gains will last. However, as the field continues to thrive and new interventions are developed, it may just be a matter of time before psychotherapy can promise to not only induce higher levels of happiness, but also to make these gains long-lasting and, perhaps, everlasting (Emmons & McCullough, 2003).

Adaptation

One of the main challenges to increasing happiness is that people tend to adapt to both positive and negative experiences, and, typically, return to their affective baseline. Brickman and Campbell (1971) called this the hedonic treadmill, a theory of adaptation that suggests that although people’s affective levels shift with positive and negative life experiences, these fluctuations are short-lived; eventually, their affective levels return to a neutral state (as cited in Diener, Lucas, & Scollon, 2006).

According to this theory, people falsely believe that increasing their happiness is possible, so they continue to invest in activities they believe will make them happier without a clue that this is not possible. However, in light of the interventions that are discussed in the sections below, this theory simply illustrates the stubbornness of a baseline happiness level and not confirmation that it is fixed and intractable. Adaptation is indeed a challenging obstacle but it is not an immovable barrier.

When one experiences a positive or negative life event, the affective response will eventually dwindle. Since people experience hedonic adaptation – which brings their strong positive emotions back to their average levels – circumstances do not typically
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have a sustained effect on subjective well-being, even if those circumstances are extreme and the person’s life may have changed permanently. Adaptation also occurs in relation to events that elicit an adverse emotional response. Eventually, the strong negative affective reaction will fade, returning individuals to their typical happiness levels (Myers & Diener, 1995).

Even in extreme cases, the power of adaptation cannot be avoided. The happiness levels of lottery winners, accident victims, and a control group were monitored and compared (Brickman, Coates, and Janoff-Bulman, 1978). The purpose of the experiment was to show the powerful influence that contrast and habituation have on happiness levels. This study showed that the happiness levels of the lottery winners increased significantly immediately after winning, although these gains were short-lived. After a year, the lottery winners’ happiness levels declined and they were no happier than the control group. Additionally, a contrast effect had taken place such that lottery winners tended to enjoy daily life less than they had before winning. Evincing a similar trend, accident victims who had suffered spinal cord injuries became less unhappy over time and were far less unhappy than had been expected.

**Homeostasis**

Subjective well-being appears to be a homeostatic system and, for most people, it resides on the positive side of the positive/negative life satisfaction spectrum (Cummins, 2010). When negative life events occur, subjective well-being attempts to protect itself and fights to return to its average set-point. It is the mechanism of adaptation that is the crucial component of subjective well-being that keeps the system relatively stable. This suggests that subjective well-being is constantly working to maintain its homeostasis and
powerfully defending itself against elements of change. When positive or negative events occur, subjective well-being will move to the upper or lower part of its set-point range. However, this movement is small and eventually the system’s defense mechanisms are activated as they fight to return to its average set-point.

When negative things happen that move subjective well-being to the lower end of its range, there are resources that are activated and are utilized to return subjective well-being to its set-point, which is usually on the positive side of the range. These resources include social support, finances, and cognitive processes such as assigning meaning to setbacks and disappointments. This same process is activated when an intensely positive event occurs, and while these events enhance moods significantly, the psychological immune system of subjective well-being is triggered and eventually pulls subjective well-being back to its homeostasis (Cummins, 2010). This psychological immune system, unfortunately, works both ways – protecting people from experiencing strong negative emotions for too long, and preventing people from experiencing strong positive emotions for too long.

Considering this strong, stable pull towards homeostasis that is determining levels of subjective well-being, how then can subjective well-being be increased consistently and permanently? According to this same study, the psychological immune system is not invincible and can be overrun. According to this study, regularly experiencing negative events and setbacks can cause this homeostasis-protected mood to fail, which then leads to chronic depression (Cummins, 2010). Therefore, since subjective well-being can be moved to the negative part of its set-point range or even lower, should not it also be possible that this homeostasis can be impacted such that the subjective well-being set-
point (i.e. happiness, or potential for and tendency to happiness) increases? In other words, if people are inundated with positive experiences and pleasurable and meaningful activities, could an overload of these activities and engaging in them on a consistent basis move subjective well-being to the high end of its set-point if not higher?

Many happiness researchers believe that lasting changes are possible with consistent engagement in certain tested happiness-boosting activities. These activities are not major life changes or events; they are small, everyday behaviors that can be enjoyed regularly. It is the regular engagement in and enjoyment of these activities that are likely to increase happiness and sustain those happiness gains (Mochon, Norton, & Ariely, 2008). Since experiencing major life events daily, such as falling in love or receiving a large sum of money, is highly unlikely, researchers contend that the best avenues to increasing happiness are through smaller, routine experiences than can be engaged in easily and often, such as regularly exercising or attending religious rituals. Researchers believe that positive affect can be generated, cultivated, and sustained, through the repetition of simple, everyday experiences, that are enjoyable and easily accessible (Mochon, Norton, & Ariely, 2008).

Poor Prognosticators

It seems that people have an inability to predict how much meaning or happiness a specific experience will generate. Thus, it seems that people are guessing when they choose endeavors in the hopes those experiences will create meaning or happiness (King & Napa, 1998). Therefore, it is incumbent upon therapists to be familiar with the research on happiness so they can properly guide their clients towards activities and experiences that have a high likelihood of increasing meaning or positive affect. For
example, one way to create meaning is through service to others (King & Napa, 1998).

People are not very good at predicting the hedonic impact of a decision. And yet, people tend to engage in events based on their predictions of the events' potential emotional results. These events can range from major life decisions (such as whether to get married, take a new job, or make a career change) to everyday decisions (such as what to have for dinner or how to spend some leisure time). People are constantly weighing the affective value of their decisions and when they finally act it is usually made on a hunch. They do sincerely believe that they have adequately weighed the emotional consequences and that their decisions will lead to experiences that will provide the largest emotional benefits. However, while they are using their intuitions, they are in reality just guessing (Glibert et al., 1998). Even when the correct guess is made and the choice really does offer the most emotional rewards, people are extremely inaccurate at predicting how long the affective rewards will last; and it is usually the prediction of the duration of the affect that influences people’s choice to engage in a particular experience or make a crucial life decision. Positive and negative events – such as a job promotion, or a professor making or being denied tenure – do greatly impact our moods, but this emotional impact is fleeting and, despite the magnitude of the event, does not even last as long as people predict it will (Gilbert et al., 1998).

Myths and Misguided Assumptions

Diener and Diener (1996) reviewed several happiness studies and determined that the affective balance of approximately 75% of those sampled was on the positive side. The sample included both sexes, all ages, and many races. However, this does not suggest that global and individual happiness levels are satisfactory and there need not be
an effort to improve upon them. Although most people are happy most of the time, there are tens of millions of people in the United States alone, that are unhappy, and even the happy people would like become happier (Diener & Diener, 1996). Furthermore, psychology students do not seem to have much of a foundation on the fundamental aspects of happiness and happiness research. As part of this same study, a survey revealed that half of psychology students believed that the elderly are mostly unhappy; a third assumed the same for African Americans; and 90% believed the same for unemployed men.

All of these beliefs are far from the truth. It seems that it is difficult for psychology students, and people in general, to fathom that the aforementioned populations, as well as people with severe disabilities and extremely challenging life circumstances (e.g. people with severe and chronic mental illness) could be happy or, at the very least, not as unhappy or depressed as most people, including psychology students, tend to assume (Diener and Diener, 1996).

There seem to be some recurring themes in the literature on happiness: Most people are blindly guessing about who is happy, and what will increase happiness and, too often, they end up being wrong. In fact, most people have a tendency to misjudge others as being less happy than they actually are. Additionally, most people have a tendency to misjudge how happy something will make them, as well as how long a boost in their mood will last (Gilbert et al., 1998).

One result of happiness research that may be surprising is that happiness and money are not highly correlated. Not being able to afford basic living essentials can certainly lead to unhappiness, but once those basic necessities are met, the amount of
happiness extra income brings is slight and limited. Obtaining large sums of money is not a solid strategy to increase happiness, and income gains and losses have not been shown to have sustainable effects on subjective well-being. Happiness is indeed attainable to people of all income levels, from the poor to the rich, as well as people of all ages, races, and ethnicities (Myers & Diener, 1995).

Kasser and Ryan (1993) found that prioritizing financial goals over other goals, such as community, affiliation in groups, and self-acceptance, was associated with negative psychological results such as depression, anxiety, and less energy. Conversely, aspiring towards goals of self-acceptance and affiliation resulted in less anxiety and less depression. This study showed that the more people strive for financial gain, the more their well-being weakens and their troubles increase. Not only does putting money as a top priority not guarantee happiness; focusing too much on achieving financial success could, in fact, be an investment in poorer psychological functioning. This certainly puts into question the general understanding of the “American Dream” or what others might call “a good life.” In fact, as the collective wealth of America has increased over the past 40 years, Americans' happiness levels have remained virtually unchanged (Myers, 2000). Compared to wealth, happiness and meaning were much better predictors of a good life. Finances were mainly unrelated to perceptions of a good life (King & Napa, 1998).

And despite the weak correlation between money and happiness, most people are firm in their belief that more money will bring them more happiness and put an end to their troubles. Furthermore, focusing too much on monetary goals could have a counter-effect on happiness. When too much concentration is placed on obtaining material possessions, then not enough time and energy is available to go after the goals and
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experiences that actually do provide gains in happiness (Csikszentmihalyi, 1999).

Another area that many assume to be correlated with happiness is physical attractiveness. Many believe the beautiful people are happier and that becoming more beautiful will increase happiness. Physical attractiveness, which is a prized value in society, actually has a low correlation with happiness, although people tend to think that physically attractive people are happier (Diener, Wolsic, & Fujita, 1995). This might be because happier people make more efforts to augment their looks and because happier people, compared to less happy people, believe they are more attractive. This same study showed that the correlation between physical attractiveness and self-esteem was marginal. Therefore, along with attaining more money, augmenting one’s appearance is not a sound happiness-enhancing strategy.

Money and attractiveness aside, some factors do show to be positively correlated with happiness. For example, married people tend to be happier than unmarried people and divorced people, although the unhappily married people are the least happy of the bunch (Myers, 2000). Entering an intimate relationship has been shown to increase happiness and those in an intimate relationship were happier than those not in one (Gilbert et al., 1998). This suggests that a happy romantic relationship will boost individuals’ happiness, but should that relationship turn sour, those still in it will become less happy than those who remain single.

There are also positive correlations between faith and happiness. This could be due to the fact that faith offers an avenue to meaning and purpose (Myers, 2000), which are also strong contributors to happiness (Debats, 1996).

One of the responsibilities of psychologists should be to prevent the
disappointment that comes when clients pursue and achieve goals they assume will increase their happiness, only to find out that this is not the case. Psychologists should have the knowledge and the responsibility to point clients in the right direction, encouraging them to pursue activities that have a high potential for increasing happiness and life satisfaction (Csikszentmihalyi, 1999). Psychologists should be aware of what fosters happiness and should provide their clients with that invaluable knowledge.

Most of the interventions that follow work on one or both of the major components of subjective well-being. That is, they attempt to: increase positive affect; help people evaluate their lives with a more positive outlook; or a combination of both.

**Happiness Interventions**

Happiness interventions, also referred to as Positive Psychotherapy, differ in many ways from conventional interventions for symptoms of depression and anxiety. Instead of trying to decrease depression or explore its root causes, happiness interventions focus on increasing activity in three areas of life: positive affect, creating purpose, and being engaged and active. Happiness interventions assume that a person’s depression can be treated by fostering positive emotions; identifying and assisting the client in using their character strengths; and creating/finding meaningful activities and endeavors. According to Seligman (2002), there are three areas of life that increase happiness and create a happy life. Seligman (2002) refers to them as the “pleasant life,” which focuses on increasing positive affect; the “engaged life,” which focuses on discovering one’s strengths and actively using those strengths in daily life; and the “meaningful life,” which is concerned with utilizing one’s strengths in service to something greater than oneself. Positive psychologists believe that actively and
successfully increasing these three areas of life are the foundation of a happy life. They contend that a lack of positive emotions, a lack of engagement, and a lack of meaning have an inverse relationship with happiness, which results in depression. They further posit that by increasing those three areas, depression will reverse itself and symptoms will be alleviated (Seligman, Rashid, & Tayyab, 2006).

Happiness, positive psychology, and well-being research have collectively made a compelling case to incorporate happiness as a treatment goal of therapy. Increased positive emotions have been shown to strengthen relationships, increase output at work, reduce depression, and produce many other salubrious benefits (Rashid, 2009). Psychotherapy is more than an opportunity for a client to describe their problems and distress. It should also be a time for clients to identify their strengths and ways to apply them; increase positive emotions; and promote hope and gratitude (Rashid, 2009).

Happiness interventions focus on positive emotions; positive character traits and strengths; and past positive life experiences, as well as strategies for creating new ones. According to Ahmed and Boisvert (2006), this approach might be more beneficial and more likely to create a stronger therapeutic alliance than traditional deficit-oriented treatments. This sentiment proved correct when working with patients with schizophrenia. Ahmed and Boisvert (2006) found that when they focused their interventions on the more positive qualities of their clients – such as their knowledge base, strengths, and ability to recall a complete memory – the clients were more receptive than when they implemented interventions that focused on their illness and their impairments in functioning. Additionally, focusing solely, or mostly, on clients' deficits and problems may elicit negative emotions and serve as a reminder to the clients of their
impairments. This traditional deficit-oriented approach could result in clients maintaining their negative self-concept and stall creation of the hope that they can indeed change (Ahmed & Boisvert, 2006).

Lyubomirsky, Sheldon, and Schkade (2005) have put forth a model of happiness that is an optimistic view for psychotherapy. They maintain that happiness is a combination of three factors. First, there is the genetically-determined set-point, which accounts for 50% of a person’s happiness level. Next are life circumstances, such as getting a new job, an income boost, getting married, or moving to a new city. This circumstances portion counts for about 10% of a person’s current happiness level but is not sustainable as people adapt to major life circumstances. The higher the magnitude and intensity of life circumstances, the longer it might take for hedonic adaptation to set in; but, eventually, the gains in happiness from life circumstances ultimately fade. The final component to happiness is “intentional happiness-relevant activity.” This accounts for roughly 40% of a person’s happiness level and – because of the adaptation process – as well as the fact that it is difficult to control or create significant happiness-relevant life circumstances – it is this category that seems best suited to creating interventions and practical options to increase and sustain happiness (Lyubormirsky et al., 2005).

Intentional happiness-increasing activities are activities that a person chooses to engage in and require some level of effort. This distinguishes them from life circumstances because circumstances just occur in people’s lives, while intentional activities are a conscious and deliberate choice made by people to act on their circumstances. Additionally, intentional activities act as a prophylactic against adaptation because they are temporary, periodic, and one can make slight or significant variations to
the activities, giving them a dynamic and consistently novel quality (Lyubomirsky, 2005). There are only a handful of studies that have been conducted with the purpose of increasing happiness and sustaining those gains. One the reasons for this lack of research is the challenges of creating and orchestrating interventions and longitudinal experiments (Lyubomirsky et al., 2005). However, despite this dearth of interventions, the ones that have been designed are showing promising results.

**Mirroring happy people.** Fordyce (1977) reviewed the literature on the happiest people to have been studied in psychological research and identified many typical traits of the chronically happy. Some of these traits were: being more active; making happiness a priority; being more extroverted and social; little time spent worrying; positive and optimistic cognitions; being more organized; socializing more; engaging in meaningful endeavors; reinforcing close friendships; decreasing ambitions and expectations; and being more present-minded. Fordyce (1977) posited that if people could adopt these traits and habits, they might be able to increase their own happiness.

Fordyce (1977) designed his experiment so some participants would receive the information on the characteristics of happy people, while other participants would receive the information as well as training exercises they could use to help incorporate those traits into their lives. The group that received both the training and the education showed significant results and achieved higher levels of happiness. The group that only received the information did not achieve significant results, although the happiness levels of those in the education only group did increase. This implies that for some people, simply learning what increases happiness may motivate people to try and find ways to incorporate that knowledge into their own lives.
In 1983, Fordyce refined his intervention and tested its principles again. Not only was it effective again; he also discovered that simply educating people on happiness and the fundamental characteristics, traits, and lifestyle behaviors of happy people had a long-lasting and beneficial outcome (Fordyce, 1983). Since one of the identifiable factors is to make happiness a priority, educating clients on happiness and its various components can help clients approach their day-to-day living from a perspective that incorporates happiness as a primary goal (Fordyce, 1983).

**Meditation and mindfulness.** Meditation and meditative-related exercise (e.g. yoga) have proven to have many strong positive effects on physical and psychological well-being. Some of the psychological benefits include increased empathy, greater imagination, greater self-regulation, vivid dreaming, and happier marriages (Walsh, 2001).

One of the reasons behind the effectiveness of meditation is that the deep internal reflection required provides an opportunity to gain greater understanding of one’s self and creates psychological abilities that accrete over time and can be applied in future circumstances. Once a person has discovered these insights and abilities, they can more readily apply them in everyday situations (Fredrickson, Cohn, Coffey, Pek, & Finkel, 2008).

In 1995, Smith, Compton, and Beryl wanted to see what effects meditation would have on Fordyce’s Personal Happiness Enhancement Program (1977, 1983). Participants were divided into three groups. One group was taught the 14 fundamental characteristics of happy people and ways they can apply them. The second group was also taught the 14 fundamentals and ways to apply them, and also met for additional sessions to learn and
practice meditation. Additionally, there was a no treatment control group. The results showed that those in the meditation group had made significantly more gains in increasing their happiness and decreasing their negative moods compared to the group that only applied the 14 fundamentals without meditation. This suggests that concentrated meditation could help reinforce a happiness enhancement treatment. There is a caveat: To assure meditation has an effect, participants must meditate at least three times a week. Participants who meditated less than three times a week did not attain any significant difference from those who did not meditate at all (Smith et al., 1995).

In another study, a mindfulness intervention was used in an attempt to improve the psychological well-being and quality of life for people who had a traumatic brain injury (Bedard et al., 2003). Participants meet weekly for 12 weeks with the main purpose of getting these participants to adopt a new way of thinking about their injuries and the limitations those injuries have imposed upon them, as well as to encourage a feeling of acceptance. These goals were achieved through the use of several mindfulness techniques, such as meditation, breathing, guided visualizations, and group talk. One of the main purposes of these groups was to help participants foster a sense of control over their lives and circumstances by exploring untapped resources and abilities that already existed within themselves. This study revealed the effectiveness of a mindfulness intervention, as participants' quality of life showed significant improvements. An additional major benefit to this intervention was that participants’ depressive symptoms were reduced by almost half.

Mindfulness can also increase the experience of feeling pleasant emotions. In another mindfulness meditation study (Davidson et al., 2003), participants were given
weekly classes where they were trained in meditation and mindfulness exercises, once a week for 8 weeks. These classes lasted 2.5-3 hours a week, with a 7-hour silent meditation retreat during week six. This study showed that mindfulness meditation resulted in an increase in immune functioning as well as left-sided anterior brain activation, which has been thought to be associated with increasing positive affect and lowering anxiety and negative affect.

In a more recent mindfulness study, participants were provided a 7-week workshop in loving-kindness meditation (Fredrickson et al., 2008). Loving-kindness meditation is designed to elicit positive emotions such as warmth, empathy, love, and satisfaction. Participants are instructed to focus on their heart while thinking of a person they care deeply about, such as a romantic partner, parent, or child. Once these positive feelings are captured, they are instructed to broaden the feelings and apply them to themselves and then to others. The hope is that after engaging in this kind of mindfulness exercise, participants will be able to more easily evoke positive emotions for themselves and others in real world circumstances. In other words, it is a method of practicing how to create and control positive emotions so they can be called upon whenever they are needed. Participants met in groups of 20-30 members for 60 minutes, once a week for 7 weeks. During these groups, participants practiced meditation that asked them to focus their positive feelings first on themselves; then to friends and family; then to anybody they knew; then to strangers; and, finally, toward every living thing. Results showed the loving-kindness meditation increased positive affect and satisfaction with life while decreasing depressive symptoms. Additionally, the findings suggested that the experience of positive emotions helped participants develop psychological attributes and abilities.
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such as self-love; meaning in life; physical health benefits; and satisfying social relationships and support.

Another mindfulness-training study with a focus on emotional regulation was found to significantly increase happiness for patients with rheumatoid arthritis when compared to cognitive behavioral therapy for pain and a placebo control group (Zautra et al, 2008). Patients also experienced significant increases in their ability to cope with pain.

**Positive affirmations.** Licther, Haye, and Kammann (1980) contended that happiness was a person’s subjective assessment of objective factors and circumstances. They contended that happiness could be increased simply through cognitive retraining activities. They explored the cognitive features of subjective well-being and showed that influencing a person’s beliefs and attitudes could increase happiness. They increased happiness merely by altering views, cognitions, and presumptions using exercises of analysis and contemplation of ideas and assumptions.

Many clinicians are trained to decrease depression and anxiety by altering distorted cognitions. Lichter et al. (1980) used a similar approach, but instead of focusing on decreasing the negative they were attempting to increase the positive. They believed that happiness and depression have an inverse relationship; as one goes up, the other goes down. Standard psychotherapy interventions focus on decreasing depression, which in turn increases happiness. However, research has shown that therapy could instead focus on increasing happiness, which in turn would decrease depression.

Lichter et al. (1980) asked participants to engage in the repetition of positive affirmations and imagery, thereby inducing a more positive state of mind. In one study, global well-being was significantly increased by participants who spent 10 minutes each
morning repeating statements of positive feeling for a period of 2 weeks. Clients were instructed to find a calm and tranquil place where they felt free to be themselves. They were to breathe deeply and take as long as needed with each affirmation. Before reciting the statements, participants read instructions out loud. These instructions were written in the first person. It was essential for the participants to assert that they will be open to the statements and give them their undivided attention. Furthermore, the participants would encourage themselves to memorize the statements, believe in the statements, and adopt the statements as part of their own identity. These daily positive affirmations included statements such as, “I accept myself”; “The closest people in my life trust me and love me”; “I possess many good attributes”; “I am optimistic about the future”; “I have faith in and I trust my choices”; and “Some things that don’t go my way are out of my control.”

This was not the first intervention that recognized the mood-enhancing power of positive thinking. In 1968, Velten argued that those seeking therapy are depressed because they induce their own negative moods with distorted cognitions and maladaptive thinking patterns. If a person can influence their mood towards the negative, then the same can be done towards the positive. A simple intervention of having participants experience a series of statements that were carefully assembled to produce positive feelings and elevate moods was shown to accomplish this lofty goal (Velten, 1968). Subjects in this study were asked to read first-person statements that expressed feeling good, having a good point of view, feeling elated, and feeling competent and confident. After reading a series of these self-referent positive statements, subjects showed significant changes on several critical measures, including making decisions more quickly, lower levels of perceptual vagueness, and higher levels of positive affect.
comparing to a neutral control group, as well as compared to a control group that did similar exercises but with negative self-referent statements (Velten, 1968).

In clinical practice, therapists could help clients develop positive self-referent statements that could be recited daily. This list could be derived from the client’s current problems and concerns and is similar to the idea of creating anxiety-provoking lists, which is a standard assignment in systematic desensitization. Clients could condition themselves to recite these positive affirmations at the moment they realize their mood and/or behavior is about to turn less desirable or unpleasant. Additionally, to avoid adapting to the effects of these positive statements, clients should be continuously altering their lists, adding new statements, and deleting old ones (Velten, 1968).

**Flow.** The “flow” experience is an aspect of happiness where a person’s complete attention is fully absorbed in an activity (Csikszentmihalyi, 1999). The challenges of the activity match the level of the participant’s skills, require the full engagement of those skills and, therefore, demand total concentration. These activities are extremely enjoyable, meaningful, and captivating. Examples of these kinds of activities include playing sports, creative endeavors such as writing, and spiritual and religious experiences and ceremonies. The more flow one can experience, the higher the chance for one to be happy. Therefore, part of the pursuit of happiness is for people to discover and then pursue activities and experiences that will generate flow. Complete and total involvement can be found in all areas of life. Flow can be found and generated in social relationships, work, sports, and leisure activities (Csikszentmihalyi, 1999) and mental health professionals can assist and encourage their clients to explore activities with high flow potential.
**Well-being therapy.** Well-being therapy is one of the more comprehensive and most researched happiness interventions. Well-being therapy is similar to cognitive behavioral therapy and mental health professionals trained in cognitive behavioral therapy could easily transition from one to the other.

Well-being therapy grew out of three connected issues: first, many patients complete psychotherapy treatment for mood and anxiety disorders, and, despite a reduction in acute symptoms, many residual symptoms remain, such as anhedonia and impaired functioning capacity (Moeenizadeh & Salagame, 2010). Second, patients in partial remission after treatment tend to experience more symptoms than just those related to negative affect, such as lower levels of psychological well-being (Moeenizadeh & Salagame, 2010). Finally, according to Fava et al. (2005), patients treated for mood and anxiety disorders often relapse, and current psychotherapy interventions are not specifically geared towards a relapse and recurrence of symptoms, nor the less acute symptoms experienced while patients are in remission (as cited in Moeenizadeh & Salagame, 2010).

Well-being therapy has shown significant efficacy when used to treat affective disorders, specifically during the residual phase of illness. As opposed to other therapies that aim to reduce the negative, one of the unique features of well-being therapy is to increase the positive (Fava, Rafanelli, Cazzaro, Conti, & Grandi, 1998). Well-being therapy is based on focusing on and enhancing functioning in several dimensions of well-being that were identified in a model created by Carol D. Ryff (1989). These dimensions include personal growth, autonomy, interpersonal relationships, environmental control, and meaning/purpose in life.
The most common use of well-being therapy seems to be as a supplement to other therapies, such as cognitive behavioral therapy, although, it can also be used on its own. Once the acute symptoms of an affective disorder have been treated, well-being therapy has shown to have a significant – and, often, more beneficial – impact when treating the residual symptoms of mood and anxiety disorders (Fava, 1999). The reason for this could be that many psychotherapy interventions focus on reducing distress, while well-being therapy focuses on inducing positive affect and effectively navigating and succeeding the various areas associated with psychological well-being (Fava, 1999).

In one study, the effectiveness of well-being therapy was compared to cognitive-behavioral methods in reducing residual symptoms of affective disorders such as major depression, generalized anxiety disorder (GAD), social phobia, panic disorder with agoraphobia, and obsessive-compulsive disorder (OCD) (Fava et al., 1998). A psychiatrist and a psychologist diagnosed the subjects in this study based on the DSM-IV (American Psychiatric Association, 1994) criteria for the various affective disorders. Treatment lasted 3-5 months. After completion of treatment, the same psychologist who made the original diagnosis reassessed the patients. Twenty patients were randomly assigned to two groups; one group received well-being therapy and the other received cognitive behavioral therapy. Patients received eight 40-minute individual sessions, once every other week (Fava et al., 1998). Well-being therapy is designed for eight sessions that could also be administered weekly, with sessions lasting from 30 to 50 minutes (Fava, 1999).

During the first two sessions, patients in the well-being therapy group were asked to describe experiences where they felt a positive sense of well-being. Regardless of how
brief these moments may have been, the purpose was to establish the circumstances and conditions that engendered well-being (Fava et al., 1998). Patients were asked to keep a record of these situations in a journal and to rate the intensity of the well-being experience from 0-100, with 0 being no presence of well-being and 100 being the highest level of well-being possible (Fava, 1999). While this exercise is intended as homework for only the first two sessions, it may take additional sessions for patients that are highly resistant and non-compliant (Fava, 1999).

The next three sessions consisted of patients recalling moments when their well-being was prematurely disrupted, as well as what automatic thoughts and beliefs preceded and caused the interruption (Fava et al., 1998). For example, a patient may have visited his nephews; they greeted him with enthusiasm and praise, and he felt loved, cared for, and appreciated. This experience lasted only moments as the patient interrupted his good mood by thinking his nephews' affection and enthusiasm for him were only because he brought them each a present (Fava, 1999).

The major distinction between well-being therapy and other therapies such as cognitive behavioral therapy is that well-being therapy places a premium on identifying situations that trigger feelings of well-being and greater mood, and it is moments of well-being and not moments of anguish or anxiety that are engendering self-examination (Fava, 1999). In other words, well-being therapy focuses more on what situations create well-being, and boosts happiness as opposed to what situations trigger distress.

The major goal of the second phase of well-being therapy is to determine which situations of well-being are unaffected by negatively-distorted cognitions and which situations are inundated with them. Additionally, in this portion of the therapy, the
therapist should challenge negative thinking and assist patients in countering and disproving those distorted thoughts. Furthermore, the therapist should encourage and motivate patients to engage in situations and events that are enjoyable or that the patients previously identified as ones that trigger well-being. The therapist should encourage patients to make such pleasurable engagements a daily task (Fava, 1999).

The final phase of well-being therapy is to determine areas of well-being in which the patient is most deficient. For example, if patients were deficient in the area of personal growth – meaning they felt stuck and bored with life – the therapist would help counsel these patents in identifying their strengths and interests and generate strategies to assist them in realizing their potential. Other areas of psychological well-being that may require focus include purpose in life, environmental mastery, positive interpersonal relationships, and self-acceptance (Fava et al., 1998). Once the magnitude of the deficiency in each of these areas is determined, the goal of therapy shifts to cognitive restructuring in the most defective dimensions. It is the therapist’s focus on these well-being dimensions, as well as encouraging changes in them, that further separates well-being therapy from other standard psychotherapy interventions (Fava, 1999).

In the Fava et al. (1998) study, both well-being therapy and cognitive behavioral therapy were effective and showed significant success at reducing residual symptoms of affective disorders. However, well-being therapy showed greater and more significant gains in three major areas: depression, autonomy, and purpose in life (Fava et al, 1998).

The limitations of this study are the small number of participants and the diversity of the disorders of the sample. However, the results indicate the effectiveness of a therapy specially geared toward increasing well-being by reducing residual symptoms of mood
and anxiety disorders (Fava et al., 1998).

In clinical practice, well-being therapy may work best as part of a larger treatment strategy. For example, using cognitive behavioral therapy and adding several components of well-being therapy, such as reporting situations of well-being and placing considerable focus on improving the aforementioned well-being dimensions, may provide patients with a more thorough assessment of their maladaptive thinking and behaviors (Fava, 1999).

In a more recent study by Fava et al. (2005), the combination of cognitive behavioral therapy and well-being therapy showed a significant clinical advantage for treating GAD over using just cognitive behavioral therapy. In this study, 20 patients were randomly assigned to two groups. One group received eight 40-minute sessions of cognitive behavioral therapy, while the other group received four 40-minute sessions of cognitive behavioral therapy followed by four 40-minute sessions of well-being therapy. In both groups, therapy sessions occurred every other week. All 20 patients had received the same diagnoses by two different psychiatrists. Well-being therapy was conducted as previously described (Fava et al., 2005). Both treatment groups showed significant improvements in reducing anxiety, with the cognitive behavioral therapy – well-being therapy combination showing a significantly higher effectiveness in reducing anxiety. Additionally, the cognitive behavioral therapy – well-being therapy combination group showed greater gains in increasing well-being (Fava et al., 2005).

One explanation given as to why the cognitive behavioral therapy – well-being therapy combination group showed a significantly greater reduction in anxiety was that in cognitive behavioral therapy, patients are asked to observe and report moments of
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distress; in well-being therapy, therapists asked patients to monitor episodes of well-being and the thoughts that prematurely interrupt them. This additional well-being therapy exercise may provide a more powerful and comprehensive cognitive reorganization (Fava et al., 2005). The results of these experiments may also suggest the need for and the benefit to patients when a therapy focuses some of its sessions on the dimensions of well-being and encourages improvement in those areas (Fava et al., 2005).

In 2010, Moeenizadeh and Salagame conducted a study comparing well-being therapy to cognitive behavioral therapy in the treatment of major depression. All participants had been given a diagnosis of depression by psychiatrists. Patients were divided into two treatment groups. Half of the patients received only cognitive behavioral therapy, while the other half received only well-being therapy. Participants received one individual therapy session every other week for 8 weeks. The methods and procedures were replicated from the aforementioned studies and broken down into the same three phases. The results of this study showed that both the cognitive behavioral therapy and well-being therapy treatment groups achieved significant outcomes in treating their depression. However, the gains in the well-being therapy group were considerably greater. Additionally, well-being therapy showed greater results than cognitive behavioral therapy in increasing psychological well-being (Moeenizadeh & Salagame, 2010).

This study suggested that well-being therapy could work on its own and not in combination or as a supplement to other therapies and not only on residual symptoms. Furthermore, because of the additional benefits afforded to the well-being therapy group, this study also makes a solid case for the need for mental health professionals to focus on the six dimensions of well-being, and not just on what causes distress but also what
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makes people happy.

In all of the well-being studies cited, the participants were men and women, ages 20-40, who had been diagnosed with an affective disorder with active symptoms for at least 12 months. There are several populations and disorders this novel therapy has yet to be tested on, such as psychosis. Well-being therapy continues to be tested, and continues to show significant efficacy when treating affective disorders such as major depression, GAD, and OCD (Fava & Ruini, 2003). Fava and Ruini (2003) posit that further research might show well-being therapy having significant benefits for a geriatric population. They hypothesize that in an elderly population, the addition of the post-treatment benefits associated with well-being therapy may produce more sustainable outcomes than current standard psychotherapy treatments (Fava & Ruini, 2003).

**Writing.** In one study that focused on the potential benefits of writing, participants were instructed to imagine themselves in the future, at their best, with no limits to their potential. They were instructed to imagine they had accomplished all of their goals through hard work and all of their dreams had come true. Then they were given 4 days to write about all they had envisioned (King, 2001). Prior to each writing session and at the conclusion of each writing session, participants rated their positive and negative mood. The mood rating after each writing session showed a significant increase in positive mood; that is, participants were happier.

Additionally, a 3-week follow-up showed that participants continued to experience a slight increase in subjective well-being (King, 2001). Therapists may wish to generate other writing exercises to achieve such happiness-increasing results. These exercises should focus on accomplishments and goals, making clients aware of their
desires and objectives. Other potential areas of writing could be about meaningful experiences, positive experiences, and other writing exercises that might encourage self-awareness, self-control, goal setting, and autonomy (King, 2001).

In another study (Burton & King, 2003), participants were asked to write about extremely positive experiences for 20 minutes each day for three straight days. A control group was set up and participants were asked to write about a different topic at each session, e.g. how they would spend their day, describe their bedrooms, describe their shoes. Positive experiences that participants wrote about included dating and traveling, and milestone occasions such as completing college and having a baby. This exercise led to a significant boost in positive mood and resulted in a significant reduction of illnesses when compared to the control group. This finding suggests not only that there are mood-enhancing benefits to writing about extremely positive experiences, but that there are salubrious benefits as well.

In a writing and self-visualization study, participants were asked to write about their “best possible selves” and were compared to a control group who were asked to write about daily life events (Sheldon & Lyubomirsky, 2006). The rationale behind this exercise is that when people write about their best possible selves, they are learning about themselves and their feelings; illustrating and highlighting their strengths and important concerns; and strengthening their self-control. The results of this study showed that positive affect increased compared to the control group, although both groups saw a decrease in negative affect. Additionally, those who continued to engage in the exercise were able to sustain the positive increases to their moods.

In another study, researchers set out to determine if being prompted to think about
controlling one's feelings and then writing about positive moments would increase
happiness and emotional intelligence (Wing, Schutte, & Byrne, 2006). Participants were
randomly assigned to one of three groups and asked to write for 20 minutes a day for
three straight days. The first group asked participants to write about one of the happiest
and most euphoric experiences of their lives, first being prompted to think about
controlling their emotions. The second group was asked to write about positive moments
without the prompt. The third group (control group) asked participants to write about
what they were going to do that day. In the first group, the prompt asked participants to
think about the feelings that were elicited during the extremely pleasant event, and to
explore ways to create or engage in other experiences that might produce similar
emotions more often. Participants in the group with the prompt showed significant
increases in happiness and emotional intelligence; plus, the happiness increases were
sustained at a follow-up assessment 2 weeks later. In the second group (positive moments
without a prompt) the results were not significant, although happiness and emotional
intelligence did increase. This study suggests that writing about positive emotional
experiences can produce a boost in happiness, and, if accompanied by first reflecting on
how to create more experiences to elicit those pleasant emotions, could help preserve and
perpetuate those happiness gains.

**Goals.** In a recent study, teaching goal-setting and planning abilities increased
well-being (MacLeod, Coates, & Hetherton, 2008). In this intervention, participants
attended three sessions that took place over 6 weeks, with 1 week off between sessions 1
and 2 and 2 weeks off between sessions 2 and 3. The reasoning for the off weeks was to
give participants the opportunity to implement the exercises learned during each session.
Sessions focused on creating goals; visualizing these goals; refining and revising these goals; planning the execution for the goals; anticipating potential obstacles and setbacks; developing strategies to overcome those potential setbacks and maneuver around those obstacles; and focusing more on the journey towards those goals than on the actual goals themselves. A matched control group was established and its participants did not receive the intervention. This goal-setting skills intervention produced a significant increase in positive emotions and satisfaction with life compared to the control group. Additionally, those in the intervention group showed significant increases in their belief in themselves that they could achieve their goals. This finding led the researchers to suggest that there may be a causal relationship between goal-setting and planning abilities and happiness.

Setting, pursuing, and achieving goals that increase feelings of autonomy, relatedness, and competence have also been shown to increase happiness (Sheldon et al., 2010). Mental health professionals can assist patients in identifying reasonable goals that can elicit greater feelings of competency, autonomy, and relatedness, as well as explore ways for these goals to be attained. Relatedness goals would include strengthening current relationships or cultivating new ones. Autonomy goals are those that increase feelings of control over how one’s time is spent. In other words, people are investing their time in doing things they prefer, find interesting, or are fun. Competence goals would be engaging in more activities that one is capable of doing and doing well, thereby eliciting a feeling of efficacy and power. However, there were two caveats to this study that therapists adopting this intervention should consider. First, participants who failed to achieve a needs-satisfying goal risked feeling worse than before they began their pursuit. Second, in order to maintain the happiness gains from pursuing needs-satisfying goals,
participants needed to continue generating, pursuing, and attaining more needs-satisfying goals. This suggests that the goals created should be reasonable, have a high probability of being attained, and could potentially provide openings for even more goals.

**Gratitude.** A grateful outlook promotes the relishing of pleasant events, allowing people to feel the greatest amount of pleasure and contentment from the experience (Sheldon & Lyumbomirsky, 2006). Expressing gratitude and having a more grateful outlook on life is a concept that religious/moralistic leaders and writers have claimed are essential components to living an ethical and virtuous life. However, these claims have been made without any scientific knowledge as to what effect gratitude has on one’s psychological well-being and satisfaction with life, including whether there are any psychological benefits at all (Emmons & McCullough, 2003).

The benefits of gratitude were finally tested and with promising results. For 10 weeks participants were asked to review their life over the previous week and write down five things they were grateful about. Participants listed things such as good parents, favorite rock bands, and just getting to live another day. In addition to counting their five weekly blessings, clients were given a sheet to rate the extent to which they felt various dimensions of well-being, such as: optimistic, unhappy, relaxed, grumpy, and focused (Emmons & McCullough, 2003). Two other experimental conditions were set up: one group listed five weekly nuisances, and the other listed five situations that occurred during the week that impacted their lives.

At the conclusion of the 10-week period, participants in the gratitude group experienced some benefits compared to the two other conditions. While they did not experience significant increases in positive affect, they did report feeling more satisfied
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with their lives and were more hopeful about the coming week’s possibilities. Additionally, they devoted more time to exercising and reported fewer physical problems. In other words, while results were not significant, they were in the right direction (Emmons & McCullough, 2003).

Experimenters from this previous study felt these results were promising and could achieve the gains in well-being they were hoping for if they increased the intensity of inducing a more grateful outlook. Emmons and McCullough (2003) attempted the study again, although the major difference this time was that participants were asked to make their gratitude list every night for 21 days before they went to sleep. Under this gratitude condition, daily positive affect increased significantly and daily negative affect decreased. Furthermore, participants’ global well-being showed a significant increase, and they reported an increase in the number of hours they were sleeping, as well as an increase in the quality of their sleep (Emmons & McCullough, 2003). These experiments indicate that by making a conscious effort to frequently concentrate on one’s advantages and favorable areas of life, one can increase happiness, satisfaction with life, and even gain some physical health benefits (Emmons & McCullough, 2003).

According to Philip, Woodward, Stone, and Kolts (2003), gratitude is an affective characteristic and a significant component to subjective well-being. Additionally, they showed that having a more grateful outlook elevated mood. Their study also suggested that a grateful attitude was negatively correlated with depression, resentment, and narcissism. In fact, gratitude’s strongest inverse relationship was with depression, suggesting that it has a strong positive correlation with happiness. In one study, participants were asked to spend 5 minutes listing all the things that occurred over the
summer that they were grateful for. The results showed that this quick and easy gratitude-inducing assignment enhanced their moods (Philip et al., 2003).

In another study, participants were asked to think about, write an essay about, or write a letter to somebody for whom they were grateful. Each group was given 5 minutes to complete the task. All three conditions showed an increase in positive affect. The highest increases were in the grateful thinking condition. These results indicate that the mere induction of more grateful thoughts can increase positive affect, improve mood and subjective well-being (Watkins et al., 2003). These studies suggest that gratitude might foster happiness by remembering and magnifying one’s experience of positive moments and situations (Watkins et al., 2003).

In another study, gratitude was tested as a happiness intervention and its effects were compared to a placebo-control group (Seligman, Steen, Park, & Peterson, 2005). This study was conducted over the Internet and participants were informed it was a study to increase happiness. After completing the interventions, participants' happiness levels were tested at four follow-up intervals (1 week, 1 month, 3 months, 6 months) to determine whether the intervention’s impact was sustainable. There were five different interventions in this study, two of which focused on gratitude. The first intervention was a gratitude visit. Participants were instructed to spend one week writing a letter that thanked a person to whom they owed a debt of gratitude and, if possible, they were to hand deliver the letter; otherwise, they could mail it. The second intervention asked participants to write down three things that occurred that day that they were happy about. They were asked to explain how and why these positive things happened. They were asked to do this exercise daily for one week. The other successful intervention in this
Results from the “three good things” intervention showed significant increases in happiness as well as decreases in depressive symptoms. These happiness gains were sustained at a 1-month, 3-month, and 6-month follow up.

Results from the gratitude visit showed the largest gains in happiness and these gains were sustained at the 1-month follow up. However, by the 3-month follow up, participants had returned to their original happiness levels. Additionally, those who continued to do the exercises after the first week saw the greatest gains in happiness (Seligman et al., 2005). Again, this shows the need to be frequently engaging in happiness-boosting activities.

In a 4-week longitudinal gratitude study, participants were asked to count their daily blessings for 4 weeks and a control group was asked to write about their daily life events (Sheldon & Lyubomirsky, 2006). Positive affect increased compared to the control group and both groups saw a decrease in negative affect.

**Meaning.** Feelings of meaningfulness have strong associations with happiness. Debats (1996) defines “meaning in life” as a feeling that one can comprehend, make sense, or find logic in one’s being. Debats (1996) set out to find if there was predictive power and clinical relevance of the meaning of life and the general relationship between meaning in life and psychological well-being.

Debats’ (1996) study showed that meaning in life had a moderate to high relationship to psychological well-being and there was a strong association between a feeling of meaningfulness and happiness. Furthermore, a sense of meaning in life
predicted improvement during psychotherapy (Debats, 1996). This study indicates that a focus on increasing or instilling a feeling of meaningfulness during therapy is a sound therapeutic intervention.

Meaningfulness appears to be a critical component in people’s psychological well-being and their potential benefits of psychotherapy. Clinicians should incorporate into their treatment planning a goal of assisting people in making sense of their lives and helping them create a logical understanding and reasoning for their existence. When people think of the components that make up the concept of a good life, having meaning in life and happiness are crucial (King & Napa, 1998).

Interventions aimed at reducing meaninglessness or increasing meaning require finesse and sophistication. There are two well-established psychotherapies that were designed to increase meaning: logotherapy (Frankl, 2006) and existential psychotherapy (May & Yalom, 2005).

While clients need to create meaning for their past sufferings and their future endeavors, they also need to believe that what has happened was meant to be, and that the direction they are moving in is meant to be (Yalom, 2003). In other words, clients need to create their own meaning and then repress the knowledge of their participation in having done so. They need to believe the results were destined.

However, many clients come to therapy because they are worried about meaning; thus, discussing and exploring meaning is often a necessary focus of therapy. There are many ways to engage a client in conversations about meaning, such as asking what they might want written about them on their tombstone (Yalom, 2003). Frankl (2006) uses a similar method, asking clients to imagine they are on their deathbed and then to express
what they will say and think about themselves and how they lived.

One of the most effective ways to increase meaning is to focus one’s energy and efforts towards causes, charities, creative projects, and other people. In other words, most meaning-creating endeavors go beyond oneself and are focused on anyone or anything else (Frankl, 2006).

May and Yalom (2005) contend that the main remedy to meaninglessness is engagement. To be fully engaged in any of many possible activities and areas that life has to offer facilitates the creation of a full and consistent life. The greatest obstacles to finding meaning are those that prevent engagement. Therapists should work on helping clients overcome whatever issues are preventing them from being more engaged (Yalom, 2003). This requires the therapist to identify what those obstacles are; what is blocking clients from loving others, from engaging in enjoyable work, and endeavors using their abilities and talents; from pursuing their interests; and ignoring creative or spiritual goals (May & Yalom, 2005).

Logotherapy contends that there are three primary paths to meaning. First is through generating work or actions. Second is through engagement or love with another person or thing (in other words, to fully experience another person or entity). The third, and most important, is to find purpose in one’s suffering; that is, to endure whatever pains and tragedies have occurred, to transcend them, and to find them dignifying rather than shameful (Frankl, 2006).

The primary techniques of logotherapy are paradoxical interventions. The idea is that by prescribing clients to do that which they find most anxious robs the situation of its anxiety-producing powers. Once the anxiety has been reduced the client is more able to
Forgiveness. Forgiveness also falls into the pleasure and engagement category of happiness-increasing activities. Forgiveness reduces or eliminates resentments and anger and is therefore often considered a positive emotion (Seligman, Rashid, & Tayyab, 2006).

In forgiveness therapy interventions, participants are taught to give up resentments and offer compassion (Reed & Enright, 2006). When one forgives, that person experiences an affective, cognitive, and behavioral change that tends to improve psychological well-being and instill a more optimistic view about the future. Forgiveness therapy promotes compassion, assists participants in ascribing meaning to their past suffering, and helps them discover new resolve (Reed & Enright, 2006).

In one forgiveness therapy study results indicated that increasing forgiveness and hope significantly decreased anxiety (Freedman & Enright, 1996). The intervention was based on Enright and the Human Development Study Group’s 17 psychological variables that motivate the forgiveness process (as cited in Hebl & Enright, 1993). These 17 variables can be grouped into 8 broader topics, with each therapy session focusing mainly on one (although sometimes several) of these topics. These topics include: definitions of forgiveness and psychological defenses; exploring the contributing factors to one’s anger; acknowledging that one has been hurt and exploring ways to regulate and reduce the hurt and begin to contemplate forgiveness; making a commitment to forgive; developing empathy and compassion towards the offender; acknowledging that there have been times when oneself has needed forgiveness; accepting the hurt; concentrating on how one has changed because of the hurt; becoming mindful of the affective impact of the hurt; and decreasing negative emotions towards the injurer. Once these negative feelings have been
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released, an opportunity for positive feelings is revealed and forgiveness can begin to take place. In another study, forgiveness therapy significantly decreased depression and anxiety in a population of elderly women (Hebl & Enright, 1993).

In a similar study, the aforementioned forgiveness therapy intervention was implemented with a population of incest survivors. This study’s results showed a significant increase in psychological well-being, increased hope and self-esteem, and decreased depression and anxiety. There also was a marked increase in positive thought, feelings and behaviors towards the offender. Furthermore, all the incest survivors experienced an increase in positive feelings towards themselves (Freedman & Enright, 1996).

Forgiveness therapy continues to be tested and shows promising and significant results. A more recent study (Lin, Mack, Enright, Krahn, & Baskin, 2004) implemented forgiveness therapy with a substance abuse population. Participants showed significant improvements in reducing anger and depression, increasing forgiveness and self-esteem, and, perhaps most importantly, a decrease in their vulnerability to drug use when compared to an alternative treatment group.

The same intervention was tested again with women who had been abused by their spouses. Again the therapy produced significant results, further demonstrating its effectiveness. Participants experienced significant decreases in depressive symptoms, anxiety, post-traumatic stress symptoms; and increases in self-esteem, environmental mastery, attributing meaning to their pain, and forgiveness (Reed & Enright, 2006).

Hope. Hope is such a positive and pleasant emotion that the inducement and enhancement of hope has become the principal and major goal of many clinical
interventions. Hope is defined as a cognitive process that shapes how one creates, pursues, and achieves one’s goals (Snyder, 1995). The motivation to pursue goals is called the agency component of hope, while the ability to create strategies to attain goals is called the pathway component. How people evaluate their abilities to motivate themselves towards their goals, and how confident they are in their abilities to create pathways to achieve their goals, determines their level hope. This theory of hope stresses how essential goals are in our day-to-day lives, and that formulating attainable goals is one of the best ways to foster and boost hope (Snyder, 1995).

Looking at the behavior of individuals with high hope and research on improving agency and pathways, Snyder (1995) extrapolated several principles that mental health professional can impart to their clients to help develop their agency and pathways. These principles are: positive self-talk about achieving; viewing a setback as a poor strategy and not an absence of skill or aptitude; viewing difficulties and complications as challenges; remembering previous accomplishments; having social support to discuss plans and strategies; listening to stories of how others succeeded; having people to look up to; exercising regularly; eating properly; having a sense of humor; resting; ability to revise goals if needed; learning new skills and subjects; and rewarding oneself for small successes on the way to the larger goal. People with higher levels of hope also have higher levels of happiness, lower levels of anxiety, and less sadness (Snyder, 1995).

The above theory of hope has led to the creation of hope therapy. Hope therapy teaches its participants the aforementioned principles and how to apply them in their daily lives, with a primary focus on goal creating and enhancing the agency and pathways components (Cheavans, Feldman, Gum, Michael, & Snyder 2006). Participants in an 8-
week study who received hope therapy once a week for 2 hours at each session showed significant increases in agency, significant decreases in anxiety and depressive symptoms, significant increases in meaning in life, and significant increase in self-esteem. In other words, they were happier (Cheavans et al., 2006).

**Spiritual.** One study looked to find the effects of engaging in easily accessible activities that might provide small increases to happiness that aggregate over time. Attending religious services showed to be one such activity (Mochon et al., 2008). In this study, happiness levels were measured before and after people attended a religious ritual. Results showed that those leaving the religious ceremony had significantly higher levels of happiness than those assessed before entering. This study also found that those who attend religious services on a regular basis experienced additional increases in their happiness for each additional service they attended. This study shows a solid relationship between attending religious services and happiness, as well as a relationship between the frequency of engaging in an activity and how that may lead to extra gains in happiness. Another finding of this study was that being dedicated to frequently engaging in a happiness-boosting activity could be a solid strategy to move a person’s baseline level of happiness to a new and higher set-point (Mochon et al., 2008). One criticism of this study is that the researchers did not determine the influence that the social aspects of attending religious ceremonies might have had on levels of happiness.

**Physical activity.** Exercising and physical activities appear to be effective happiness-increasing interventions. In one study (Armstrong & Edwards, 2003), mothers with depressive symptoms exercised three times per week and attended one social support group once a week for a period of 12 weeks. The exercise was to walk 30-40
minutes at a medium pace. The social group was informal; the women met for tea and
conversation, and their children were welcome to attend and play. The depressive
symptoms of these women improved significantly when compared to a control group.
Significant reductions in depressive symptoms were evident by the 6th week and virtually
all of the depressive symptoms were gone by the 12th week. This study indicates that
exercising can be an effective activity to improve psychological well-being and decrease
depressive symptoms. Other benefits of this intervention included improvements in
physical fitness, self-image, sleeping habits, and day-to-day coping abilities. A criticism
of this study is that researchers did not determine how much, if any, of the gains in
happiness and the reduction of depressive symptoms could be attributed to attending the
support group.

In the previously cited study that showed the happiness benefit of frequently
engaging in religious experiences, researchers also tested the mood-enhancing ability of
frequently going to the gym or doing yoga (Mochon et al., 2008). Happiness levels of
people were measured before and after they went to a gym and to yoga, and results
showed that those questioned after exercising were significantly happier than those
questioned before entering the gym or yoga facility. Similar to the religious services
portion of this study, exercising provided additional happiness gains for those who
engaged in the activity more frequently. In fact, the more often one exercised, the larger
the aggregate gains in happiness. Similar to study on attending religious services, a
criticism of this study is that the researchers did not determine the influence that the
social aspects of regularly attending a gym or yoga class might have had on levels of
happiness.
Strengths. In the previously mentioned Internet-happiness interventions study, one intervention that focused on strengths showed significant happiness-boosting results (Seligman et al., 2005). This intervention asked participants to take a test that would evaluate their signature strengths to determine which five strengths were at the top of their list. Participants were instructed to find a novel and creative way to use one strength each day for one week. This exercise produced significant increases in happiness and decreases in depression. The happiness gains were sustained at a 1-month follow-up, 3-month follow-up, and 6-month follow-up assessment. As in this study’s gratitude exercises, those participants who continued using their strengths after the week concluded saw the greatest gains in happiness.

Prosocial behavior. Researchers wanted to see what kind of effect practicing and cultivating the strength of kindness would have on happiness (Otake et al., 2006). Researchers postulated that the strength of kindness has three facets: the desire to be kind, the ability to see kindness in others, and engaging in kind acts on a regular basis. Participants were asked to be aware of every kind act they performed throughout each day and to record the number of acts and the specific details of these kind acts for one week. The results showed a significant boost to the participants’ levels of happiness compared to a control group. Additionally those who performed and recorded more acts of kindness showed greater increases in happiness than those who performed fewer acts of kindness. Furthermore, participants in the intervention group became more grateful. Researchers in this study concluded that performing kind acts and being aware of kindness can indeed generate happiness.

The literature previously reviewed has shown a minimal relationship between
money and happiness. However, one study found a way that money can significantly increase happiness (Dunn, Aknin, & Norton, 2008). Pro-social spending (i.e. spending money on others or on charities and causes) resulted in significant boosts in happiness compared to those who spent money on themselves. The findings of this study showed a causal relationship between happiness and spending money on others. This study also showed another cognitive fallacy that most people make in their pursuit of happiness: people initially thought that spending money on themselves and their own personal interests would make them happier than spending money on others or charitable causes.

**Behavioral activation.** Behavioral activation was not developed as a happiness intervention; however, it seems to have all the elements of one. As much of the happiness-enhancing research has shown, engaging in intentional activity is one of the most effective means to increasing mood and creating positive affect. Behavioral activation assists people in exploring activities they find enjoyable; encourages them to engage in these activities; and pushes them to participate in new activities and experiences, such as traveling to new locations, exercising, developing a new hobby (Jakupcak et al., 2006), and pursuing educational and vocational goals (Jakupcak, Wagner, Paulson, Varra & McFall, 2010). It is through engagement in these meaningful and pleasurable activities that negative affect (such as anxiety and depression) is reduced and positive affect is stimulated.

In one study, veterans with post-traumatic stress disorder (PTSD) received 16 sessions of individual behavioral activation therapy. The intervention was shown to be effective, as participants experienced a significant reduction in PTSD symptoms, and significant improvements in quality of life (Jakupcak et al., 2006).
In a more recent study, behavioral activation interventions were again tested with veterans who had PTSD and this time they also had depression (Jakupak et al., 2010). Eight veterans were offered eight weekly sessions of behavioral activation therapy and only six of them completed four or more sessions. The first session was 90 minutes, the next three sessions were from 50-60 minutes, the next two sessions were 45-60 minutes, and the final session was 60 minutes. Completing four sessions was considered receiving the treatment. Four veterans completed all eight sessions, one veteran dropped out after session 4, and another veteran dropped out after session 5. The intervention produced significant improvements in the quality of life of the veterans as well as a significant reduction of PTSD symptoms and depressive symptoms. A limitation of this study was the small sample size and the fact that all of the veterans were white males. However, gains from treatment were sustained at a 3-month follow-up.

Behavioral activation places a premium on finding creative solutions to engage in activities that are consistent with clients’ goals. For example, in the Jakupak et al. (2010) study, one veteran wanted to incorporate more religious experiences into his daily life but had too much anxiety in large crowds and, therefore, avoided going to church. Along with his therapist, he explored other ways to add a spiritual component to his daily life and identify other moments throughout his day when he could pray, such as while exercising and becoming active in a small church-based club.

Mazzucchelli, Kane, and Rees (2010) contended that behavioral activation interventions could be used as happiness-increasing interventions. They did a meta-analysis on behavioral activation interventions and their ability to increase well-being. They suggested that since a great deal of well-being-increasing research focused on ways
to engage in meaningful and pleasant activities, behavioral activation interventions were already well-established methods of treatment that are available to mental health professionals and have been shown to foster well-being in a wide range of clinical and non-clinical populations. Twenty behavioral activation studies were analyzed and the results showed a moderate effect size of .52 when comparing the difference between the increases in happiness from behavioral activation interventions to control conditions.

Mazzucchelli et al. (2010) posited that since behavioral activation intervention procedures were already well established, could be applied to a wide range of populations, and could increase well-being, they too should be a part of the umbrella of positive psychology, and well-being, and happiness-increasing interventions.

**Integrating several approaches.** Seligman, Rashid, and Tayyab (2006) created several positive psychotherapy interventions for individuals and groups that focused on increasing positive emotions, engagement, and meaning; the three areas of life that Seligman (2002) posits leads to higher levels of well-being and satisfaction. These interventions were used to treat participants with unipolar depression. Participants were divided into three groups. The first group received positive psychotherapy interventions. The second group received standard psychotherapies. These standard psychotherapies were a blend of widely-used clinical interventions that one would typically receive when seeking therapy. Licensed psychologists, licensed social workers, and graduate student interns supervised by a licensed psychologist administered the various standard therapies. Each of these mental health professionals was free to apply whatever interventions and methods they typically used in their practice. The third group received the same eclectic treatments as the second group, with the addition of anti-depressant medications. The
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results were significant, finding that compared to the other two groups, the positive psychotherapy interventions were more effective at decreasing depressive symptoms and putting depressive disorders into remission. Additionally, the positive psychotherapy interventions increased happiness and satisfaction with life. Furthermore, the improvement on mood from the positive psychotherapy group was sustained for at least one year (Seligman et al., 2006).

The following are examples of group exercises from the positive psychotherapy interventions: write down three good things that happened that day before you go to sleep and explain why you think they occurred; write an obituary about yourself, focusing on what you would most like to be remembered for; write a letter to somebody you are grateful to but have not yet had the chance to tell them; after you write the letter, call or see that person and read it to him or her; think of something you enjoy but usually rush through, and the next time you engage in this activity, slow down and savor it, then write about how it was different doing it slowly and while relishing every moment, and then compare and contrast the experience to how it feels when you hurry through it (Seligman et al., 2006).

For individual therapy the exercises were different. Each session focused on one or more of the three areas that Seligman (2002) contends lead to a happy life: pleasure, engagement, and meaning. Exercises included the following: participants were instructed to write an introduction about themselves focusing on their positive qualities and highlighting their personal strengths. Based on their introductory essay, clients continued to discuss their strengths and identify/describe other situations where they applied them. Gratitude falls under the pleasure and engagement categories and clients were assisted in
fostering a more grateful outlook. Clients were asked to keep a gratitude journal, listing daily blessings as well as writing a gratitude letter to a person they have not yet thanked. Forgiveness also falls into the pleasure and engagement category and clients practiced forgiveness exercise. Participants wrote a letter describing who wronged them and how, and then wrote that they forgave the offender.

Optimism and hope fall under the category of positive emotion and the pleasurable life. Several exercises were implemented to induce and increase both optimism and hope. Clients were asked to identify their missed opportunities and then to list three new opportunities. In other words, clients were taught to see that for every opportunity that was missed or lost, almost always another one presented itself (Seligman et al., 2006).

Summary

In general, therapists could incorporate into their treatment plans some, most, or all of these interventions. They could also focus their therapy sessions on positive emotions, meaning, and engagement. This could be their primary focus or as a supplement to their standard interventions.

Sin and Lyubomirsky (2009) did a recent meta-analysis of 51 positive psychology interventions primarily designed to increase well-being and focus on positive affect. These interventions were applied to populations of depressed and non-depressed participants and showed that they were effective for increasing happiness and decreasing depressive symptoms. The strength of these interventions yielded a medium effect size for increasing happiness (mean $r = .29$) and reducing depressive symptoms (mean $r = .31$). Many of these interventions were self-administered and may produce even greater results.
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when administered under the care of a mental health professional. Furthermore, this study found that these interventions were more effective for participants with depressive symptoms compared to those without depressive symptoms. This result suggests that these interventions can have a practical, applicable, and effective role in clinical practice, which should encourage mental health professionals to learn and incorporate them.

The hope is that through interventions that are designed to increase positive emotions, thoughts, and behaviors, clients will not only increase their psychological well-being and reduce their psychological distress, but will also gain the additional motivation to confront life and begin to thrive, prosper, and flourish (Layous, Chancellor, Lyubomirsky, Wang, & Doraiswamy, 2011). In other words, live happily ever after.
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CHAPTER III

Methods

The purpose of this project was to develop a presentation on happiness that informed mental health professionals, particularly clinicians and educators, on the relevance and necessity of incorporating happiness into their professional settings. The presentation informed mental health professionals on techniques to successfully include happiness as a legitimate goal of treatment, and a fundamental subject of psychotherapy training.

It is self-evident that happiness is a goal of most consumers seeking mental health services and it is vital that practitioners are aware of happiness research, such as what happiness is, how one’s happiness can be increased, how those increases can be sustained, and what clinical and practical exercises are available.

Additionally, the presentation highlighted several myths and misguided assumptions that many people make about what will make them happy and provided strong admonitions to clinicians to dissuade their clients from these ineffective activities, goals, and behaviors, not only to assist their clients in avoiding severe disappointment but mainly to refocus their clients’ goals and activities to more effective happiness-creating strategies.

The search criteria used for the selective literature review included happiness and happiness interventions, subjective well-being, life satisfaction, positive psychology, and positive psychotherapy.

I received supervision from Dr. Murray. This doctoral project supervisor was available for consultations and offered superior feedback and guidance. I attended a
doctoral project proposal meeting with Dr. Murray and Dr. Scott Fraser. Dr. Fraser, serving in the role of an academic consultant, provided corrective feedback, additional insights, and suggestions regarding this selective literature review and the presentation.

I interviewed field consultants specializing in clinical interventions with clientele seeking to become happier. The field consultants included: Ildiko Tabori, PhD, clinical psychologist in private practice; Ruben Preuss, LMFT, therapist in private practice; Michael Whitman, Psy.D, clinical psychologist in private practice and the clinical supervisor at Chabad Residential Treatment Center; and Rebecca L. Crandal, M.D., psychiatrist in private practice. The field consultants were interviewed and were asked seven questions (refer to Appendix A).

The information received from field consultant interviews was with the objective of enhancing the knowledge of mental health professionals, educators, clinicians, and counselors, in accumulating knowledge on happiness, and happiness-boosting interventions, and the role and the goal of happiness in therapy and in educational arenas. This information was also utilized in the development of a presentation to help identify happiness-boosting strategies clinicians are currently using with success, or may be unaware of, as well as, how clients respond to such activities and the likely obstacles clinicians will face while trying to motivate clients to engage in new happiness-boosting activities.

The findings were explicated so that educators and practitioners can utilize best practices in order to develop syllabi and treatment plans that include happiness as a primary and practical focus of training and practice, and an important and attainable goal of psychotherapy.
Professional Input and Feedback

Field Consultant Interviews

Four field consultants were interviewed in order to provide additional information beyond the published research that could be useful towards the completion of this doctoral project. The purpose of these interviews was to gather additional insight as to how happiness is addressed in therapy, which areas of well-being receive the most focus, and what happiness-boosting techniques are most applicable and most effective. All four field consultants were chosen because they are full-time psychotherapists and place a premium on happiness as an area of psychotherapy. These field consultants incorporate increasing happiness as a major treatment goal in therapy, and they implement a wide range of strategies in order to achieve this goal.

Michael Whitman, Psy.D. Is a licensed clinical psychologist who has been practicing psychotherapy for over 12 years. Dr. Whitman also has experience working as a prison psychologist and is currently a professor of psychology at Academy of Couture Art, and a clinical supervisor at the Chabad Residential Treatment Center. Dr. Whitman has been a psychologist in private practice for over 5 years.

Rebecca L. Crandall, M.D. is a psychiatrist with a specialty in addiction and forensic psychiatry and anxiety and mood disorders. Additionally, she has provided outpatient psychotherapy at her private practice since 1996.

Ildiko Tabori, Ph.D. is a licensed clinical psychologist who has been practicing psychotherapy since 1997. In addition to her private practice, she is a consulting clinical psychologist and neuropsychologist for a retirement community and for 5 years was an
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adjunct professor at Pepperdine University Graduate School in Psychology and Education.

Ruben Preuss, M.A., LMFT, is a licensed marriage and family therapist. Mr. Preuss has been conducting psychotherapy for over 5 years. In addition to his private practice, Mr. Preuss works as a staff therapist for Kaiser Permanente in Oxnard, California.

Question #1 asked the field consultants to comment on the frequency with which they discuss happiness with their clients. All four field consultants bring up the subject of happiness during the first session. Dr. Crandall (personal communication, November 30, 2012) explained that she addresses happiness during the first session, and is more likely to bring it up during the earlier sessions than the later ones. Dr. Crandall stated that as the therapy continues other issues are discussed and the discussion of happiness becomes far less frequent. The other three field consultants continue to address happiness throughout the course of therapy. Mr. Preuss (personal communication, November 3, 2012) brings up happiness and focuses on the positive aspects of life throughout the entire course of therapy. He helps his clients focus on what is working and why it is working and what are the positive aspects of their lives. Happiness and the positive side of life shape the focus of his therapy. Dr. Tabori (personal communication, November 9, 2012) contends that happiness is the immediate and ultimate goal of therapy and touches on it in almost every session. Dr. Whitman (personal communication, December 1, 2012) also addresses happiness frequently, perhaps every other session, and believes it is the crux of therapy.

Question #2 discussed the process of how the therapists addressed happiness. Mr.
Preuss (personal communication, November 3, 2012) and Dr. Tabor (personal communication, November 9, 2012) ask their clients to explore what they believe will make them happy. Mr. Preuss then helps his clients create a plan where they can feel the positive effect of accomplishing tasks while on their way to reaching their happiness goals. Dr. Tabor asks her clients to explore past experiences of happiness as well as to define happiness. Afterwards, similar to Mr. Preuss, she helps them generate a plan on how they can achieve their happiness goals. Dr. Whitman (personal communication, December 1, 2012) prefers to substitute the words “satisfaction” and “gratification” for the word “happiness.” He then works with his clients on exploring how they can get more satisfaction out of their lives whether it is from their work or their relationships. He illustrates for his clients that they have options and are not stuck in their current situations and that happiness is indeed obtainable. Dr. Crandall (personal communication, November 30, 2012) will first explore with her clients their behaviors that are causing them unhappiness and focus on removing or changing them.

Question #3 discussed the interventions that the field consultants use to increase happiness and life satisfaction that may not have been reviewed in Chapter 2. The primary purpose of this question was to uncover creative interventions that the field consultants may have generated on their own. Field consultants each had their own, unique style of increasing happiness. Mr. Preuss (personal communication, November 3, 2012) uses visualization techniques. He asks his clients to draw a river placing their current self on one end and their future, happy self on the other. He then has them draw rocks, labeling each rock with a task they need to accomplish to get to the other end of the river and become their future self. This exercise is reminiscent of Hope Therapy, as it
attempts to create small and doable tasks that can foster a sense of agency and accomplishment, which then increases happiness. Dr. Tabori (person communication, November 9, 2012) illustrates for her clients that their behaviors are a product of the choices they are making. She then assists them in exploring which of their choices bring them the most satisfaction and the least displeasure. Dr. Whitman (personal communication, December 1, 2012) will encourage his patients to exercise. He will also look at their habits that might have a physiological impact on their mood, such as drinking alcohol, and encourage them to reduce or cease engaging in those habits. He will also explore and highlight his patients’ strengths and emphasizes for them what is going well. He helps them see the positive side of their lives and builds their hope by pointing out their past accomplishments and the positive qualities they possess that have helped them over the years. Dr. Crandall (personal communication, November 30, 2012) encourages her patients to engage in more positive thinking and positive affirmations. She also tries to foster a more grateful outlook through various gratitude-inducing exercises. She highlights her patients’ negative thinking patterns and helps them incorporate more positive alternatives. She also encourages physical activity and exercise that fits into her patients’ interests.

Question #4 asked how the field questions motivated their clients to use their strengths. Each field consultant had a different method of motivation. Mr. Preuss (personal communication, November 3, 2012) posited that motivating his clients happens over the course of therapy as the therapeutic alliance strengthens and they begin to trust him more. Once the bond between Mr. Preuss and his clients is strong, they are more accepting of his encouragement and more willing to explore the various ways to apply
their strengths outside of the therapy room. Dr. Crandall (personal communication, November, 30, 2012) explores her clients’ strengths and makes sure that they understand them. She then proceeds to emphasize that gains in happiness could be achieved through the use of strengths. She also incorporates yoga, breathing exercises, and meditation that focus on them being motivated to utilize their strengths. Dr. Crandall will do exercises in the session to get them motivated to do the same exercises during the days between sessions. She also suggests that they develop motivational positive affirmation statements that they can say and read daily to help motivate them. She will also suggest readings. She explores with them their likes and hobbies and encourages them to fully engage in activities they find enjoyable. Dr. Whitman (personal communication, December 1, 2012) contended that motivation was tricky because it comes from within. He does highlight his patients’ strengths and the positive aspects of their lives. He tries to motivate his patients by highlighting their strengths and pointing out creative ways they can utilize their strengths. Dr. Tabori (personal communication, November 9, 2012) believes that encouragement and goals help motivate her patients. She encourages her clients to use their strengths and she helps them generate small doable goals that can create a sense of accomplishment and lead to pursuing even more goals. The size and scope of these goals can be as small as mailing something. Similar to Mr. Preuss, she contends that the therapeutic alliance plays a role in motivating her patients and that the stronger the alliance, the more ability she has to motivate her clients to take action.

Question #5 discussed the broad categories of happiness interventions such as gratitude, being more social, and positive affect, and which of these categories are a focus of therapy. All field consultants incorporate encouraging their clients to be more pro-
social into their treatment plans. They accomplish this by encouraging their clients to volunteer and to offer assistance to those less fortunate.

Three field consultants incorporate gratitude exercises into their therapy and assist their clients in fostering a more grateful outlook. They encourage their clients to make lists of things they are grateful for, or to think of one thing before they go to sleep, and to focus on what is going well in their lives. Mr. Preuss (personal communication, November 3, 2012) preferred to use the word appreciation. He encourages his clients to appreciate the positives in their lives and to focus their attention on those parts.

Three of the field consultants incorporate mindfulness and meditation into their treatment and therapy sessions. Dr. Crandall (personal communication, November 30, 2012) will suggest it to all her patients and even incorporate meditation into her sessions. Dr. Tabori (personal communication, November 9, 2012) will teach her patients progressive muscle relaxation techniques and brief meditations that can be done by setting aside as little as 3 minutes per day. Mr. Preuss (personal communication, November 3, 2012) uses meditation with every client and will teach his clients how to be present-minded. He will also teach them breathing exercises and how not to get ahead of themselves. He will meditate with his clients during sessions and give them exercises they can incorporate into their daily routines. Dr. Whitman (personal communication, December 1, 2012) does not incorporate mindfulness or meditation into his therapy sessions although he will sometimes use some of the language of the mindfulness field.

All field consultants make forgiveness a part of their therapy, although each one uses a different approach. Mr. Preuss (personal communication, November 3, 2012) reframes it for his clients, highlighting how not forgiving is taking something from them.
He illustrates how they are preventing themselves from doing things because they are angry at whoever has injured them and how letting go of that anger will free them from strong negative emotions. The other three field consultants promote forgiveness during the course of therapy. They acknowledge that this usually happens later rather than sooner, as the therapy progresses and their clients are in a stronger position to forgive. They all believe that forgiving can be a healing process that has more to do with the self than the other and ultimately results in the relinquishing of many negative feelings and negative energy.

Three of the field consultants make exercise a part of their treatment plan. They assess their clients’ current physical states and assist them in determining ways they can incorporate appropriate physical activity into their daily or weekly routine. They explain the physiological benefits of exercise and highlight for their clients how exercise is shown to be an effective mood booster. Mr. Preuss (personal communication, November 3, 2012) differs from the other consultants. He may suggest some light physical activities, such as walking, but he is concerned that motivating his clients to exercise is too risky as there is a high dropout rate and it might lead them to feeling like they have failed.

Three of the filed consultants did not make spirituality a main component of their therapy. Mr. Preuss (personal communication, November 3, 2012) does not promote it at all. Dr. Whitman (personal communication, December 1, 2012) is cautious about bringing up the subject. He may assess a person’s spiritual interests and encourage them to pursue those interests, but he will not push the issue. And, with some patients, he will not bring it up at all. Dr. Tabori (personal communication, November 9, 2012) considers
spirituality the process of her clients forming a greater connection with themselves.

Beyond this definition, spirituality in her psychotherapy practice is extremely limited. Dr. Crandall (personal communication, November 30, 2012) has a spirituality practice of her own and acknowledges that when conducting therapy it is always in her consciousness. She believes that she will address the subject with as many as 50% of her patients. She approaches it as forming greater connections with oneself and with others. She will assess how spiritual a person is and if she feels that area is deficient or can be strengthened she will encourage patients to explore that area and engage in more spiritual activities.

Three of the field consultants consider meaning in life to be an essential part of therapy. Dr. Whitman (personal communication, December 1, 2012) makes existential issues and meaning in life a focus of his therapy. He will encourage his patients to find meaning in their daily lives. He believes that work is one area where meaning can be found and will explore his patients’ jobs to see whether they can extract more meaning from their current careers. He will point out deficits in meaning if he feels it is an issue for his patients and will go so far as to ask the question “why do you think you are here?”

Dr. Crandall (personal communication, November 30, 2012) sees meaning in life as a part of spirituality and makes it a focus of her therapy. Both Dr. Crandall and Dr. Tabori (personal communication, November 9, 2012) believe that meaning in life can be fostered through volunteering and giving back to others. They will discuss with their patients different ways they can be of service to others. Mr. Preuss (personal communication, November 3, 2012) does not make meaning in life a priority of this therapy but will address it if his clients steer the therapy towards the subject. He believes the topic is too
Three field consultants make increasing positive affect a part of their therapy. They will assess the level of positive affect their clients are experiencing and help them explore ways to have pleasant and enjoyable experiences more often. All field consultants will be more directive with these interventions and suggest activities such as reading a book, going to a movie, going out to dinner, and getting a facial. Dr. Whitman (personal communication, December 1, 2012) may suggest ways to increase positive affect during the course of therapy but does not make it a main focus or a priority. He believes most positive affect experiences are fleeting and prefers to focus on more sustainable endeavors.

All field consultants make being more social a part of their therapy and believe it to be an important aspect of life. They all see it as a primary goal, bringing it up frequently in their sessions, and encouraging their patients to be more social. They will explore their patients’ interests and help them discover ways they can pursue those interest while meeting new people and broadening their ideas of socializing and expanding their social support systems.

Questions #6 and #7 discussed the areas of well-being that were most frequently focused on during therapy sessions and which of those areas did each field consultant and their clients think was most important. Dr. Tabori (personal communication, November 9, 2012) contends that this is different for each client. Clients will focus on a range of areas from family life, to social life, to finances, and the importance of each area is different for each client. She herself did not think of any one area being more important than another. She also felt the frequency of each area was somewhat equal, although she
noted that career issues may be a little more frequent than others. Dr. Whitman (personal communication, December 1, 2012) believed that personal growth and development were two of the more important areas of well-being. He explained how he tries to help his patients become more aware of their needs and to foster a greater sense of empathy for themselves. He believes for his patients, self-awareness and self-love were two areas that were of prime importance. Dr. Crandall (personal communication, November 30, 2012) stated that for her and her clients, mastering things, developing a sense of accomplishment, and socializing, were the most important and most frequent areas. Mr. Preuss (personal communication, November 9, 2012) believes relatedness to be the most important area of well-being. He explained how most of his clients are in therapy because of relationship difficulties and that improving their relationships with others was the most important and most frequent area addressed by both him and his clients.

Question #8 asked how each field consultant would respond to a client who literally said, “I want to be happier.” Three of the field consultants explained that they would explore with their clients what happiness meant to them. They would ask their clients to discuss moments in their lives that brought them happiness and help them find ways to engage in other experiences similar to those happy ones. Dr. Whitman (personal communication, December 1, 2012) added that he reframes the question and substitutes the words gratifying and meaningful to replace happiness. Dr. Crandall (personal communication, November 30, 2012) will explain to her patients that it will take time and work and might even require some major life changes. She will then explore her patients’ strengths and untapped skills and help them find ways to implement them. She gives them a hopeful answer but emphasizes that it may be a long process.
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Question #9 returned to the topic of meaning in life and asked the field consultants how they would respond if a client literally asked them the question, “why me?” Mr. Preuss (personal communication, November 9, 2012) will ask the question back to his clients. He then tries to shift the focus from their suffering to managing negative feelings and fostering a more positive outlook. If his clients answer the question with a negative and defeated take on their life, he will challenge their beliefs and help them find a more positive way or different way to address the question. Furthermore, he will recommend books or stories of how other people have overcome similar suffering and sorrow. However, he added that he finds the question too abstract and the question does not come up that often. Dr. Whitman (personal communication, December 1, 2012) will try to reframe the way his patients look at their lives. He will help them realize that pain and suffering lead to growth and assist them in discovering the positive ways they have grown from their painful experiences. Dr. Tabori (personal communication, November 9, 2012) will answer the question saying that she does not know why, or because you can handle it. She will allow her patients to suffer and sit there with them, helping to contain their pain and comfort them when needed. She assures them they can get through their pain and she will be there to help guide them through it. Dr. Crandall (personal communication, November 30, 2012) will tell her patients that the universe is sending them a message about growth and change. She makes the issues about a larger spiritual message and helps her patients integrate their suffering as a part of the journey of their lives. She helps them explore how their pain has and will continue to help them grow and change, and how it has allowed them to get to know themselves on a deeper level.
Evaluation and Feedback Results

Eleven people attended a presentation given on March 23, 2013 at the Wright Institute in Los Angeles. At the conclusion of the presentation, all those in attendance were given a copy of the PowerPoint slides, and an evaluation form (See Appendix B). The evaluation form asked the attendees to provide feedback on the presentation, presenter, and the PowerPoint slides.

The first seven questions on the evaluation form were constructed using a 5-point Likert type scale (5=strongly agree, 4=agree, 3=somewhat agree, 2=disagree, 1=strongly disagree). The form addressed several aspects of the presentation such as its effectiveness in increasing understanding of happiness, how helpful it was, whether it provided new insight, how clear and informative the presenter was, whether the presenter was attentive and able to answer questions, and whether the PowerPoint was informative and helped attendees gain any new perspective. The form concluded with three additional open-ended questions, asking attendees to write what was most helpful about the presenter, suggestions for improvement, and one open space for any additional comments.

All of the attendees strongly agreed that the presentation increased their understanding of happiness and how it could be increased and sustained ($M=5$, $SD=0$). All of the attendees either strongly agreed or agreed the PowerPoint presentation offered new insight into the discussion of happiness research in a clinical setting and how it could be applied ($M=4.81$, $SD=.40$). All of the attendees either strongly agreed or agreed the PowerPoint was helpful and presented clearly ($M=4.63$, $SD=.50$) and was well organized ($M=4.81$, $SD=.40$). All attendees strongly agreed the presenter was well organized ($M=5$, $SD=0$).
and either strongly agreed or agreed the presenter was knowledgeable and clear in his communication ($M=4.90$, $SD=.30$). All of the attendees either strongly agreed or agreed the PowerPoint presentation was informative and encouraged a new perspective on happiness ($M=4.90$, $SD=.30$).

Responses to the open-end questions indicated that attendees found the presenter enjoyable, humorous, informative, well organized, clear, and engaging. Attendees stated the material was informative and offered them alternative perspectives and new information on an interesting subject. One attendee commented that the presenter embodied a great deal of what he was discussing. Another attendee commented that s/he planned to follow up on the information and impart some of it to his/her own patients. One recurrent criticism from the attendees was that the PowerPoint was not displayed on a large enough screen.

**Sample of Product**

Please see Appendix C for a sample of the presentation slides.
Discussion and Recommendations

Summary

The purpose of this doctoral project was to review the literature on happiness research and extract the most applicable data and interventions that would be useful to clinicians. The literature that was reviewed highlighted the traits, characteristics, behaviors, and cognitive processes of the chronically happy and compared them to the unhappy. It was discovered that adopting the behaviors of the happiest people was a practical task and provided a real opportunity to increase one’s personal happiness level. The literature also illustrated several interventions that could lead to significant increases in happiness and how those interventions could be applied by clinicians.

The main challenges to increasing happiness, such as adaptation, homeostasis, genetic dispositions, and human error, were also explored. Various prophylactic measures that could help navigate around the aforementioned challenges were highlighted and explained, such as varying activities slightly or significantly to counter adaptation.

Another main goal of this project was to create a taxonomy of the broad areas of happiness interventions specifically mirroring happy people, pro-social behaviors, spirituality, exercise, gratitude, hope, forgiveness, meditation and mindfulness, positive affirmations, flow, goals, meaning, well-being therapy, and behavioral activation. This will allow clinicians using creative intervention to cross check whether those interventions fit into any one or more of those categories.

Field consultants explained which categories worked best in their private
practices, and how they create their own interventions within those categories to achieve mood-boosting results. The field consultants described how interventions geared toward meditation and mindfulness, gratitude, meaning, forgiveness, evaluating strengths, exploring meaning, and goal settings can be conducting in sessions. Field consultants described intervention categories that could be effective out of session or as homework assignments such as being more social, volunteering, reading books, exercising, expressing gratitude, and finding new ways to use strengths.

In addition to identifying happiness interventions that could be applied in a clinical setting, this project took careful aim to emphasize for clinicians what is not effective. Clinicians can advise their clients on the marginal, if any, happiness gains that may be possible from financial success or enhancing one’s physical appearance. Clinicians can always explain to their clients that moving to a new city, or getting a new job or a promotion, will not provide them with sustainable happiness gains and that within time they will adapt to those circumstances. Clinicians can further explain to their clients that adaptation will almost always occur in respect to major life circumstances, and it is the smaller, everyday, routine activities that can be changed slightly or significantly that will provide a long-lasting increase in happiness. Highlighting failed strategies and the reasoning behind them could help clinicians steer their patients away from goals and activities that will most likely result in disappointment. It was explained how people are poor predictors at guessing the affective value of their choices, as well as how long the emotional rewards from a choice could be sustained. Dispelling myths and misguided assumptions as to what does not work or has little, if any, impact on increasing mood should serve as a valuable and productive resource for clinicians.
This project should give clinicians the ability to help their patients develop happiness-boosting strategies that may not have been generated otherwise without the knowledge of this research. It is the hope that clinicians are now another step closer to being able to adequately assist their patients in their pursuit of happiness.

**Limitations**

There are two main limitations both stemming from the same issue. Researchers have generated and tested happiness interventions sporadically since the late 1970s. The bulk of happiness interventions specifically developed for clinical practice and reviewed in the project are all relatively current. Most of the interventions described in this project are from the last 13 years. As previously mentioned in chapter 2, a survey conducted in 2000 looked at psychological abstracts since 1887 and found that studies of negative emotions exceeded studies of positive emotions by a ratio of 14:1 (Myers, 2000).

Since most of the happiness interventions are relatively recent, it was difficult to find field consultants who were not only familiar with the literature and research but also were implementing it in their private practice. The field consultants for this project were familiar with the broad happiness-boosting categories, and were familiar with many, but not all, of the interventions. No one field consultant implemented the bulk of the research, however, they did make happiness a primary focus of their treatment and therefore were able to enhance this project and describe some of what has and has not worked in a clinical setting.

The other main limitation was finding longitudinal studies that could show significant and long-term sustainability for the various mood-boosting interventions. Some researchers were able to conduct follow-up evaluations showing 6 months to a year
of sustainable gains in happiness; however, longer-term follow-up studies were not conducted.

**Future Directions**

There are two major directions that happiness research is heading in. First would be to show the long-term effects of the happiness interventions. Replicating the research or creating new interventions with a longitudinal design in mind would bolster the argument that happiness gains are indeed sustainable, long-lasting, or perhaps even everlasting.

The second direction would be for more clinicians to become familiar and proficient with the research and interventions and begin to offer happiness as a viable and reasonable treatment goal. Perhaps a comprehensive happiness orientation could evolve, something comparable to Cognitive Behavioral Therapy or Psychodynamic interventions. This would allow clinicians to learn, practice, and incorporate a full treatment plan with the main goal of therapy moving from deficit focus and symptom reduction to increasing happiness and crafting a life of meaning, engagement, positive affect, and fulfillment.

**Personal Statement**

I was first introduced to the science of happiness in 2006 during a social psychology class at UCLA. I was enrolled in the class as a prerequisite to apply to graduate school, and happiness research was the subject of the very last lecture. The lecture described the many ways that people could increase their happiness on their own and what the current research said about why people were happy. However, there was no information on how clinical psychologists applied any of the research. Since clinical psychology was to be my future, I was eager to learn more about the research and
investigate whether there were any clinical applications.

Over the next several years, I read many books on happiness, all of them describing the latest research and what types of activities were shown to effective, but still nothing that seemed to be specifically geared for a clinical setting. Once I arrived in graduate school and became more adept at researching literature, I began to compile articles that were aimed at applying happiness research to clinical populations, with either significant results or results heading in the right direction.

Once I began my clinical training, I discussed my interest in the subject with my supervisors, who were agreeable to letting me try some of what I was learning in process groups and in individual therapy. I found that when I focused therapy on the various categories of happiness research, it seemed to strengthen my alliance with my patients and my groups, and I became convinced this area would be a large part of my future as a clinician.

Focusing on the positive and gearing patients away from goals shown to have no emotional rewards and directing them towards goals that could potentially increase happiness seems to activate and motivate my patients to reengage in life and explore their own strengths and interests. Focusing on the positive and increasing positive affect also appear to broaden their minds, as they were more able to improvise strategies to reduce their distress and cope better with their adverse symptoms. I quickly became convinced that there is a place for happiness in therapy, and that it was my calling to review the literature and put together this project to inform and encourage clinicians to incorporate, or at the very least consider, making happiness a worthy clinical pursuit.


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APPENDIX A

FIELD CONSULTANT INTERVIEW QUESTIONS
Questions for Field Consultants

1. How often do you have conversations with your clients about their happiness in all aspects of their life?

2. How do you address happiness in therapy beyond the presenting symptoms?

3. What interventions do you use to increase your clients’ happiness, well-being, or satisfaction with life in addition to the treatment directed at presenting conditions?

4. How do you motivate your clients to engage in activities that utilize their strengths?

5. Do you ever focus a part of your therapy with a patient on any of the following areas? Please explain how.
   A) Pro-social behavior, such as charity work
   B) Fostering a more grateful outlook
   C) Mindfulness or meditation interventions
   D) Forgiveness
   E) Exercise
   F) Spirituality
   G) Meaning in life
   H) Increasing positive affect routinely
   I) Being more social, extroverted

6. What areas of well-being do you most often focus on in your therapy sessions?

7. What areas of well-being do you and your clients believe to be most important?

8. If a client walked in to your office and asked, “I want to be happier?” how would you respond?

9. What interventions do you use to create meaning? For example, when a client describes his/her suffering and asks “why me?” how do you respond to that?
APPENDIX B

PRESENTATION EVALUATION FORM
Presentation Evaluation Form

Please rate the presentation by circling the appropriate number following the questions below:

1. The presentation increased my understanding of happiness and how it can be increased and sustained.

   5  4  3  2  1  
   Strongly Agree   Agree   Somewhat Agree   Disagree   Strongly Disagree

2. The power point presentation offered new insight into the discussion of happiness research in a clinical setting and how that research can be applied.

   5  4  3  2  1  
   Strongly Agree   Agree   Somewhat Agree   Disagree   Strongly Disagree

3. The power point presentation was helpful in delivering the information and offering the contents in a clear manner.

   5  4  3  2  1  
   Strongly Agree   Agree   Somewhat Agree   Disagree   Strongly Disagree

4. The power point presentation was well organized.

   5  4  3  2  1  
   Strongly Agree   Agree   Somewhat Agree   Disagree   Strongly Disagree

5. The presenter was knowledgeable and clear in his communication of the information.

   5  4  3  2  1  
   Strongly Agree   Agree   Somewhat Agree   Disagree   Strongly Disagree

6. The presenter was attentive to questions and open to feedback during the presentation.

   5  4  3  2  1  
   Strongly Agree   Agree   Somewhat Agree   Disagree   Strongly Disagree

7. Overall, this power point presentation was informative and encouraged a new perspective on happiness.

   5  4  3  2  1  
   Strongly Agree   Agree   Somewhat Agree   Disagree   Strongly Disagree

8. What did you like or find most helpful from the presentation?

   ____________________________________________________________

   ____________________________________________________________

9. What suggestions might you have to improve the presentation?

   ____________________________________________________________

   ____________________________________________________________
Thank you for taking a moment to complete this evaluation. Please return the completed form to the presenter.
APPENDIX C

PRESENTATION SLIDES
Clinical Applications of Happiness Research

James Harris, M.A.
Doctoral Candidate
California School of Professional Psychology
At Alliant International University

Joan Murray, Ph.D.
Doctoral Project Supervisor
Presentation Goals

- Provide a comprehensive understanding of happiness
- Explain why increasing happiness is challenging
- Describe effective interventions that have been shown to increase happiness
- Discuss how the topic of happiness and happiness interventions can be incorporated into psychotherapy
Happiness and Subjective Well-Being

**Definition:** *Happiness and Subjective Well-being*

- Cognitive Component
  - Satisfaction with life: the process of how people evaluate their life and circumstances (Fordyce, 1977)
- Emotional Component
  - High Positive Affect
  - Low Negative Affect (Fordyce, 1977)

People who have high levels of subjective well-being have:

- A positive evaluation of their lives
- On average, experience positive affect more of the time than negative affect (Diener, 1984; Diener & Diener, 1996)
Happy and Unhappy People

- Happy People:
  - less susceptible to illness
  - less focused on themselves
  - less insulting and antagonistic

- Unhappy People:
  - Evaluate circumstances and experiences as unpleasant and unwanted
  - Develop adverse emotions such as sadness, anger, and worry

- Less happy people do not experience more unhappy events than happy people

- Happy people tend to experience more happy moments than less happy people

(Myers & Diener, 1995; Otake, Shimai, Tanaka-Matsumi, Otsui, & Fredrickson, 2006)
Happy and Unhappy People

• No single factor promises happiness
• Strong and satisfying social relationships were a trait of all happy people.
• Happiness is not possible without close social relationships

(Diener & Seligman, 2002)
Areas of Well-Being

- Work, Faith, Close relationships (e.g. marriage), Focusing on and pursuing reasonable goals that engage one’s skills (Myers & Diener, 1995)
- Autonomy, Personal growth, Self-acceptance, Environmental mastery, Positive relationships, Purpose in life (Ryff, 1989)
Perks of Positive Emotions

• Expand range of a person’s attention and cognitions
• Increase a person’s physical, intellectual, and social resources
• Encourage people to abandon familiar strategies & behaviors
• Motivate people to be creative and improvise ideas, thoughts, and actions
• Build sustainable resources
• Reverse impact of negative emotions and often has a salubrious effect
• Help accrete resources that could be used during future negative experiences and personal setbacks

(Fredrickson, 1998)
Perks of Positive Emotions (cont.)

- Increase resiliency
- Increase ability to regulate emotions
- Increase capacity to quicken recovery from the physiological effect of negative feelings
- Assist with “meaning making”
- Increase coping ability
- Correlated with:
  - Being imaginative, efficient and resilient
  - Successful, coping, satisfying and closer relationships
  - Greater income, better health and longer life

(Tugaed & Fredrickson, 2004; Lyubomirsky, 2011)
Presentation Goals

- Provide a comprehensive understanding of happiness
- **Explain why increasing happiness is challenging**
- Describe effective interventions that have been shown to increase happiness
- Discuss how the topic of happiness and happiness interventions can be incorporated into psychotherapy
Challenges to Increasing Happiness

• Genetics
• Adaptation
• Homeostasis
• Poor Prognostications
• Myths and Misguided Assumptions
Genetics

- Genetically determined happiness set-point (Lykken & Tellegen, 1996)
- Genetics may account for 40-50% of the variance, while the remaining variance was determined by non-shared environmental factors (Bartels & Boomsma, 2009)
- Genetically influenced set-point is not fixed and change is possible (Fujita & Diener, 2005)
- The general consensus: genetics are thought to account for roughly 50% of a person’s happiness level, with the potential to account for as much as 80%. This means anywhere from 20%-50% is malleable (Lyubomirsky, 2001)
- Even if happiness does fall within a genetically-determined set range, and even if permanently changing this set-range is a daunting challenge, then at the very least, research and current interventions can focus on raising a person’s happiness level so that it gravitates to the highest point of that range (Lyubomirsky, 2001)
Adaptation

- The hedonic treadmill (Brickman and Campbell, 1971 as cited in Diener, Lucas, & Scollon, 2006)
- Extreme cases: lottery winners and accident victims, adaptation still took effect (Brickman, Coates, and Janoff-Bulman, 1978)
Homeostasis

- Psychological immune system: protecting people from experiencing strong negative emotions for too long, and preventing people from experiencing strong positive emotions for too long
- The psychological immune system can be overrun: chronic depression (Mochon, Norton, & Ariely, 2008)
- Therefore, since subjective well-being can be moved to the negative part of its set-point range or even lower, should not it also be possible that this homeostasis can be impacted such that the subjective well-being set-point (i.e. happiness, or potential for and tendency to happiness) increases?
- Many happiness researchers believe that lasting changes are possible with consistent engagement in happiness-boosting activities (Cummins, 2010)
Poor Prognostications

- People are guessing when they choose endeavors in the hopes those experiences will create meaning or happiness
- For example, one way to create meaning is through service to others
- People are not very good at predicting the hedonic impact of a decision.
- People are extremely inaccurate at predicting how long the affective rewards will last

(Gilbert et al., 1998; King & Napa, 1998)
Dispelling Myths and Misguided Assumptions

- Most people are happy most of the time, still, millions of people are unhappy, and happy people would like to be even happier (Diener & Diener, 1996)
- Psychology students do not seem to have much of a foundation on the fundamental aspects of happiness and happiness research (Diener & Diener, 1996)
- Most people have a tendency to misjudge others as being less happy than they actually are (Gilbert et al., 1998)
- Most people have a tendency to misjudge how happy something will make them (Gilbert et al., 1998)
- Happiness and money are not highly correlated (Myers & Diener, 1995)
- Prioritizing financial goals over other goals is associated with negative psychological results such as depression, anxiety, and less energy (Kasser & Ryan, 1993)
- The more people strive for financial gain, the more their well-being weakens and their troubles increase (Kasser & Ryan, 1993)
- As the collective wealth of America has increased over the past 40 years, Americans' happiness levels have remained virtually unchanged (Myers, 2000)
- Most people believe that more money will bring them more happiness and put an end to their troubles (Csikszentmihalyi, 1999)
- Physical attractiveness has a low correlation with happiness (Diener, Wolsic, & Fujita, 1995)
- Correlation between physical attractiveness and self-esteem is marginal (Diener, Wolsic, & Fujita, 1995)
- Married people tend to be happier than unmarried people and divorced people (Myers, 2000)
- Unhappily married people are the least happy of the bunch (Myers, 2000)
- Positive correlations between faith and happiness (Myers, 2000)
Presentation Goals

• Provide a comprehensive understanding of happiness
• Explain why increasing happiness is challenging
• **Describe effective interventions that have been shown to increase happiness**
• Discuss how the topic of happiness and happiness interventions can be incorporated into psychotherapy
**Sustainable Happiness Model**

- Genetically-determined set-point accounts for 50% of a person’s happiness level
- Life circumstances count for about 10% of a person’s current happiness level. Not sustainable as people adapt to major life circumstances
- “Intentional happiness-relevant activity.” This accounts for roughly 40% of a person’s happiness level

(Lyubomirsky, 2005)
Happiness Interventions

- *Mirroring Happy People*: Adopt traits and habits of happy people: being more active; making happiness a priority; being more extroverted and social; little time spent worrying; positive and optimistic cognitions; being more organized; socializing more; engaging in meaningful endeavors; reinforcing close friendships; decreasing ambitions and expectations; and being more present-minded (Fordyce, 1977)

- *Education about happiness* (Fordyce, 1983)
Happiness Interventions

- **Meditation and Mindfulness**: Increases empathy, greater imagination, greater self-regulation, vivid dreaming, and happier marriages (Walsh, 2001)
- Gain greater understanding of one’s self and creates psychological abilities that accrete over time and can be applied in future circumstances (Fredrickson, Cohn, Coffey, Pek, & Finkel, 2008)
- Fosters a sense of control over their lives and circumstances (Bedard et al., 2003)
- Increase the experience of feeling pleasant emotions (Davidson et al., 2003)
- Increase in immune functioning (Davidson et al., 2003)
- Elicited warmth, empathy, love, and satisfaction (Fredrickson et al., 2008)
- Increased self-love; meaning in life; physical health benefits; and satisfying social relationships and support (Fredrickson et al., 2008)
Happiness Interventions

- **Positive Affirmations**: Happiness could be increased simply through cognitive retraining activities (Licther, Haye, & Kammann, 1980)
- Altering views, cognitions, and presumptions using exercises of analysis and contemplation of ideas and assumptions increased happiness (Licther, Haye, & Kammann, 1980)
- 10 minutes of repetition of positive affirmations and imagery, thereby inducing a more positive state of mind (Licther, Haye, & Kammann, 1980)
- Statements that were carefully assembled to produce positive feelings and elevate moods were shown to accomplish increased happiness (Velten, 1968)
- In clinical practice, therapists could help clients develop positive self-referent statements that could be recited daily (Velten, 1968)
Happiness Interventions

• **Flow**: person’s complete attention is fully absorbed in an activity (Csikszentmihalyi, 1999).
• The challenges of the activity match the level of the participant’s skills, require the full engagement of those skills and, therefore, demand total concentration.
• The more flow one can experience, the higher the chance for one to be happy.
• Complete and total involvement can be found in all areas of life (Csikszentmihalyi, 1999).
• Mental health professionals can assist and encourage their clients to explore activities with high flow potential.
Happiness Interventions

- **Well-being Therapy**: First two sessions: describe experiences where patients felt a positive sense of well-being (Fava et al., 1998)
- The next three sessions: recalling moments when well-being was prematurely disrupted, as well as what automatic thoughts and beliefs preceded and caused the interruption (Fava et al., 1998)
- The major goal of the second phase of well-being therapy is to determine which situations of well-being are unaffected by negatively-distorted cognitions and which situations are inundated with them (Fava, 1999).
- The final phase of well-being therapy is to determine areas of well-being in which the patient is most deficient. Once the magnitude of the deficiency is determined, the goal of therapy shifts to cognitive restructuring in the most defective dimensions (Fava, 1999)
Happiness Interventions

- **Writing**: Imagine themselves in the future, at their best, with no limits to their potential (King, 2001)
- Write about extremely positive experiences for 20 minutes each day for three straight days (Burton & King, 2003)
- Write about “best possible selves” (Sheldon & Lyubomirsky, 2006).
Happiness Interventions

- **Goals**: teaching goal-setting and planning abilities increased well-being (MacLeod, Coates, & Hetherton, 2008)
- Setting, pursuing, and achieving goals that increase feelings of autonomy, relatedness, and competence have also been shown to increase happiness (Sheldon et al., 2010)
- Relatedness goals would include strengthening current relationships or cultivating new ones
- Autonomy goals are those that increase feelings of control over how one’s time is spent
- Competence goals would be engaging in more activities that one is capable of doing and doing well
Happiness Interventions

- **Gratitude:** A grateful outlook promotes the relishing of pleasant events, allowing people to feel the greatest amount of pleasure and contentment from the experience (Sheldon & Lyumbomirsky, 2006)
- Review life over the previous week and write down five things they were grateful (Emmons & McCullough, 2003)
- Make their gratitude list every night (Emmons & McCullough, 2003)
- Think about, write an essay about, or write a letter to somebody for whom they were grateful. All three conditions showed an increase in positive affect. The highest increases were in the grateful thinking condition (Watkins et al., 2003)
- Gratitude: remembering and magnifying one’s experience of positive moments and situations (Watkins et al., 2003)
Happiness Interventions

- **Meaning**: Feelings of meaningfulness have strong associations with happiness (Debats, 1996)
- “Meaning in life” as a feeling that one can comprehend, make sense, or find logic in one’s being. (Debats, 1996)
- Logotherapy (Frankl, 2006) and existential psychotherapy (May & Yalom, 2005)
- What has happened was meant to be, and that the direction they are moving in is meant to be (Yalom, 2003)
- Conversations about meaning: What might they want written about them on their tombstone (Yalom, 2003)
- Frankl (2006): imagine they are on their deathbed and then to express what they will say and think about themselves and how they lived.
- Focus one’s energy and efforts towards causes, charities, creative projects, and other people (Frankl, 2006).
- Remedy to meaninglessness is engagement (May & Yalom, 2005)
- Identify what is blocking clients from loving others, from engaging in enjoyable work, and endeavors using their abilities and talents; from pursuing their interests; and ignoring creative or spiritual goals (May & Yalom, 2005).
- Logotherapy: three primary paths to meaning: generating work or actions, engagement or love with another person or thing (in other words, to fully experience another person or entity), to find purpose in one’s suffering; that is, to endure whatever pains and tragedies have occurred, to transcend them, and to find them dignifying rather than shameful (Frankl, 2006).
- Paradoxical interventions: prescribing clients to do that which they find most anxious robs the situation of its anxiety-producing powers (Frankl, 2006).
Happiness Interventions

- **Forgiveness**: reduces or eliminates resentments and anger and is therefore often considered a positive emotion (Seligman, Rashid, & Tayyab, 2006).
- Forgiveness therapy: taught to give up resentments and offer compassion (Reed & Enright, 2006).
- Promotes compassion, assists participants in ascribing meaning to their past suffering, and helps them discover new resolve (Reed & Enright, 2006).
- Forgiveness therapy: based on Enright and the Human Development Study Group’s 17 psychological variables that motivate the forgiveness process (as cited in Hebl & Enright, 1993). These 17 variables can be grouped into 8 broader topics, with each therapy session focusing mainly on one (although sometimes several) of these topics. These topics include: definitions of forgiveness and psychological defenses; exploring the contributing factors to one’s anger; acknowledging that one has been hurt and exploring ways to regulate and reduce the hurt and begin to contemplate forgiveness; making a commitment to forgive; developing empathy and compassion towards the offender; acknowledging that there have been times when oneself has needed forgiveness; accepting the hurt; concentrating on how one has changed because of the hurt; becoming mindful of the affective impact of the hurt; and decreasing negative emotions towards the injurer.
Happiness Interventions

- **Hope**: a cognitive process that shapes how one creates, pursues, and achieves one’s goals (Snyder, 1995)
- The motivation to pursue goals is called the agency component of hope
- The ability to create strategies to attain goals is called the pathway component
- Formulating attainable goals is one of the best ways to foster and boost hope (Snyder, 1995).
- Develop their agency and pathways: positive self-talk about achieving; viewing a setback as a poor strategy and not an absence of skill or aptitude; viewing difficulties and complications as challenges; remembering previous accomplishments; having social support to discuss plans and strategies; listening to stories of how others succeeded; having people to look up to; exercising regularly; eating properly; having a sense of humor; resting; ability to revise goals if needed; learning new skills and subjects; and rewarding oneself for small successes on the way to the larger goal (Snyder, 1995).
- Hope therapy teaches its participants the aforementioned principles and how to apply them in their daily lives, with a primary focus on goal creating and enhancing the agency and pathways components (Cheavans, Feldman, Gum, Michael, & Snyder 2006)
Happiness Interventions

- **Spirituality**: Attending religious services was shown to increase happiness (Mochon et al., 2008)
- The greater the frequency of attending services, the greater and the more sustainable were the gains in happiness (Mochon et al., 2008)
- Frequently engaging in a happiness-boosting activity could be a solid strategy to move a person’s baseline level of happiness to a new and higher set-point (Mochon et al., 2008)
Happiness Interventions

- *Exercising and physical activities* appear to be effective happiness-increasing interventions (Armstrong & Edwards, 2003)
- Frequently going to the gym or doing yoga (Mochon et al., 2008)
- The more often one exercised, the larger the aggregate gains in happiness (Mochon et al., 2008)
Happiness Interventions

• **Strengths**: evaluate signature strengths and use them daily in novel and creative ways (Seligman et al., 2005)

• Produced significant increases in happiness and decreases in depression (Seligman et al., 2005)

• Continuous use of strengths leads to significant gains in happiness (Seligman et al., 2005)
Happiness Interventions

• **Pro-Social Behavior**: performing and recording act of kindness (Otake et al., 2006)

• Pro-social spending (i.e. spending money on others or on charities and causes) resulted in significant boosts in happiness compared to those who spent money on themselves (Dunn, Aknin, & Norton, 2008)
Behavioral Activation

- **Behavioral activation**: engaging in intentional activity assists people in exploring activities they find enjoyable; encourages them to engage in these activities; and pushes them to participate in new activities and experiences, such as traveling to new locations, exercising, developing a new hobby (Jakupcak et al., 2006), and pursuing educational and vocational goals (Jakupcak, Wagner, Paulson, Varra & McFall, 2010).

- Finding creative solutions to engage in activities that are consistent with clients’ goals (Jakupak et al., 2010)

- Meta-analysis on behavioral activation interventions and their ability to increase well-being. Results showed a moderate effect size of .52 when comparing the difference between the increases in happiness from behavioral activation interventions to control conditions (Mazzucchelli, Kane, & Rees, 2010)
Presentation Goals

- Provide a comprehensive understanding of happiness
- Explain why increasing happiness is challenging
- Describe effective interventions that have been shown to increase happiness
- Discuss how the topic of happiness and happiness interventions can be incorporated into psychotherapy
Recommendations

• In session interventions: meditation, gratitude exercises, writing exercises, exploration of meaning, identifying moments of well-being, evaluating strengths, forgiveness exercises, goal setting, defining happiness

(R. Preuss, personal communication, November 3, 2012)
(R. Crandall, personal communication, November 30, 2012)
(M. Whitman, personal communication, December 1, 2012)
(I. Tabori, personal communication, November 9, 2012)
Recommendations

• Out of session: utilize strengths, exercise, meditation, gratitude exercises, being more social, volunteerism, recommend books

(R. Preuss, personal communication, November 3, 2012)
(R. Crandall, personal communication, November 30, 2012)
(M. Whitman, personal communication, December 1, 2012)
(I. Tabori, personal communication, November 9, 2012)
Key References


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INTERVIEW CONSENT FORM FOR FIELD CONSULTANTS
I have been informed that this doctoral project interview will be conducted by James Harris, a graduate student at the California School of Professional Psychology at Alliant International University, Los Angeles. I understand that this project is designed to study the clinical applications of happiness research, and that I have been contacted by the above student to offer input as a Field Consultant because I have some expertise and/or clinical/professional knowledge about the stated project topic. The purpose of the interview is to not only fill the informational “gaps” that exist in the professional literature about this topic, but to also examine if what is discussed in the research literature is actually being practiced/observed in the community by field professionals.

I am aware that my participation as one of the Field Consultants will involve answering some interview questions (face-to-face, if possible) designed to understand clinical applications of happiness research. I am aware that the interview will be audiotaped -- or conducted via phone or email correspondence, if preferred. The amount of response to these interview questions can be as lengthy or brief as I see appropriate for myself, and I can choose to respond only to those questions that I feel qualified to answer, if needed. The interview process may take approximately 60 minutes of my time to complete, and the interview will be audiotaped (if face-to-face or via phone contact) to ensure its quality and accuracy.

I have been informed that my participation in this study is voluntary and I can withdraw at any time. I understand that this is a professional interview/contact where I will be asked to share my clinical/professional expertise on the stated project topic. Some of the interview contents may be used within the project report as personal communication citations, and my contribution to this study will be appropriately cited within this project.

I am aware that although I may not directly benefit from this study, my participation in this project will further increase knowledge and awareness in the field of psychology -- specifically, pertaining to the clinical applications of happiness research. I understand that I may contact James Harris at jharris11@alliant.edu OR his/her project supervisor, Joan Murray, Ph.D. at 1000 S. Fremont Ave. Unit #5, Alhambra, CA, 91803 or (626) 270-3367 if I have any questions regarding this project or my participation in this interview as a Field Consultant. I understand that at the end of this study, I may request a summary of the results or additional information about the study from the above student.

I have read this form and understand what it says. I voluntarily agree to participate in this professional interview as a part of the student’s doctoral project. I understand that I will be signing two copies of this form. I will keep one copy and the student, James Harris, will keep the second copy for his/her records. If I have received this Consent Form and the Interview Questions via email, by returning my answers via reply, I am agreeing to the above-stated conditions.

Participant’s Signature

Date

Student’s Signature

Date
VITA

Educational History

2009 – Present  California School of Professional Psychology – Los Angeles (CSPP-L.A.)
                Alliant International University
                Clinical Psy.D.

2009 – 2011  California School of Professional Psychology – Los Angeles (CSPP-L.A.)
              Alliant International University
              M.A. Clinical Psychology

2006 – 2008  University California Los Angeles (UCLA) Extension
              Relevant Coursework: Introductory Psychology, Abnormal Psychology, Developmental Psychology, Human Motivation, Social Psychology, Psychology & the Law

              Brandeis University, Waltham, MA

Awards and Scholarship

2011  Dean’s Award of Excellent Scholarship
      Alliant International University
      Presented to students who exhibit excellence academic performance

Academic Employment

2008 - Present  Teaching Assistant, UCLA Extension
                Classes: (1) Social Psychology, (2) Psychology & the Law

2012 - Present  Teaching Assistant, SMC
                Class: Social Psychology

Research Experience


Professional Training

2012 – Present  Psy.D. Intern, Wright Institute Los Angeles, Los Angeles, CA
2011 - 2012    Psy.D Intern, Chabad Residential Treatment Center, Los Angeles, CA
2010 - 2011    Practicum Student, Hillview Mental Health Center, Pacoima, CA