The Happiness Route: finding alternatives to the problem-based approach in social work for vulnerable groups

Laura A. Weiss & Gerben J. Westerhof

Published online: 03 Jul 2020.

Submit your article to this journal ↗

Article views: 110

View related articles ↗

View Crossmark data ↗

Routledge
Taylor & Francis Group

The Happiness Route: finding alternatives to the problem-based approach in social work for vulnerable groups

Laura A. Weiss [ID][a] and Gerben J. Westerhof[b]

[a]Optentia Research Focus Area, North-West University, Vanderbijlpark, South Africa; [b]Department of Psychology, Health & Technology, University of Twente, Enschede, The Netherlands

ABSTRACT

The Happiness Route is a positive psychology intervention (PPI) for lonely people with health problems and low socio-economic status with the aim to improve their well-being. To be able to pursue an intrinsically motivated activity, participants received a budget of €500. A randomized controlled trial showed that the intervention was just as effective as the problem-based control condition, but participants were more satisfied with the Happiness Route. An interview study indicated that individuals change in different ways, showing that one size does not fit all. Lessons learned during the implementation are shared, such as the importance of the project leader, the role of the intermediaries to reach the target group and the role of autonomy-support in the training of counsellors. We conclude that a PPI can be used as a complement to the traditional focus on problems and can bring more balance into the care for the most vulnerable people.

New positive psychology interventions (PPIs) are developed every year, with a growing interest for PPIs in vulnerable groups, like those with psychiatric or somatic disorders (Chakhssi, Kraiss, Sommers-Spijkerman & Bohlmeijer, 2018). The Happiness Route is such an intervention with the aim to improve well-being rather than to treat symptoms and solve problems in lonely people with physical or mental health problems, a low socio-economic status and low levels of well-being (Weiss et al., 2013). Whereas many PPIs have been studied in an experimental context, the Happiness Route was developed and studied in the everyday practical context of social work. In this article, we will shortly describe the intervention, discuss two studies we carried out, and reflect on the lessons learned for implementing PPIs in everyday practice.

The Happiness Route

The Happiness Route was first developed in the city of Almelo, the Netherlands. The intervention had been implemented in about 10 cities in the Netherlands and received a European award in social work. The basic idea was to provide a new approach for a vulnerable group that focuses on activating people to take responsibility for their own well-being. Participants received around four home visits from a professional, e.g., a social worker, trained in the happiness-based approach. Together, they

looked at values, positive memories and future dreams, with the goal to find a passion. Participants received a one-time budget of a maximum of €500, to be able to pursue an activity that they were passionate about. Activities included, for example, a photography course, music lessons, or visiting the local soccer matches. The basic idea was that this activity would help them to break the vicious cycle of loneliness, health problems, financial constraints, and languishing.

Before starting the study, we provided a stronger theoretical basis (Weiss et al., 2013). We used the Self-Determination Theory (Ryan & Deci, 2000), as the activity is expected to represent a strongly intrinsically motivated activity that supports the needs for autonomy, competence, and relatedness. We also made the activation process more explicit and provided evidence-based methods for choosing and carrying out the activity.

Empirical studies

The Happiness Route was thoroughly studied in its applied context in social work. A randomized controlled trial (RCT) with 108 participants was conducted to assess the effects of the intervention at pre-test, after 3 months, and after 9 months (Weiss et al., 2020). Participants of the Happiness Route were compared to those of an active control group that received house visits with the intention to optimize problem-based care. The Happiness

Route was found to be as effective as the problem-based control group: the primary outcome well-being, as measured with the Mental Health Continuum-Short Form (MHC-SF), as well as some of the secondary outcomes, i.e. depressive symptoms and loneliness, improved significantly at the 9-month follow-up in both groups. The Happiness Route was more successful in bringing people out of a languishing state. Furthermore, satisfaction with the treatment was significantly higher in the Happiness Route.

Studies on the perspective of participants in PPIs are rare but important to understand how they work and how they can accommodate individual experiences. We examined how participants in the Happiness Route experienced change in their satisfaction of autonomy, relatedness and competence (Weiss, 2016). Semi-structured interviews with twenty former participants of the Happiness Route were conducted. Change or continuity in the fulfilment of autonomy, competence and relatedness was coded for every participant individually with good interrater reliability. Analyses yielded four main findings. First, need fulfilment was low at the start of the intervention in many cases. Second, the counsellor played an important role for need fulfilment. Third, the activity participants chose was crucial for change in need fulfilment to occur. Fourth, people seemed to benefit most when all three needs were fulfilled in the end.

Application and feasibility

During the study, the Happiness Route was implemented in seven local municipalities across the Netherlands. Sixty-six counsellors from the social work sector were trained. Furthermore, relevant intermediaries in the municipality's healthcare and welfare system were informed about the project and encouraged participants to apply for the Happiness Route. Based on the findings of the studies we conducted and our experience during the project, we will reflect on the following implementation issues, arranged from more macro- to more micro-level: the policy context, the role of the project leader, the reach of the target group, the training of professionals, and the delivery of the intervention.

The policy context

The Happiness Route focuses on the improvement of well-being rather than treating symptoms or solving problems. At first, the reactions to the project were sometimes sceptical. Representatives of municipalities argued that they did not feel responsible for the well-being of citizens. The project team argued that more of the same problem-focused approach does not always help the target group that often already receives much care (Van der Plaats, 2002). Furthermore, well-being is an important resource and improvements in well-being can bring important health gains. Over time, the policy context in the Netherlands changed, as a new approach was advocated that focused on choice, talents, and participation. This new approach matched the self-determination theory very well and helped with the implementation of the intervention in municipalities.

Role of the project leader

In each municipality, we worked together with a project leader who was responsible for the recruitment of participants and counsellors as well as for the distribution of the money. The success of the project depended to a large extent on the project leader. Being committed and enthusiastic and having enough time and endurance are essential features for project leaders and the success of the implementation. It is beneficial if the project leader already has a good network in social work and care. Yet it can also be successful without an existing network if the project leader is willing and has the time to build this up. In the starting phase, a lot of time and effort has to be put in finding enough intermediary organizations and set up information meetings. We learned that informing professionals once, in the beginning, is not enough. People can forget things, misunderstand the method and employers have to be informed. Therefore, it is vital that the project leader invests time to keep up the contact. It could also help to make more formal agreements on how many participants an organization commits to deliver. Another recommendation for project leaders would be to be open to new possibilities for implementation. If the project is more viable when it takes on another form, this should be supported. A local community often know best what works in their context and should be able to modify the intervention accordingly into their care processes.

Recruitment of the target group

Recruitment was the hardest part of the project. The target group of lonely people is notoriously hard to find and to engage in interventions in social work. We included intermediaries who were in contact with possible participants. We learned that when a project is newly implemented, it takes time until it really 'lands' in a local community and gets well-known by the intermediaries. Intermediaries who have been informed can forget about the project in their daily work. It takes a while

until they quickly identify the right candidate and until it is recognized as an option during their work routine. Therefore, it can take several months until the project delivers its first participants. Project leaders should prepare the counsellors for this and take the slow-starting period into account during the planning.

The positive character of a happiness-based approach could be a viable alternative, especially for people who would not consider taking part in an intervention that targets their problems, like care avoiders (Koekkoek et al., 2006). Being able to offer a more attractive, acceptable and less stigmatizing approach could reach groups that are normally hard to reach (Bolier, 2015), bridging the treatment gap (Kohn et al., 2004). When trying to help achieve long-lasting changes in people's lives, professionals can be more successful when they support their clients in changing their actions rather than their circumstances (Sheldon & Lyubomirsky, 2006).

Training of counsellors

All counsellors were trained during a one-day workshop. First of all, professionals were encouraged to change and rethink. Many care professionals act from an inner urge to help and protect and have been educated and worked in the problem-based tradition for years. While work experience is extremely important and the competences of the counsellors are vital and should be used, counsellors may need to incorporate a new vision when working in a happiness-based style. When using the Happiness Route or other positive approaches, it is important to let go of some automatic reactions patterns, where control is taken over with the aim to help. That is not an easy process and can feel uncomfortable at first. During training, this was explicitly discussed and practised. Most importantly, counsellors have to learn how to optimally offer autonomy support to clients (Visser, 2010). Instead of directly coming up with solutions or ideas, the focus is on how to empower the participants to think for themselves. The participants need to get enough room for developing their own ideas and being able to apply their talents and competencies. Professionals thus have to take a step back. Autonomy support has to be trained repeatedly throughout the process. It is vital that counsellors recognize their urge to help and notice when they steer in a certain direction during the counselling process, in order to be able to step back again. It requires a different approach with confidence in the abilities of the client. This is also in line with methods like motivational interviewing (Rollnick et al., 2009) and solution-focused support (Lohuis et al., 2017).

The delivery of the intervention

Our interview study strongly indicated that individuals change in different ways, showing that one size does not fit all. The success of an activity is partly defined by the fit between the person and the activity. Certain kinds of activities work better for certain types of people (Lyubomirsky & Layous, 2013). It is inherent to the Happiness Route to provide the best possible person-activity fit by searching for the passion of an individual. Although it is not possible and desirable to do this in every care situation, it is important that care professionals regularly check if an intervention or care situation fits a person. Intrinsic motivation (Ryan & Deci, 2000) could be a helpful indicator of the quality of the person-activity fit.

The fulfilment of the three basic psychological needs is a precondition for good levels of well-being. Not only PPIs but also health and social care in general and interventions in these settings could make use of the self-determination theory. It could be helpful at the goal setting stage at the beginning of an intervention to find an answer to the question: 'Which specific need support is needed for an individual in which area?' It could also be useful to evaluate progress in achieving goals in need satisfaction and, if needed, adjust the intervention accordingly or stop with the intervention when the goals have been reached. Based on the findings, we believe that social work and care can profit from incorporating autonomy, competence and relatedness support (Pelletier et al., 2001; Sheldon & Filak, 2008; Visser, 2010).

Conclusions

The Happiness Route is an example of how a new PPI can be used in the complex context of social work. Its case provides us with new insights into the possibilities for the promotion of well-being for vulnerable groups beyond an experimental context. At least as effective as the traditional problem-based approach, satisfaction with the treatment was significantly higher in the Happiness Route. The case also provides us with important information on the implementation of such an intervention. The intervention is still successfully run in several municipalities, also after finishing the study. The case shows that a PPI can be used as a complement to the traditional focus on problems and illness in social work and can bring more balance into the care for the most vulnerable people.

Acknowledgments

Disclosure statement

Funding

ORCID

Laura A. Weiss http://orcid.org/0000-0002-1302-8729

References

Bolier, L. (2015). *Positive psychology online: Using the internet to promote flourishing on a large scale* [Doctoral dissertation, University of Twente]. https://ris.utwente.nl/ws/portalfiles/portal/6053568/thesis_J_Bolier.pdf

Chakhssi, F., Kraiss, J. T., Sommers-Spijkerman, M., & Bohlmeijer, E. T. (2018). The effect of positive psychology interventions on well-being and distress in clinical samples with psychiatric or somatic disorders: A systematic review and meta-analysis. *BMC Psychiatry*, *18*(1), 211. https://doi.org/10.1186/s12888-018-1739-2

Koekkoek, B., van Meijel, B., & Hutschemaekers, G. (2006). "Difficult patients" in mental health care: A review. *Psychiatric Services*, *57*(6), 795–802. https://doi.org/10.1176/ps.2006.57.6.795

Kohn, R., Saxena, S., Levav, I., & Saraceno, B. (2004). The treatment gap in mental health care. *Bulletin of the World Health Organization*, *82*(11), 858–866. https://doi.org//S0042-96862004001100011

Lohuis, A. M., van Vuuren, M., Sools, A., & Bohlmeijer, E. (2017). Ambiguities of 'doing what works': How professionals make sense of applying solution-focused support for people with intellectual disabilities. *International Journal of Developmental Disabilities*, *63*(3), 170–183. https://doi.org/10.1080/20473869.2016.1198102

Lyubomirsky, S., & Layous, K. (2013). How do simple positive activities increase well-being? *Current Directions in Psychological Science*, *22*(1), 57–62. https://doi.org/10.1177/0963721412469809

Pelletier, L. G., Fortier, M. S., Vallerand, R. J., & Briere, N. M. (2001). Associations among perceived autonomy support, forms of self-regulation, and persistence: A prospective study. *Motivation and Emotion*, *25*(4), 279–306. https://doi.org/10.1023/A:1014805132406

Rollnick, S., Miller, W. R., Butler, C. C., & Aloia, M. S. (2009). *Motivational interviewing in health care: Helping patients change behavior*. Taylor & Francis.

Ryan, R. M., & Deci, E. L. (2000). Self-determination theory and the facilitation of intrinsic motivation, social development, and well-being. *American Psychologist*, *55*(1), 68–78. https://doi.org/10.1037/0003-066X.55.1.68

Sheldon, K. M., & Filak, V. (2008). Manipulating autonomy, competence, and relatedness support in a game-learning context: New evidence that all three needs matter. *British Journal of Social Psychology*, *47*(2), 267–283. https://doi.org/10.1348/014466607X238797

Sheldon, K. M., & Lyubomirsky, S. (2006). Achieving sustainable gains in happiness: Change your actions, not your circumstances. *Journal of Happiness Studies*, *7*(1), 55–86. https://doi.org/10.1007/s10902-005-0868-8

Van der Plaats, J. (2002). *Eindrapportage Zorg in Beeld Verlicht*. Gemeente Almelo.

Visser, C. (2010). Self-determination theory meets solution-focused change: Autonomy, competence and relatedness support in action. *InterAction - the Journal of Solution Focus in Organisations*, *2*(1), 7–26.

Weiss, L. A. (2016). *Direction: Happiness. Improving well-being of vulnerable groups* [Doctoral dissertation, University of Twente]. https://ris.utwente.nl/ws/portalfiles/portal/6047856/thesis_L_Weiss.pdf

Weiss, L. A., Oude Voshaar, M. A. H., Bohlmeijer, E. T., & Westerhof, G. J. (2020). The long and winding road to happiness: A randomized controlled trial and cost-effectiveness analysis of a positive psychology intervention for lonely people with health problems and a low socio-economic status. *Health and Quality of Life Outcomes, 18*, 162. https://doi.org/10.1186/s12955-020-01416–x

Weiss, L. A., Westerhof, G. J., & Bohlmeijer, E. T. (2013). Nudging socially isolated people towards well-being with the 'Happiness Route': Design of a randomized controlled trial for the evaluation of a happiness-based intervention. *Health and Quality of Life Outcomes*, *11*(1), 159. https://doi.org/10.1186/1477-7525-11-159