Dimensions of Happiness: A Qualitative Study Of Family Practice Residents

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Background: **Happiness is related to both positive and negative forces. Positive factors, or happiers, that compensate for stressors in residency have only recently been recognized in a pilot study of 14 family practice residents. These happiers are positivism, the pursuit of goals, relationships, a religious belief system, and feedback. The purpose of this qualitative study was to describe happiers of residency in family practice in each postgraduate year and relate the findings to established theories on well-being.**

Methods: **A qualitative interview with participant observation was used to study 59 residents at four family practice residency sites. Interviews were semistructured and audiotaped. Tapes and field notes were analyzed for trends. The Faces Scale was administered as a happiness visual analog scale.**

Results: **The importance of a well-balanced lifestyle, as well as the pursuit of goals, relationships, and accentuation of the positive, were found to be happiers for all residents interviewed. Religious commitment, feedback, and a sense of control or autonomy were important to the level of happiness of more than 60 percent of residents interviewed. Feedback was more important to 1st-year residents, and a sense of control was more important to 2nd-year and 3rd-year residents.**

Conclusion: **The seven happiers described in this study were similar to happiness factors reported in the social science literature. Our findings could contribute to theories of resident well-being and further the research on well-being in residency training. (J Am Board Fam Pract 1995; 8:367-75.)**

A comprehensive review of the social science and medical literature (1960 to present) defines two domains of research on well-being. Social science studies describe factors that positively influence and medical education studies describe factors that negatively influence the level of happiness in individuals. The majority of research on well-being has been undertaken by investigators in the social sciences. Happiness is measured directly and is related to memory consolidation and recall, personal experience, and such emotions as joy and contentment.[1-11]

Investigations of well-being in residency training reported in the medical literature, however, focus on negative factors. Typically, researchers look for the most common perceived stressors in residency.[12] Residents are asked to rank a list of stressors (Table 1), and happiness in residency is then measured indirectly as the lack of stressors. Because all listed stressors are negative, it is impossible to determine the impact of positive factors on residents. A consequence of the failure to investigate positive functioning is that the theories of happiness, developed in the social sciences, have not been applied to well-being in residency.

To define theories about the differences in level of happiness, researchers in the social sciences use instruments designed to assess memory recall and consolidation and life experiences and situations with theoretical constructs of positive functioning. These instruments are administered to large samples of the general population. Theories are then proposed concerning the derivation of happiness and why individuals vary in level of happiness when similar experiences are shared.[10]

Methodological techniques and theory-based research from the social sciences can be applied; however, they might not be sufficient to study happiness in residency. Studies designed to measure happiness use instruments with forced choice questions that provide self-limiting data and do not allow subjects to personalize their answers. Studies that describe medical education also have

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Table 1. Most Common Self-Reported Perceived Stressors Affecting 1st-, 2nd-, and 3rd-Year Family Practice Residents.*

Perceived Stressor	Reports by Residents (n = 122) Percent
Fatigue and long hours	82
Feelings of professional inadequacy	67
Loneliness	55
Competitive milieu	48
Family or marital problems	33
Insufficient supervision	29
Financial difficulty	8
Problem with drug or alcohol abuse	5
No support system	—
Being single	—

*Adapted from Ford.[7] Data are percentages of reports.

limitations in design and methodology, such as limited psychometric characteristics of the instruments and small nonrandom samples. Data from these studies are limited because the validity and reliability of tools constructed by the authors lack documentation.[12-19]

To date only one study has attempted to determine the factors that increase the level of happiness in residency and to address methodological limitations of studying happiness in a small, defined population. Manusov, in a pilot qualitative study on happiness in residency, reported that there are five "happiers" in internship.[20] A happier was defined as a factor that increases the level of happiness in an individual. Five happiers common to all 1st-year residents studied were (1) positivism, (2) the pursuit of goals, (3) relationships, (4) a religious belief system, and (5) feedback. These happiers are similar to the six perspectives summarized by Ryff[21] in the definitions of theory-guided dimensions of well-being. Ryff argues that Rogers's perspectives on the view of the functioning person, Maslow's conception of self actualization, Jung's formulation of individuation, and Alport's conception of maturity can be integrated into a more inclusive summary. More specifically, Ryff argues that the characteristics of well-being described in the six formulations share similar features of positive psychological functioning. The six features that are associated with an increased level of happiness are (1) self-acceptance, (2) positive relationships with others, (3) autonomy, (4) environmental mastery, (5) purpose of life, and (6) personal growth. Happiness, therefore, is related to these areas of positive functioning.[10,21] Manusov[20] suggested that the happiers can be emphasized in support groups, in lectures, and with individual counseling in an effort to increase the level of happiness during training.

The purposes of this study were to describe the happiers of residents in family practice in each postgraduate year at four different sites and to address limitations of previous studies, such as restricted sample size and measurement instruments. In addition, this qualitative study was designed to apply established theories of happiness to the investigation of resident well-being. The resultant modified theory of happiness in residency could then be used as a basis for suggestions to increase the level of happiness in residency.

Methods

Interviews with participant observation, a style of qualitative research, were used to study residents at four family practice residency training programs. This approach was chosen to allow the investigator to gather data in depth and in detail. The protocol was reviewed and approved by the Investigation Review Board (IRB) and the Human Use Committee at the Uniformed Services University of the Health Sciences (USUHS) and the IRB at each site before the initiation of interviews. The principal investigator was an assistant professor at USUHS and did not have any contact with the participants before or after the interview. There were 4 collaborators, assigned as faculty, 1 from each residency program. The participants at the four sites were interviewed from March to May 1994.

The residents were recruited from Case Western Reserve, David Grant US Air Force Medical Center, Georgetown University-Providence Hospital, and Carolinas Hospital family practice residency training programs. The four centers were chosen because of diverse geographic locations and program structures, population served, and the availability of a collaborator at each site. All four hospitals had other specialty residency training programs.

The university-based residency training program at Case Western was affiliated with University Hospitals, Cleveland, Ohio, and had 17 faculty

positions including 4 fellows. An accelerated program offered experienced students a 4th year internship track. The clinic offered services to a diverse ethnic population of varying socioeconomic levels and a large number of underserved patients. David Grant USAF Medical Center family practice residency program was a military center with 10 faculty physicians and a full-time behavioral scientist. The medical center, located 50 miles northeast of San Francisco, limited the population served to eligible military members, retired military members, and their dependents. Georgetown University-Providence Hospital had a community-based training program administered by Georgetown University. The family practice center was located in northeast Washington, DC, and had 8 full-time faculty, 5 part-time faculty, 1 social worker, 1 nurse practitioner, and 1 behavioral scientist. The patient population varied, and the center had a strong commitment to the underserved. The Carolinas Hospital family practice residency program was a hybrid in an urban, community-based, university-affiliated hospital located in North Carolina. The program had 8 faculty and 1 behavioral scientist. The clinic population served was socioeconomically and ethnically diverse.

All 86 available residents were eligible to participate in the study. The participants were asked by the site coordinator (collaborator) whether they would participate in a study on happiness in residency. There were 6 residents in each level at Case Western, although the 1st-year class had only 5 residents (n = 17), 10 residents in each level at the David Grant Medical Center (n = 30), 6 residents in each level at Carolinas Hospital (n = 18), and 7 residents in each level at Providence Hospital (n = 21). Sixty-seven percent of the residents from each year at the four sites were interviewed. Sixty-seven percent is the minimal response rate for survey data and was used to determine the minimum number of interviews.

An hour-long interview with the principal investigator was scheduled by the site collaborator. The participant was chosen randomly, and the interview was scheduled to accommodate clinical responsibilities; because the interviewer was present for 1 week, there was a sample from each time of day and day of the week. The principal investigator met with the resident in a clinic office during office hours. Each resident was asked to sign informed consent. The residents then completed a self-administered demographic questionnaire that asked for age, year of residency training, marital status, primary source of social support, current rotation, and the number of hours in the hospital per week. Two copies of the Faces Scale (Figure 1) were given to each participant by the principal investigator. On the first scale the resident was asked to circle the face that best described how he or she felt at that time. The face circled represented a nonverbal representation of the current emotional state. On the second scale the residents were asked to circle the face that best described how they felt as a base line. The face circled represented happiness as a trait, or the more durable sense of well-being. The purpose of the Faces Scale is to be able to relate a perceived level of happiness on a visual analog scale to the information obtained during the interview. The validity and reliability of the Faces Scale, as a measurement tool, has been documented (test-retest reliability = 0.70, validity coefficient = 0.82).[10] The faces circled were contrasted and compared with data obtained from the interview and observation.[20]

The principal investigator then interviewed each participant alone in the family practice center during working hours, in most cases during the resident's scheduled office hours. The participants sat in a chair across from the interviewer. The principal investigator asked about clinic and about life experiences. After any questions about the study were answered, residents were asked to name synonyms that describe when they are

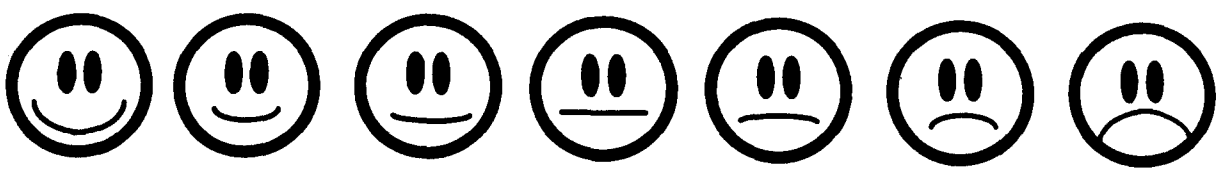

Figure 1. Faces Scale, a single-item indicator of well-being. Reprinted with permission. In: Andrews F, Withey S. Social Indicators of Well-Being: Perceptions of Life Quality. New York: Plenum Publishing Corp., 1976.

happy, to characterize what about themselves that makes them happy, what about others that makes them happy, what about their personal life that makes them happy, and what about their professional life that makes them happy.

The residents were then asked to state the first thought that entered their minds about the following stressors and to describe how someone could be happy despite these stressors: fatigue and long hours, feelings of professional inadequacy, loneliness, competitive milieu, family or marital problems, insufficient supervision, financial difficulty, problem with drug or alcohol abuse, lack of support system, and being single. These stressors are negative factors associated with residency that have been described in previous studies[7] (Table 1).

Each resident was then asked to recall a specific time within the last 6 months when he or she was happy and to discuss this experience with the investigator. The story was used to elaborate further on the resident's perception of happiness and to add depth to the report by using excerpts from the interview. The principal investigator attempted to maintain a standardized interview that included appropriate seriousness and levity and reflective listening, asking questions to highlight or clarify points from the interview in progress or interviews with other residents. Each session lasted between 35 and 45 minutes and was audiotaped to minimize note taking and to record the interview for later study.

Analyses

Trend and frequency analyses of the tapes and field notes were done after the interviews. Each tape was reviewed by the primary investigator and transcribed, and the transcripts were then distributed to each collaborating investigator. In addition, three interview tapes from a site other than their own were sent to each collaborating investigator to increase interrator reliability. Data were classified according to five categories for happiers and as quotations. Statements that did not apply to one of the five categories were grouped in additional categories. The principal investigator instructed each collaborating investigator on the analysis of the taped interview.

After data were collected and reviewed, the 5 collaborators met to analyze further and summarize the results and to compare the classification of the happiers. The written transcriptions and groups of comments were compared with field notes, observations by the investigators, and existing literature. Body position, interaction with the interviewer, and intonation were included in the analyses. The principal investigator's field notes about personality characteristics were compared with the perspectives of the site collaborators. The analyses continued until all 5 investigators agreed on the comparison of data. Any disputes were settled by the application of current published theories on well-being.[18,22]

Results

There was a total of 86 potential residents with 59 interviews (68 percent) (Table 2). Of the 59 subjects, the mean age of the group was 32 ± 6 years; there were 31 men (52 percent) and 28 women (48 percent); 34 residents (58 percent) were married, and 25 (42 percent) were single. Nineteen 1st-year residents (33 percent), 19 2nd-year residents (33 percent), and 21 3rd-year residents (34 percent) were interviewed. The demographic characteristics, including ethnicity, of the sample population were similar to those of the larger group from which they were drawn: 43 (73 percent) were white, 4 (7 percent) were African American, 6 (10 percent) were Asian, 1 (2 percent) was Hispanic, and 5 (8 percent) were Arab. Intersite differences in demographic characteristics are listed in Table 2. Providence Hospital and Case Western had older and more ethnically diverse residents.

All residents, except 3, circled a happy to neutral face on the current Faces Scale. One resident

Table 2. Demographic Characteristics of Residents Interviewed.

Residency Year	Case Western	David Grant Medical Center	Providence Hospital	Carolinas Hospital
1	4 of 5	8 of 10	4 of 6	4 of 6
2	4 of 6	6 of 10	6 of 7	3 of 6
3	4 of 6	6 of 10	3 of 7	5 of 6
Total (%)	12 of 17 (71)	20 of 30 (67)	13 of 21 (62)	12 of 18 (67)
Mean age, years	37 ± 6	30 ± 3	35 ± 8	28 ± 2
Percent male	33	41	11	55
Percent married	55	55	69	36

circled the most unhappy face (G) and two circled face E (Figure 1). There were no differences in faces circled among residents by programs, sex, age, marital status, support system, hours in the hospital, or residency year. There were no intra- or inter-resident differences between base-line and current level of happiness when the two scales were compared.

Every resident was interested in a study that focused on positive functioning and expressed excitement to the site collaborator and principal investigator about the study. All 59 residents appeared comfortable and relaxed during the interview. The interviewer experienced no difficulty in obtaining information, and each resident was eager to discuss what raised his or her level of happiness. The residents had had influential life experiences that added depth to the interviews. Four of the residents were trained as physicians outside the United States and had to repeat a residency training program in the United States. Some had been musicians, preachers, engineers, or teachers before attending medical school. One resident decided to go to medical school after years of medical publishing. Each resident discussed at length positive functioning despite being tired or pressured by time and responsibilities.

Happiness

The most common synonyms for happiness were peaceful, joyful, content, calm, excited, loving, optimistic, glad, interested, talkative, crazy, bouncy, creative, carefree, relaxed, and alert.

> There are qualities about myself that I like which make me happy. My ability to empathize and sympathize with other people, my ability to calm and reassure them, or somehow make things better for them. To have good friends and keep them. To do residency and go through a divorce and take care of myself. To not be paralyzed in any area because of what is going on. Running. After I finish running, it is the closest thing to a religious experience because I thank God I am physically able to do it. — *3rd-year female resident*

> I am getting to know better and better of what to do, what I need to do, what my job is. Having a better sense of myself. My marriage makes me happy, my family, my extended family. My cats make me happy, my garden makes me happy, but most importantly recently I am starting to feel like I have a framework for new information that I am getting about my work. Being honest in my assessment of how I am doing; I work hard; I am reasonably intelligent. I am more open to people than I used to be. I feel more at ease with people, in general, of all kinds. — *2nd-year female resident*

Fifty-seven residents believed they were happy. They described in detail what factors increased their level of happiness. The unhappy times were explained as situational, which changed from day to day and depended on sleep, work, level of perceived stress, and social factors. The more durable sense of well-being, believed to be happiness, was more constant. Happiers, or factors that increased the level of happiness, were used to increase the overall daily sense of happiness and, in turn, served to strengthen the resident's durable sense of well-being.

When asked why they circled a happy face and described happiness despite a stressful, demanding residency training, the residents offered several explanations.

> Residents circle a happy face because it is relative. If I put it in absolute terms, I wouldn't circle a happy face. In life I am happy with how I am spending my time. I am definitely not happy with that, but relative to that I know I only have to do this for this year and next year, and then third year will be great. I am not happy with my performance. But these are two separate areas. I enjoy what I do, especially the interactions with other people. If it is a short-term thing, I can handle it. If this would continue throughout the rest of my life, I would definitely get out. I am unhappy, but there are other things in my life that I am happy about. I don't get overcome by one all-consuming part of my life, like work and medicine. — *1st-year male resident*

> I think it is just part of society's expectations that happiness is a sign of strength, so I think people perceive that it is a sign of weakness in themselves or a problem on their part that they are not happy. I think people often try to tell themselves they are happy or tell others, but they are not. There may be an element of mistrust on their part, someone in their department asking this question. I don't really know who is looking at me for what, what people are talking about. I don't know what really goes into my evaluations, so I can see why interns would really be hesitant to document on a report form that they are miserable. — *1st-year male resident*

In addition, residents often expressed that it was their choice to go to medical school and that the stress of residency training is the price to pay

to achieve their goal. All the residents interviewed believed that they were being honest about their levels of happiness. Although there were times that they were not happy about the conditions of residency environments, the balance between the positive and negative factors was in the direction of happiness.

We have to be strong, happy, and accepting. When I rationalize it, they are right. I want to admit that I have free will, so I shouldn't complain. But I am also human. I am expected to go with the flow. I know I can change my plan if I wanted to. Sometimes I don't like it. Overall it makes sense. — *1st-year female resident*

The happiers, or factors that positively affected the balance of happiness, were the same as those described by the pilot study on happiness in residency. The pilot study found three major happiers, factors that were described by all the residents to increase the level of happiness, and two minor happiers, or those behaviors or traits that increased the level of happiness in greater than 50 percent of the interns interviewed.[20] In this study, two additional happiers emerged primarily in upper level residents. The importance of a balanced lifestyle and a sense of control or autonomy were described by 2nd- and 3rd-year residents as additional happiers important to their overall happiness (Table 3).

Major Happiers

Positive Relationships with Others

My relationship with my husband is a primary source of strength and happiness. We have been married 13 years, and I feel better enjoying the relationship. The support I get gives me an underlying sense of security. I feel spontaneously happy when I get home, and the children rush out to meet me. — *2nd-year female resident*

Table 3. Major and Minor Happiers Described by 59 1st-, 2nd-, and 3rd-Year Residents Interviewed.

Major happiers mentioned by all residents
Positive relationships
Goals and achievements
Accentuate the positive
Balanced lifestyle
Minor happiers mentioned by many residents
Religion or religious commitment
Feedback
Sense of control and autonomy

As in the pilot study of happiness in internship, every resident interviewed mentioned the importance of a positive relationship in his or her overall sense of well-being or happiness. The residents included in this study emphasized more often than any other happier the importance of positive relationships. The definitions of theory-guided dimensions of well-being published by Ryff[21] have described a high scorer in the level of happiness as one who has warm, satisfying, trusting relationships with others. The happy person is concerned about the welfare of others; capable of strong empathy, affection, and intimacy; and understands give and take of human relationships.[23,24] The older residents with children also included the importance of parenthood in their level of happiness.

The Pursuit and Achievement of Goals

My most happy time was graduation from medical school. I was feeling a sense of great accomplishment that I was able to make it through the whole thing, and plenty of people had fallen by the wayside for one reason or another. It gave me a lot of self-pride. — *2nd-year female resident*

All the residents mentioned the importance of having and achieving goals, such as graduating from residency, dictating a record, learning clinical medicine, and getting home by 5 o'clock. The goals of 2nd-year residents were associated with leadership and management in inpatient medical care. Third-year residents shifted their goals to mastering family practice and looked toward practice after completing residency. Many of the older residents stressed the importance of perseverance through hardship to finish residency.

Goals and achievements are related to environmental mastery, having a purpose in life, and personal growth in the definitions of theory-guided dimensions of well-being. High scores in environmental mastery reflect a sense of mastery and competence in managing the environment. Because 1st-year residents often score low in environmental mastery, this area is often a stressor that can result in a feeling of professional inadequacy. As the resident progresses, the mastery becomes more of a happier. The 2nd- and 3rd-year residents are challenged with both an increased level of responsibility and the prospect of leaving the residency to be independent. Paradoxically,

the environmental mastery becomes both a happier and a stressor. Achieving balance between mastery and personal growth becomes the happier.

There is a big difference between 1st-year commitments and those in our 3rd year. First year is a lot of work, physically and emotionally fatiguing, and we don't know a lot of things. We are sort of at other people's mercy. We follow what they say. As I learn how to deal with things and how to handle things, I feel more comfortable with my knowledge and with what I am doing. I feel better about myself. In 3rd year the call schedule is better. Just feeling more comfortable with my patients and the attending physician and seeing medicine, as not my profession but as something I have achieved at a level where I can sit back and talk about it, make me feel like a full-fledged doctor now. — *3rd-year female resident*

Accentuate the Positive

Accentuating the positive was another common method to compensate for negative feelings. Each resident could think of a positive statement to minimize a negative situation. "I can see the light at the end of the tunnel" or "I don't know this because I am here to learn" are examples of how residents accentuate the positive. One resident explained that being positive and having positive experiences were important to her level of happiness. Being positive was described as internal, and positive experiences were external.

I guess when there are rough situations or stressful periods, I try to look at the positive aspect of it or think of something positive that puts it into perspective and makes it less stressful. — *2nd-year female resident*

Accentuating the positive can be viewed as rationalization or as a less mature defense mechanism, such as denial.[25] In terms of the definitions of theory-guided dimensions of well-being, however, accentuating the positive is likened to self-acceptance. Someone who scores high in self-acceptance possesses a positive attitude toward the self and acknowledges and accepts multiple aspects of self, including good and bad qualities. There were no differences by residency year, age, sex, marital status, or program location for this variable.

A Balanced Lifestyle

Work can suck, and if home also sucks, I am going to be miserable. If I am at least happy in my personal life, I would work a lot better. If things go right with Cecelia citizen, Cecelia doctor does OK. If Cecelia citizen is not doing well, Cecelia doctor does poorly, too. That means I have to take time to chill out and recharge my battery. If I need to just vegetate in the day, not get dressed, and watch stupid movies all day, then that is what I will do. I do a lot of things — walk, talk to friends, or bitch about work or my life. I find that extremely critical. — *2nd-year female resident*

Engaging in activities other than medicine was important to all groups of residents interviewed. Whether it was exercise, dating, playing with others, reading, or playing the piano, getting away from medicine was important to achieving happiness of residents, regardless of program location, age, and sex. Getting away is explained as a balance between the personal and professional life.

Minor Happiers

Religion or Religious Commitment

I read Ecclesiastics in the Bible, which talks about how everything is meaningless, like ambition. All of that is meaningless because it doesn't count for much in the long run. I try to keep that perspective and when I realize how meaningless this is compared with the more important things in life, like my family and God, I think that things that go on here need to be put into proper perspective. — *3rd-year male resident*

Religion or religious commitment was mentioned by many residents as a happier. Although the social aspect and activities related to the church contributed to their level of happiness, religious commitment also helped to define self and added a perspective to an otherwise tumultuous time. Others believed that the peace obtained by prayers or personal devotions increased their level of happiness. Prayer and church attendance increase religious beliefs and therefore life satisfaction.[2,26] There were no differences in religious commitment as a happier by age, sex, residency year, or marital status. There were, however, a greater number of residents at David Grant Medical Center who described the importance of religious commitment to their level of happiness.

Feedback

It helps when my patients express appreciation. I am a person who needs feedback from other people to have a sense of accomplishment, I guess because I have

always had a lot of feedback. I just get used to it after awhile and crave it, the kind of positive feedback that says that I did great, that I made a difference. — *1st-year male resident*

Positive feedback raised the level of happiness of many of the residents interviewed. It was more common as a happier during the 1st year. As residents gained a sense of mastery and competence in managing patients, the need for feedback was less intense. The residents did report that appreciation from patients or "a job well done" from faculty did make them feel good, but it was not a major motivating factor for their happiness.

Sense of Control and Autonomy

Described more commonly in the 3rd postgraduate year were control over time and autonomy to be self-determining and independent, which many residents believed were factors important to their level of happiness. In particular, 1st-year residents, who might have had little perceived sense of control and/or autonomy, were less likely to describe control as a happier. On the other hand, older residents who had described broader life experiences, such as overcoming multiple barriers to attend residency training, were also less likely to mention control as a happier. In addition, many residents emphasized control over time as important. A decrease in demands and responsibilities, which allowed for more personal time, increased the level of happiness in many residents. In others, control over their professional life was important to their happiness. Autonomy to care for their patients and act independently was important to many residents. The importance of autonomy and control might be related to other happiers, such as goals and achievements, environmental mastery, purpose in life, and personal growth.

Other happiers mentioned less frequently were humor, kindness and honesty, respect, altruism, and primary needs, such as sleep and food.

Discussion

The nature and definition of happiness have been discussed in detail in the social science literature. The theories offered by notable researchers have included aspects of self and how we interact with our environment and others. These theories have not been applied to residency training. Although leaders in postgraduate education have made efforts to decrease stressors (e.g., decrease work hours, and so on) they have not, to date, emphasized increasing happiers. This study addressed many of the limitations of the pilot study that investigated aspects of positive functioning in residency. The sample size was larger, all three levels of residency were interviewed, and a greater diversity of residents were interviewed. These changes served to increase the generalizability of the results. The collaboration of 5 investigators strengthened the methodology of qualitative research by eliminating single-investigator bias and providing cross-investigator validity.

Four programs, unique in different aspects, were chosen for this study. At least 67 percent of residents in each year of training were interviewed. The interviews were completed on varying days and times of day. In addition, the population of participants varied in age, marital status, ethnicity, and sex. Each program represented a different geographic location and learning and practice emphasis. Residents at military, university and community, university, and community programs that often care for the underserved were interviewed.

The five happiers described in the first study were also found in this population of residents with the addition of two new happiers — a balanced lifestyle and a sense of control or autonomy. Differences in the importance of varying happiers appeared according to residency year and age of the resident. Interestingly, most residents (95 percent), circled happy faces on the Faces Scale. Even the 3 who described themselves as unhappy were able to describe what factors increased their level of happiness.

There are, however, limitations to this study. A visual analog scale with smiling faces could be socioculturally biased. Circling a face with a down-turned smile might not have been as well accepted as describing a feeling of unhappiness. Although the interviews addressed the issue of why someone would circle a happy face when they are actually unhappy, residents' defense mechanisms, such as denial or rationalization, could have inhibited the responses of the participants.

Finally, the theory-guided dimensions of well-being, an integration of theories by Rogers, Jung, Alport, Maslow, Erickson, and Buhler, described by Ryff,[21] are applicable to postgraduate medical education. The investigations published that

comprise the general theories of happiness are applicable to residency training as well.

That this very diverse group of residents consistently related the same happiers can be important information for residents, medical educators, and behavioral scientists. Program directors can be encouraged to design curricula that actively maximize these happiers. Prospective residents can be encouraged to select programs that will offer the happiers most important to them. In addition, the information can be used by faculty advisors to help recognize residents who lack these happiers and to help these residents make the most of factors that could increase their level of happiness. The differences among the minor happiers by resident year might be used to remind faculty about the varying perceptions and needs of residents. The information developed will strengthen general theories on happiness and well-being in residency and serve to stimulate future research.

Areas of further study could include the development of a standardized tool to define happiers, a study of the generalizability of happiers to residents outside family practice, an analysis of the impact of the presence or absence of happiers on academic performance during residency, and a measurement of well-being after happiers have been emphasized in a residency training program.

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