



## Wellness within illness: Happiness in schizophrenia

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### ABSTRACT

Schizophrenia is typically a chronic disorder and among the most severe forms of serious mental illnesses in terms of adverse impact on quality of life. Yet, there have been suggestions that some people with schizophrenia can experience an overall sense of happiness in their lives. We investigated happiness among 72 outpatients with non-remitted chronic schizophrenia with a mean duration of illness of 24.4 years, and 64 healthy comparison subjects (HCs). Despite continued treatment with antipsychotic medications, the individuals with schizophrenia manifested a mild to moderate level of psychopathology. People with schizophrenia reported lower mean levels of happiness than HCs, but there was substantial heterogeneity within the schizophrenia group. Level of happiness in persons with schizophrenia was significantly correlated with higher mental health-related quality of life, and several positive psychosocial factors (lower perceived stress, and higher levels of resilience, optimism, and personal mastery). However, level of happiness was not related to sociodemographic characteristics, duration of illness, severity of positive or negative symptoms, physical function, medical comorbidity, or cognitive functioning. Except for an absence of an association with resilience, the pattern of correlations of happiness with other variables seen among HCs was similar to that in individuals with schizophrenia. Although happiness may be harder to achieve in the context of a serious mental illness, it nonetheless appears to be a viable treatment goal in schizophrenia. Psychotherapies targeting positive coping factors such as resilience, optimism, and personal mastery warrant further investigation.

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### 1. Introduction

The United Nations recognized pursuit of happiness as a fundamental human goal (UN News Centre, 2011). But is happiness a viable goal in the context of schizophrenia? Schizophrenia has been likened to a cancer of the mind (Sheldon, 1988), characterized not only by psychopathologic symptoms, but also medical comorbidity, accelerated aging, shortened lifespan, cognitive impairment, and psychosocial disability (Kirkpatrick et al., 2008; Meyer and Nasrallah, 2009; Palmer et al., 2009). Because of suffering and disability caused by schizophrenia, most attention has been directed toward understanding and reducing its negative effects. Yet, mental health is characterized not only by the absence of dysfunction, but also by the presence of positive mental states and outcomes (Seligman and Csikszentmihalyi, 2000; Jeste and Palmer, 2013).

Although there has been growing empirical attention to broad positive constructs such as quality of life, satisfaction with life, and subjective well-being in schizophrenia (Schrang et al., 2013), we found

only two published studies focused on happiness in schizophrenia. Buckland et al. (2013) conducted a qualitative study of happiness among 13 younger adults with schizophrenia, and Agid et al. (2012) found that people with schizophrenia's happiness levels are equivalent to healthy comparison subjects (HCs) on a four-item happiness scale. However, the latter patient sample was restricted to 31 people with remitted first-episode schizophrenia. We found no published studies assessing happiness among people with chronic non-remitted schizophrenia, even though a chronic non-remitted state characterizes a majority of those with this disorder (an der Heiden and Häfner, 2000).

There is no consensus definition, but the term happiness connotes an immediate (affective) positive emotion and a more enduring mood or disposition (De Prycker, 2010). Some authors distinguish hedonic (positive emotions) and eudaimonic (such as self-actualization and meaning) happiness (Delle Fave et al., 2011). Lyubomirsky and Dickerhoof (2010) contrast “bottom-up” models whereby happiness is determined by circumstances versus “top-down” models which view happiness as resulting from personality/temperament. Lyubomirsky and Dickerhoof proposed a third possibility that the effects of circumstances on happiness are modulated by how the circumstances are construed, i.e., “people are happier when they interpret their life circumstances in an optimistic ‘glass is half full’ fashion ...and

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this is true regardless of how ‘ideal’ their circumstances may actually be” (p. 231). Under the “bottom up” model one might predict that people with schizophrenia have lower happiness than HCs; under a “top down” model, schizophrenia may be unrelated to happiness. Under the construal model, one would expect people with schizophrenia to have lower levels of happiness overall, yet also find heterogeneity in happiness in this group, with positive psychological traits such as optimism promoting higher levels. Outside the context of schizophrenia research, commonly reported correlates of happiness include optimism, resilience, spirituality, positive social relationships, and physical and mental health (Dember and Brooks, 1989; Rim, 1993; Affleck et al., 2001; Abdel-Khalek, 2006; Cohn et al., 2009; Holder and Coleman, 2009; Holder et al., 2010).

We conducted a study of happiness among community-dwelling adults with chronic schizophrenia compared to HCs, as well as its associations with demographic, illness-related, and psychosocial factors. In accord with the notion that life circumstances affect levels of happiness, we hypothesized that relative to HCs, people with schizophrenia would have lower levels of happiness, and that level of happiness would be negatively correlated with duration of illness and severity of psychopathology but positively correlated with level of education, physical health, and cognitive functioning. Additionally, in accord with the construal model of happiness, we hypothesized that happiness would be correlated with positive psychosocial factors—i.e., resilience, optimism, social support, personal mastery, positive attitudes toward own aging, and spirituality.

## 2. Methods

### 2.1. Subjects

Participants included 72 outpatients with schizophrenia (including 12 with schizoaffective disorder) and 64 HCs recruited as part of an ongoing study of aging in schizophrenia at the University of California, San Diego (UCSD) Center for Healthy Aging and Stein Institute for Research on Aging. Inclusion criteria were: (a) age > 21 years (observed range 23–70 years), (b) DSM-IV-TR diagnosis of schizophrenia or schizoaffective disorder or, for HCs, absence of major neuropsychiatric disorders, (c) outpatient status, and (d) English fluency. Exclusion criteria were: (a) alcohol or substance abuse or dependence in the 3 months preceding enrollment, (b) diagnosis of dementia or other conditions known to affect neurocognition, and (c) medical problems that would interfere with participant's ability to complete study assessments. The protocol was approved by the UCSD Human Research Protections Program; all the subjects provided written informed consent for participation.

Participants with schizophrenia were recruited through UCSD outpatient psychiatry services, San Diego County Adult and Older Adult Mental Health Services, and San Diego Board-and-Care facilities (adult residential facilities that provide meals and shelter). The HCs were recruited with flyers in the community, advertisements in local media, word of mouth, and a registry of non-patients from an ongoing study of successful aging (Jeste et al., 2013).

Antipsychotic medications (mean [SD] daily dose) included: risperidone ( $n = 17$ ; 6.6 [4.2] mg), clozapine ( $n = 15$ ; 350.0 [243.0] mg), aripiprazole ( $n = 15$ ; 18.8 [6.5] mg), quetiapine ( $n = 11$ ; 530.0 [254.1] mg), olanzapine ( $n = 11$ ; 23.0 [12.4] mg), perphenazine ( $n = 5$ ; 2.5 [7.0]), and other ( $n = 24$ ). Nine individuals with schizophrenia/schizoaffective disorder (12.5%) were not on any antipsychotic medication; 24 (33.3%) were on >1 antipsychotic.

### 2.2. Measures

Participants were evaluated in person and completed a survey packet developed for our Successful AGing Evaluation (SAGE) study (Jeste et al., 2013). The persons with schizophrenia and most HCs

completed the survey with a research assistant who was available to help read or clarify survey instructions; the rest completed it at home.

#### 2.2.1. Sociodemographic characteristics and medication status

Age, education, gender, race/ethnic background, age of onset and duration of illness, living situation, and medications were determined via interview and review of available medical records.

#### 2.2.2. Happiness

Happiness was measured with four items from the Center for Epidemiologic Studies Depression (CES-D; Radloff, 1977) scale rated in reference to the preceding week: “I felt hopeful about the future,” “I was happy,” “I enjoyed life,” and “I felt that I was just as good as other people.” Each item was rated from 0 = “Rarely or None of the Time (less than one day)”, to 3 = “Most or All of the Time (5–7 days).” Total scores range from 0 to 12; higher scores reflect more happiness. Fowler and Christakis (2008) established that these four items load on a separate factor that can be employed as a happiness scale (CESD-H); in their maximum-likelihood factor analysis of the full CES-D these four items formed Factor 3 with loadings from  $-.465$  (“I felt that I was just as good as other people”) to  $-.727$  (“I enjoyed life”).

#### 2.2.3. Severity of psychopathology

Psychopathologic symptoms were assessed through interview with the Scales for Assessment of Positive and Negative Symptoms (SAPS and SANS; Andreasen and Olsen, 1982). Subjects also completed the Brief Symptom Inventory—Anxiety subscale (BSI-A; Derogatis and Melisaratos, 1983). Mental health related quality of life was assessed with the Mental Health Component from the MOS Study 36-Item Short-Form (SF-36; Ware and Sherbourne, 1992).

#### 2.2.4. Physical health

Physical functioning was assessed with the SF-36 Physical Component score. Medical comorbidity was assessed with the number of categories endorsed and severity index from the Cumulative Illness Rating Scale for Geriatrics (CIRS-G; Parmelee et al., 1995). Weight and height were measured to calculate Body Mass Index (BMI).

#### 2.2.5. Psychosocial factors

Objective and perceived stress were measured with the Life Events Scale (Berkman and Syme, 1979) and the Perceived Stress Scale (Cohen et al., 1983), respectively. Trait and event-related resilience were evaluated with the Connor–Davidson Resilience Scale—10 item version (CDR-10; Campbell-Sills and Stein, 2007), and Hardy–Gill Resilience Scale (HGRS; Hardy et al., 2004), respectively. Optimism was assessed with the Life Orientation Test—Revised (LOT-R; Scheier et al., 1994). Participants also completed the Duke Social Support Index (DSSI)—social interaction subscale (Blazer et al., 1990) and the Personal Mastery Scale (PMS; Pearlin et al., 1990). Attitude toward aging was measured with the Philadelphia Geriatric Center (PGC) Morale Scale (Liang and Bollen, 1983). Participants also completed the Brief Multidimensional Measure of Religiousness/Spirituality (BMMRS) Index of Daily Spiritual Experience (Idler et al., 2003).

#### 2.2.6. Cognitive functioning

Cognitive functioning was assessed with the Telephone Interview for Cognitive Status—Modified (TICS-M; Welsh et al., 1993) and selected subtests from the Delis–Kaplan Executive Function System (D-KEFS; Delis et al., 2001). For the present study the TICS-M was administered in person rather than by phone. As executive functioning may be particularly important and vulnerable to progressive decline in schizophrenia (Fucetola et al., 2000; Palmer and Heaton, 2000; Wobrock et al., 2008), several D-KEFS subtests were included: Trail Making Letter–Number Sequencing, Color Word Inhibition (Switching), and the Letter Fluency (FAS total). Using the SPSS 21 normal rank function, D-KEFS raw scores were converted to z-scores (coded so higher scores

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