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Defining Happiness for Young Adults with Schizophrenia: A Building Block for Recovery

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Abstract

Purpose—Findings from this mixed methods descriptive study include a definition of happiness for young adults with schizophrenia (SCZ).

Methods—Thirteen men and women, ages 23 to 35, completed a series of three individual one-hour interviews over six weeks.

Results—This definition included themes of material happiness, relational happiness, and health happiness. Although these themes correspond to those for young adults without SCZ, four barriers to happiness were identified for this vulnerable population: 1) fear, 2) isolation, 3) medication, 4) not being considered "normal."

Conclusion—Implications of these findings include designing interventions to support recovery by overcoming barriers to happiness.

Keywords

schizophrenia; social support; qualitative research; young adults

Introduction

Schizophrenia (SCZ) is a chronic and debilitating illness, striking young adults in their late teens to early twenties (Frese, Knight, & Saks, 2009). In 2006 combined indirect and direct costs exceeded \$150 billion per year (American Psychiatric Association, 2006). Early onset

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of SCZ, identified by positive and negative symptoms and social and occupational dysfunction, leaves those with SCZ lacking skills and abilities necessary for social integration and maintenance of personal support systems. Evidence-based treatment for schizophrenia does exist, but there are limitations. Evidence-based practice recommendations for typical and atypical antipsychotics, relieve positive symptoms of schizophrenia, but do little to alleviate negative symptoms consistent with poor treatment outcomes (Gadelha, Noto, & de Jesus Mari, 2010; Buchanan, Kreyenbuhl, & Kelly, 2010). Evidence-based psychosocial treatment options include: assertive community treatment, supported employment, cognitive behavioral therapy, family-based services, token economy, skills training, psychosocial interventions for alcohol and substance use disorders, and psychosocial interventions for weight management (Dixon, Dickerson, Bellack, et al, 2010). However, availability of these programs is limited by areas where they are being offered, funding after the initial grant period for research, and qualifications of individuals in need (Medicaid eligibility, disability earnings).

In spite of limitations of current medications and lack of accessibility to psychosocial treatments, hope for better outcomes for individuals with schizophrenia is increasing for these reasons: variable reports of positive symptom management outcomes, newer and more effective medications, supportive psychosocial interventions, people managing the illness and actually doing well (Emsley, Chiliza, Asmal, & Lehloenya, 2011) and research exploring pharmacological and behavioral treatments to improve cognition (Twamley, Vella, Burton, Heaton & Veste, 2012). Continued research is needed to determine efficacy of new medications and application of new skills learned in these programs to life outside of the research program and to personal recovery. In addition, research aimed at studying ways to enhance the development of social relationships and meaningful life roles for this population is needed (Howells & Zelnik, 2009). These last two areas address a very personal dimension of recovery: happiness.

Purpose

A pilot study on the meaning of happiness for young adults with SCZ was conducted to expand upon the concept of person centered recovery by inviting young adults with SCZ to identify what happiness meant to them. The purpose of this paper is to review findings from this study regarding the definition of happiness for young adults, ages 18–35 with SCZ, as described during the course of 3 sequential one-on-one interviews with thirteen individuals. First, definitions of recovery and appreciative inquiry provide the framework needed for understanding how the meaning of happiness for young adults with SCZ may influence recovery. Following the definitions is a description of study methods along with discussion of the results. Finally we share implications for psychiatric nursing practice with this population by exploring the proposed relationship between happiness, quality of life and the four aspects of recovery along with psychiatric nursing interventions in each area.

Recovery

The definition of recovery for this study focused on psychological recovery and the needs of the person with SCZ rather than physical recovery, which addresses finding a cure or eliminating all symptoms. Components of this definition include: 1) finding and maintaining hope, 2) reestablishing a positive identity, 3) finding meaning in life, and 4) taking responsibility for one's life (Andresen, Caputi, & Oades, 2006). Movement toward recovery requires care emphasizing person centeredness to effectively assist those with SCZ to meet needs and challenges (Adams & Greider, 2005).

Person-centered treatment includes perceptions of young adults with SCZ regarding conflicting needs of managing symptoms of the disease and effects of medications, and their

developmental needs, illuminating what gives meaning to their lives. Articulation of a definition of happiness can identify barriers that prevent happiness from being part of their experience. Once these barriers are identified they can be addressed and experiences promoting happiness can be constructed. Young adults with SCZ can become partners in planning their recovery, allowing them to take responsibility for their life through seeking and finding meaningful experiences that bring happiness. Experiences that generate happiness are likely to be repeated, resulting in hope and the establishment of a positive identity.

Appreciative Inquiry

Appreciative Inquiry (AI) focuses on relationship building through appreciating what is, envisioning what might be, and discussing and planning for what is desired. AI is recognized by three traits: 1) the value placed on discovering the best about people, places and things, 2) the use of life-giving forces to build on the positive core, and 3) the recognition of value, worth, hope and opportunities waiting to be discovered through inquiry (Stavros & Torres, 2005). AI includes four phases: discover, dream, design and destiny (Cooperrider & Whitney, 2005). AI allows mental health care practitioners to practice person-centered care working with individuals to focus on the “best” of the past, to bring out their “Positive Core” and move those forward into their present and future.

Philosophically, AI is supported by Positive Psychology (Seligman, Steen, Park, & Peterson, 2005). At its core is the belief that by helping others build upon qualities that allow them to do more, people can flourish. Flourishing is described by Keyes (2007) as a state with high levels of subjective well-being and psychological and social functioning. The challenge is to discover what helps people carry on under aversive conditions. This is done through exploration of what we know, how we know it and how we acquire that information. AI demonstrates belief in an individual’s ability to reach high, achieve what they set out to do, find the positive in a situation, speak in positive ways, and collaboratively construct better ways of living. Studies suggest this type of mental health promotion should be the primary objective of treatment for mental illness (Keyes, 2007).

AI was originally used in the 1980s to promote increased morale and workplace productivity. Evidence for its use in health promotion has increased since the early years of AI. The Valeo Dialogue on Health and Care (Grossman, Rudman, Suchman, Arthur, Ion, & Litt, 2002), demonstrated the utility of AI for defining a concept to meet the health care needs of a population. More recently, studies from 2006–2009 have shown potential for use of AI to increase social inclusion, well-being, collaboration and innovation (Doveston & Keenaghan, 2006; Hazard, Callister, Birkhead and Nichols, 2009; Reed, Richardson, Marais, & Moyle, 2008; Richie, & Marichionni, 2009). Because of AI’s success in engaging participants, it is ideal for inviting and maintaining participation of young adults with SCZ, who often isolate and are fearful of social situations. Conversations with young adults with SCZ dealing with abstract concepts such as happiness are challenging. Use of creative strategies to help them articulate what they think and feel related to happiness is productive (Miller & Happell, 2006).

Happiness is poorly defined in the literature and biases in measurement of happiness are numerous (Hsee & Tang, 2007). Existing definitions are based on research limited by sample composition, making it difficult to generalize to young adults with SCZ (Seligman, Steen, Park & Peterson, 2005). As a result, defining happiness for this group is a needed research endeavor.

Methods

Defining happiness for young adults with SCZ was part of a descriptive mixed method pilot study (Buckland, 2009). The methodology of AI provided the framework for conducting three in-depth semi-structured one hour interviews over a period of six weeks with each of thirteen young adults with SCZ. One researcher conducted all interviews. The research took place over the course of six months and was approved by the institutional review board of the university where it was conducted.

Study Participants

A theoretical sample derived using convenience, purposive and snowball sampling, yielded participants who fit the criteria and had interest in the study. One of the thirteen participants, a male, piloted materials used for the study. The study group consisted of thirteen participants, three female and ten male, ranging in age from 23–35 (mean age = 27); four non-Caucasian or mixed race; seven diagnosed with schizophrenia, six with schizoaffective disorder; six with a high school education, seven with post high school education; eight with history of substance abuse, the rest non-users (Buckland, 2009). Recruitment occurred through advertisements and newsletters within public and private community mental health centers, and mental health advocacy groups within a large urban area.

Interested individuals either contacted the researcher or were contacted by the researcher after giving permission, through their mental health practitioner, for the researcher to call them. This process assured confidentiality and eliminated any sense of coercion. Participants signed written consent forms and met the following inclusion criteria: “1) have a DSM-IV diagnosis of schizophrenia or schizoaffective disorder, 2) be under the care of a medical practitioner, 3) have symptoms managed through use of medication, 4) speak English, and 5) be in a stable living environment within the designated geographical area...” (Buckland, 2009, p.58). Exclusion criteria included: 1) use of substances other than prescribed medications or a form of nicotine on the day of the interview, 2) current hospitalization and 3) inability to successfully answer questions related to decisional capacity. All participants received a \$25 gift card to a local food and department store as compensation for each interview. A \$25 gift card was given to all completing the entire study. Parking, cab fare, and bus tokens were provided as needed.

Data Collection

To facilitate collection of information from the participants about what happiness meant to them, a pilot interview protocol was drafted. This protocol was based on the work of AI researchers, healthcare guidelines for use of AI and consultation from a trained AI facilitator (Cooperrider & Whitney, 2005; Stavros & Torres, 2005; Franklin, 2006; Preskill & Catsambas, 2006; Kelm, 2007). In addition to an individual with SCZ piloting the interview protocol, a family member of a person with SCZ and a psychiatric nurse practitioner who works with individuals with SCZ reviewed the protocol.

The initial interview protocol was based on the AI four phase model, Discover, Dream, Design and Destiny. It was adapted to include three phases: 1) Discover (describe peak experiences of happiness in the past, present; identify what you value in yourself; name what you would wish for in the future), 2) Dream, Design and Destiny, (review happiness themes from the first interview, create an affirmative design statement that tells what they would like more of, identify resources needed to support their design) and 3) Revisiting Happiness (review and identify more happiness themes, ways to increase happiness in their lives and resources available). In between each interview, participants were encouraged to keep a journal of their experiences of happiness. This fueled discussion each week. Within each

phase of the protocol, prompts, along with exercises (journaling, collage, storytelling, guided imagery and goal setting) helped participants articulate their definition of happiness. A copy of the final interview protocol is available elsewhere (Buckland, 2009).

Three individuals called to inquire about the study but did not participate. One individual dropped out after the first interview citing lack of time. Complete data were obtained on thirteen individuals. Participants selected the interview venue: public mental health center, private mental health advocacy center, clinical studies unit at a university or a private residential treatment center. Digital recording of interviews was optional with three participants opting for written transcripts only. At the end of each interview participants were allowed to review recordings or written transcripts to confirm or exclude any material.

Immediately following each interview, tapes were sent to the transcription company or non recorded interviews were transcribed into a word document. Detailed notes of all interviews and immediate transcription following each interview minimized issues of trustworthiness and consistency. The transcriptions were reviewed, notes included to reflect upon impressions, and questions posed regarding correction of problems or considerations for future interviews. All transcripts were coded so data could be collated for each participant. Identifiers were only available to researchers. Data was kept in secure data centers.

Data Analysis

The data analysis strategy included interpretive analysis with subsequent content analysis. This plan merged both qualitative and quantitative approaches necessary for inclusion of participants' subjective views and for objective confirmation of identification of happiness themes. Data analysis for the first study phase used interpretive analysis, including three components: descriptive (gender, age and context for happiness), topic (identifying all themes of happiness; use of in vivo codes – those in the words of the study participants), and analytic coding (reviewing data over time to refine themes) (Morse & Richards, 2002). One researcher conducted this inductive and exploratory interview process and also coded and revised themes in the interviews. Components of happiness materialized through use of this reflective and iterative process.

Once these codes were identified, the same researcher created a Code Book with definitions of each theme and explained its use to two professionals from other disciplines: psychology and social work. These professionals used the Code Book to perform content analysis, defined as: "systematic, objective, quantitative analysis of message characteristics," (Neuendorf, 2002, p. 1). This was the second phase of data analysis. Inter-rater reliability was assessed through independent engagement in this activity. The coders were charged with the task of matching codes from the Code Book with previously identified segments of the transcripts. Once each coder completed identification of codes, percent agreement was computed for a validity check. Methods used to heighten trustworthiness of data included: prolonged engagement with the participants, triangulation of coders from different disciplines, and member-checking within interviews.

Results

Participants entered the study with some hesitation, unsure they would have much to talk about. A quote illustrating this sentiment was, "To tell you the truth, I guess I didn't expect to be able to come up with things about happiness when you asked me" (Buckland, 2009). However, the strength-based approach of AI made it possible. A definition of happiness, with three overarching themes, emerged from the data collected. In addition to these themes, unique challenges to experiencing happiness also became apparent.

Definition of Happiness

As the data was collected and reviewed, reflections upon in vivo codes from the participants and researcher constructed codes, provided the basis for analytical coding by category of happiness. Originally, through analytic coding, seven categories of happiness emerged: emotional, spiritual, cognitive, active, physical, social and material. Dimensions of happiness and properties of happiness also took shape. Dimensions referred to either "... individually constructed happiness (those experiences thought of and carried out on an individual level) or socially constructed happiness (those experiences initiated by, with or for others and carried out on an interactive level)" (Buckland, 2009). Properties of happiness refer to traits or attributes shown by the category. Quotes from participants illustrate categories of happiness, with dimensions and properties, as defined in this study.

Quote #1: "People who help me make me happy." The category is "social happiness" because it has to do with a relationship; the dimension is "socially constructed" because it is happiness brought out in relationship with others; the property is "supported" because it has to do with others assisting an individual (Buckland, 2009).

Quote #2 "Drawing pictures – abstract art – occupies me so I am not depressed, blocks, reduces, painful ideas." The category is "cognitive happiness" having to do with how a person thinks that makes them happy; the property was "creative" referring to generative activities that tap into a person's ability to make new things; the dimension is "individually constructed" because you do it by yourself. (Buckland, 2009)

Once the analytic coding was complete, content analysis began. The two additional coders from social work and psychology combed through hundreds of pages of transcripts. Using the researcher created Code Book, coders marked text by matching content to one of the seven categories listed previously. Initial percent agreement for this effort was approximately 75% (Buckland, 2009). This number was low due to two factors: 1) double coding for many portions of the text (example: identifying "attending a church service" as being both social happiness and spiritual happiness), and 2) leaving sections of text uncoded when coded by one of the others (example: marking a code for "having a girlfriend" as social happiness only once on a page where identified multiple times). Coders shared that coding became more difficult over time, and necessitated going back to previous codes as thinking about the codes evolved.

To increase percent agreement, codes were collapsed into three categories, Relational Happiness (with others, with self, with the spiritual), Health Happiness (mental positive state, bodily positive state), and Material Happiness (owning or having access to things and/or experiences) (Author, 2009). These three final categories represent the definition of happiness, with 90% agreement. See Table 1 for detailed examples of each category.

Unique Challenges

Although conversations about happiness elicited many examples, it became apparent that other themes were referenced as well. Themes concerned challenges to experiencing happiness: 1) fear, 2) isolation, 3) medication, and 4) being "normal" (Buckland, 2009).

The experience of fear was addressed by finding ways to keep safe. Common features of safety expressed by the participants included:

Processing Feelings: "You know, I don't want to be scared, because I'm pretty scared right now...I want to be able to identify my feelings and emotions...so I can

tell my fears to someone and not keep it inside me and screw up ... not let it take over my life.”

Feeling in Control of Your Mind: “...it’s a dangerous world, you know? ...the mind is a dangerous place...because you can bring yourself to places you have never experienced before, and you won’t know what to do...”

Being a Part of the World: “I’m going to have to get out in the world and that’s just something I’m always afraid to do, but I can’t let it get me down...Fear sucks. Fear will control you. Fear does not feel good.”

(Buckland, 2009, p.84).

The experience of isolation was another barrier to happiness. Relationships are seen as the antidote to isolation. Relationships included basic friendships, “I want to get to know people, and have a good time with people...I’d like to make friends,” and maintaining family ties, “...one thing people with schizophrenia need is family...I got my parents, which is great. I mean I can’t believe...after everything I’ve done, they still care.” (Buckland, 2009, p.96). Symptoms of SCZ, such as hearing voices and avolition were identified as getting in the way of breaking out of the pattern of isolation: “...but I still felt kind of isolated because I was hearing these voices, like, all the time” and “...because then I’m locked up in the room all day, and it’s like, what the hell are you doing? Nothing. Obviously, it’s terrible.” (Buckland, 2009, p.87).

The experience of medication, although valued, posed difficulties. Medications have different side effects making it difficult to keep alert, maintain initiative, control weight, engage in enjoyable activities and feel a positive sense of sexuality and self-esteem. Comments included: “I feel like I’m too medicated. But I don’t have a voice...It’s up to my doctors or parents...” or “I feel like it detracts from my sex appeal. I think it weakens my libido. I can’t get it on.” (Buckland, 2009, p.88).

The fourth challenge to happiness was related to the desire to feel “normal.” Because stigma from others and self is so pervasive, feeling normal is elusive. Normalcy meant being seen as responsible, similar to others, and accepted: “People who treat me like an adult,” “And so it was nice to know when I went to these meetings like some of the people were going through similar situations. And I didn’t feel like I was so strange or something,” and “With mental illness...it’s not that they’re judging you or anything, but it’s an uncomfortable situation where you have to explain this or that.” (Buckland, 2009, p. 89–90).

Conclusions and Implications for Nursing Practice

Limitations

Because this study had a small urban sample, with young adults in stable housing, and at least a high school education, findings cannot be generalized to all young adults with SCZ. Participants in this study came because they wanted to be involved. Even though they thought they had little to talk about, they were interested in the topic. In spite of their illness, their level of functioning was high compared to many others with SCZ who may be homeless, drug addicted, hospitalized, imprisoned. Additional exploration of happiness with a wider range of participants would allow the opportunity to confirm these findings.

Another limitation of the study is having one researcher as interviewer. Although the consistency of interviewing technique was an asset, the personal passion for the topic may have clouded some objectivity. Inclusion of multiple coders addressed some of this, but the energy and enthusiasm brought to the interviews may have been the driver behind the

effectiveness of the AI methodology rather than the method itself. Use of multiple interviewers specifically trained in the protocol could address this limitation.

Implications

Using AI as a tool for working with young adults with SCZ proved fruitful. Results showed that each of the four components of recovery, 1) finding and maintaining hope, 2) reestablishing a positive identity, 3) finding meaning in life, and 4) taking responsibility for one's life (Andresen et al., 2006), were addressed using this methodology. Because of this, use of AI as an interview tool holds promise for promoting recovery.

Component 1, finding and maintaining hope, was demonstrated through statistically significant results indicating levels of hope increased over the 6 week interview period. Details are reported elsewhere (Buckland, 2009). Component 2, re-establishing a positive identity, was demonstrated as participants, who felt they had little to share, moved to filling up each hour of interviewing, indicating they were able to find positive experiences from the past, present and into the future that they identified as integral to their lives. In addition, findings about happiness for this group provided an opportunity for the participants to see themselves as more like their peers without mental illness than different. These commonalities can help bridge the gap formed by stigma, from within oneself and from others. Component 3, finding meaning in life, was evidenced as the participants identified activities they enjoyed and looked forward to, and then set goals in order to work toward including these meaningful experiences in their lives. Component 4, taking responsibility for one's life, was a continual theme throughout the course of the interviews. Participants were encouraged to identify, through between interview journaling and reflection during interviews, what made them happy and to incorporate that into their lives.

Implications exist for use by psychiatric nurses and other health professionals in mental health practice. Using principles of AI with individuals with SCZ during intake interviews, within counseling sessions, and at provider appointments, could help build rapport, making the therapeutic relationship stronger. Other uses include goal setting in social arenas and school or job training, and dealing with treatment issues such as medication management, and behavioral therapies. Use of AI would encourage individual ownership of the process and investment in the outcomes. Knowing the challenges to experiencing happiness for this group provides insight into ways to surmount those barriers. For psychiatric nurses, being able to ask questions to identify those challenges and work in collaboration with individuals with SCZ to overcome those challenges would help address issues of importance that may have not otherwise been brought up. The definition of happiness provides a framework for initiating these discussions.

Younger adults with schizophrenia tend to be more hopeful and have greater expectations than those who have lived longer with a diagnosis of schizophrenia; the younger adults are not yet worn down by the effects of their illness (Kaplan, Salzar, & Brusilovskiy, 2012). By using the definitions of happiness found in this study, paired with the young adult's experiences and needs, psychiatric nurses can help these young adults focus on overcoming the barriers to happiness that would lead to a poor quality of life. Efforts to engage these young adults to improve their experience of happiness and quality of life may provide the framework needed to sustain hope as they age leading to recovery (Kaplan, Salzar, & Brusilovskiy, 2012).

AI use also has implications for families and friends. Family and friends could learn the principles of AI to focus on the positive, and to enhance inclusion. By focusing on the positive, family and friends increase opportunities for young adults with SCZ to engage in events that support positive image building. By using AI principles to engage, family and

friends increase the amount of time they spend with the young adults with SCZ, reducing isolation and increasing inclusion.

Future Research

Using this protocol to interview a wider range of participants with SCZ would be an important next step in confirming this definition for this population. Once accomplished, measurement tools could be developed, tested and established as valid and reliable for this group. Having tools to measure happiness effectively could streamline the work of helping young adults with SCZ overcome challenges they have related to happiness and identify productive ways to increase their movement to recovery. With a definition of happiness for these young adults, additional treatment strategies enhancing quality of life may reduce costs associated with negative symptoms and social and occupational dysfunction.

Development of evidence-based treatment options to overcome barriers to happiness would be an additional avenue to explore. One example of this would be increasing access to social support by developing programs to address Relational Happiness. Another example would be creating AI psychological education groups to educate individuals with SCZ and their families and friends about ways to utilize AI in everyday life to promote all three components of happiness (relational, material and health) through changing their thinking about the barriers that limit them.

This study uncovered a useful methodology for engaging young adults diagnosed with SCZ. Capitalizing on this collaborative practice holds promise within clinical and personal relationships. The benefits of this experience for young adults with SCZ are twofold: they develop ways of thinking that are solution focused rather than problem focused, and they begin to identify experiences of happiness, thought unattainable previously, but given a place in their lives now. But beyond the immediate benefits, the potential for enhancing the skills and abilities of family members, psychiatric nurses and other mental health professionals as they live and work with young adults with SCZ could transform the way individuals with SCZ are viewed and ultimately included in our world.

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Table 1**Final Happiness Themes/Categories and Examples**

Theme 1 A	Relational Happiness/With Others	<p>Quote: "I like a dynamic where I can just engage others in conversation and become part of a community. Because that's what I'm missing ... I need to feel their love and support ..."</p> <p>Dimension: Socially constructed—initiated by, with or for others and carried out on an interactive level</p> <p>Property: Engaged—involved in the social experience; supported—having others to assist you; caring—being there for others or they are there for you</p>
Theme 1 B	Relational Happiness/With Self	<p>Quote: "And I'm pretty happy each and every day when I get my anger out. Afterwards I'm happy. Every morning I have to get my anger out, otherwise I won't be happy, and I try hard not to go without getting my anger out in the morning very first of the day, or I just, get it done. And so then I can be happy. Then oh, I'm alive. I'm happy, you know."</p> <p>Dimension: Individually constructed—thought of and carried out on an individual level</p> <p>Property: Expressing Feelings—being able to recognize your feelings and process them</p>
Theme 1 C	Relational Happiness/Spirituality	<p>Quote: "I acquired some friends and we formed a band, and so we ended up pretty, I mean, what I consider successful, not like money-wise or anything, but happiness-wise we were successful because we had a Christian band so we tried to have good values and play at churches and then we tried to spread the word ..."</p> <p>Dimension: Socially constructed—initiated by, with or for others and carried out on an interactive level)</p> <p>Property: Life Guidelines—those tenets that one looks to in order to live according to a plan that embraces a higher power</p>
Theme 2 A	Health Happiness/(mental positive state)	<p>Quote: "I'm able to figure out my medication. I'm able to figure out my bills and all that stuff, I mean, just basic life stuff. Because basic life just makes me happy, you know."</p> <p>Dimension: Individually constructed—thought of and carried out on an individual level</p> <p>Property: Self-sufficiency—being able to take care of personal needs; decision making—activities/qualities, common sense/intelligence that assist in making choices</p>
Theme 2 B	Health Happiness/(bodily positive state)	<p>Quote: "I'd just like to be healthy. Being able to cross my legs is a big one, because doing that, it's just—I can't do it. Climb up stairs without huffing. Being stable on my medication."</p> <p>Dimension: Individually constructed—thought of and carried out on an individual level</p> <p>Property: Health care—taking care of what you need to do to have a healthy body and mind</p>
Theme 3	Material Happiness (owning or having access to things or experiences)	<p>Quote: "Well I mean, I haven't even applied yet but that's where I'm thinking about going. I'm pretty sure and they have a childhood, youth and family services degree, major and where you work in. It's not—you're never going to get paid a lot, but as long as I can have a car, some frogs. You know."</p> <p>Dimension: Individually constructed; thought of and carried out on an individual level.</p> <p>Property: Object and Financial Assets; owning items and having access to what money can buy</p>