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Investigation of the Multidimensional Well-Being Assessment (MWA) in a sample of African Americans

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Graduate School of Education and Psychology

INVESTIGATION OF THE MULTIDIMENSIONAL WELL-BEING ASSESSMENT (MWA) IN A SAMPLE OF AFRICAN AMERICANS

A clinical dissertation submitted in partial satisfaction

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Doctor of Psychology

by

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Shelly P. Harrell, Ph.D. – Dissertation Chairperson

This clinical dissertation, written by

Gera Anderson

under the guidance of a Faculty Committee and approved by its members, has been submitted to and accepted by the Graduate Faculty in partial fulfillment of the requirements for the degree of

DOCTOR OF PSYCHOLOGY

Doctoral Committee:

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Many thanks to various members of the Association of Black Psychologists (ABPSi), the Southern Chapter of the Association of Black Psychologists (SCABpsi), the Association of Pan African Doctoral Scholars (APADS), and the Association of Black Women in Higher Education (ABWHE). In particular, I would like to thank Tifase Memsaji-Webb and Joann Staten.

I would like to express my sincerest gratitude to Dr. Daryl Rowe. I am forever grateful to have had the opportunity to learn from you and be "tested and refined by fire." I also owe a very warm and heartfelt thank you to Drs. Carrie Castaneda-Sound, Natasha Thapar-Olmos, and Carolyn O'Keefe, for your knowledge and insight to which you contributed to this work. I give a shout-out to all my study buddies, partners in research, and warriors in the struggle because "Friends don't let friends go ABD."

Lastly, I say thank you to my African and indigenous ancestors. Without standing on your shoulders, I would have never reached these heights.

VITA

Gera L. Anderson

Education

Pepperdine University, Los Angeles, California

Doctor of Clinical Psychology Candidate, 2016

Argosy University, Honolulu, Hawaii

Master of Arts, Clinical Psychology, with emphasis in School Psychology, 2013

University of Minnesota, Minneapolis, Minnesota

Master of Education, Educational Psychology, 1997

DePaul University, Chicago, Illinois

Bachelor of Arts, Psychology, October 1986

Clinical Experience

Desert Psychological: The Offices of Stephanie Holland, Inc. **Las Vegas, Nevada**

Clinical Psychology Intern August 2015–August 2016

Supervisor: Stephanie Holland, PsyD

- Participated as a trainee offering services to at-risk populations from various backgrounds and with a wide range of challenges, with sensitivity to cultural and individual differences
- Provided evidenced-based services at Caliente Youth Correctional Facility
- Worked with adjudicated youths ages of 12-18 (male and female) that had been committed to the State of Nevada for correctional care
- Evaluated, diagnosed, and developed individualized treatment psychological diagnosis and recommended treatment
- Conducted psychological testing, evaluations, and assessments may be for the purpose of the provision of appropriate services plans for the youth committed to the facility
- Work as part of a multidisciplinary team (i.e., superintendent, cottage staff, school staff, parole officer, nurse, and mental health staff) in order to assist each youth successfully complete the Caliente Program and prepare them for parole
- Provided service to youth ages 12-18 who were committed to Department of Child and Family Services (DCFS) for mental health care through Youth and Parole.
- Provided psychological evaluations for City of Henderson selection of police hire candidates, including MMPT-RF
- Evaluated military veterans to provide medical disability examinations for compensation and pension benefits
- Provided Clark County Family Court child custody evaluations to assess the parenting skills and suitability of each respective parent for the best interests of the child(ren) at stake
- Administered, scored, and interpreted psychological tests. Common tests included the WAIS-II,

WISC-IV, WRAT-IV, MMPI-RF, PAI, TOMM, D-KEFS and NEPSY-II. Projective tests included RAT, and Rorschach

- Conducted clinical interview with and recommended candidates for an armed security guard position with G4S
- Evaluated applications from individuals with permanent disabilities to determine eligibility for federal Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI)

Kedren Acute Psychiatric Hospital/Community Mental Health Center **Los Angeles, California**
Practicum Intern September 2013–July 2014
Supervisor: Berta Ortiz, PhD

- Participated as a member of an interdisciplinary treatment team, comprised of psychiatrists, social workers, rehabilitation specialists, nurses, internist, and nutritionist, providing psychosocial rehabilitation services to patients with severe, acute mental illness, who meet the criteria for involuntary hospitalization
- Conducted comprehensive clinical interviews and mental status examination
  Administered, scored, and interpreted psychological tests. Common tests include the WAIS-II, MMPI-2, BDI, and BAI
- Attended daily staffing meetings to discuss patient cases
- Integrated all data and produced a psychological testing report for diagnostic purposes
- Presented the findings of psychological testing to the patient and the treatment team

YouThink Student Ambassador "Be The Change" (BTC) Program **Los Angeles, California**
Youth Partner September 2013–August 2014
Supervisor: Shelly Harrell, PhD

- Provided support to youth ranging in age from 14-18 years, representing a diverse population of African American, Asian, and Hispanic adolescent residents of South Central Los Angeles and surrounding communities who have had first-hand exposure to complex social problems, including poverty, immigration, racism, and urban violence.
- Facilitated youth empowerment and leadership development by conducting monthly youth development counseling support groups
- Conducted weekly individual client consultations aimed at maintaining high levels of wellness
- Organized and led Be The Change Empowerment workshops designed to build community
- Participated in outcome observations of selected activities such as college preparation workshops, photography workshops, and community action activities
- Contributed to youth program development and its evaluation
- Attended psychiatric grand rounds that addressed the various forms of pathology found among inpatient psychiatric patients

SHIELDS for Families, Psychological Assessment Center **Long Beach, California**
Assessment Extern September 2012–August 2013
Supervisor: Daniel Oakley, Psy.D.

- Provided cognitive, academic, behavioral, and projective assessments for students ranging from 5-17 years of age, to evaluate cognitive, learning, behavior and school problems. SHIELDS' client composition is made up of diverse ethnic and cultural backgrounds, primarily Latino and African-American, presenting with various diagnostic issues and psychosocial problems, as well as histories of trauma
- Conducted psychological assessment batteries with children and adolescents suffering from a variety of "presenting problems", including psychosis, cognitive difficulties, neurological difficulties, learning disorders, mood and anxiety disorders, and substance abuse disorders primarily from the School-based Mental Health department
- Conducted common tests including the ASDS, ASRS, CMS, CELF, CEFI, CTOPP, Conners 3 Short (Parent, Teacher), Conners 3 Rating Scale (Parent, Teacher), Conners CBRS (Parent, Self-report), CPT-II, GORT, KABC-II, MMPI=A, TEMAS, TONI-III, WISC-IV, and WJ-III, and Tests of Achievement Projective tests including the RISB and the Rorschach
- Conducted diagnostic interviews with client and family members
- Scored and interpreted assessment data from psychological testing
- Developed treatment plans and recommendations for diagnostic cases
- Integrated information in comprehensive reports

Community Coalition for Substance Abuse Prevention and Treatment **Los Angeles, California**
Individual & Group Therapist, Wellness Coach September 2012–August 2013
Supervisors: Shelly Harrell, PhD

- Provided support to youth ranging in age from 14-18 representing a diverse population of African American, Hispanic and Caucasian male and female adolescent residents throughout South Central Los Angeles at Community Coalition (CoCo), a community-based organization that provides psychotherapeutic, academic and political support to youth through their SCYEA (South Central Youth Empowerment through Action) partnership
- Conducted individual psychotherapy sessions with youth utilizing Humanistic, CBT (Cognitive Behavior Therapy), ACT (Acceptance and Commitment Therapy), and evidence based treatment interventions for adolescents
- Provided crisis counseling and conduct suicide assessments, as needed
- Conducted weekly staff support groups
- Provided academic counseling and support to adolescents ages 14-18
- Helped youth to develop interpersonal skills, healthy attachment, and peer support networks
- Provided psychotherapeutic support to promote wellness throughout the organization

Pepperdine Community Counseling Center **Encino, California**

Individual Therapist September 2012–August 2015

Supervisors: Meredith Merchant, PhD and Bruce Rush, PsyD

- Provided brief and long-term psychotherapy to adults from diverse populations in an outpatient community setting, with clientele including individuals with major depressive disorder, anxiety disorders, interpersonal difficulties, and other life issues
- Conducted structured intake assessment interviews, determined diagnoses, and formulated appropriate treatment plans
- Administered, scored, and interpreted psychodiagnostic measures to form client conceptualization and track changes in client presentation over time
- Attended and presented clinical presentations in weekly supervision

Pepperdine Community Counseling Center **Los Angeles, California**

Individual & Group Therapist September 2010–July 2012

Supervisor: Aaron Aviera, PhD

- Provided brief and long-term psychotherapy to adults and families from diverse populations in an outpatient community setting, with clientele including individuals with presenting problems such as major depressive disorder, dysthymic disorder, dysthymia, adjustment disorder, adult antisocial behavior, and parent-child conflict
- Conducted structured intake assessment interviews, determined diagnoses, and formulated appropriate treatment plans
- Administered, scored, and interpreted psychodiagnostic measures to form client conceptualization and track changes in client presentation over time
- Attended and presented clinical presentations in weekly supervision
- Responsible for responding to crisis calls as the on-call therapist, utilizing a clinic pager on a rotating basis

Union Rescue Mission (Pepperdine Counseling Center) **Los Angeles, California**

Individual Therapist August 2011–September 2011

Supervisors: Stephen Strack, Ph.D. & Aaron Aviera, Ph.D.

- Provided brief and long-term psychotherapy to adult males and females enrolled in a long-term faith-based, residential substance recovery program representing diverse ethnic, racial and socioeconomic backgrounds in the Central Los Angeles Skid Row area
- Serviced clients most commonly presented with dual diagnoses that included depression, anxiety, antisocial personality disorder, and conduct disorder
- Led weekly diabetic support group that emphasized managing symptoms and lifestyles changes such as exercise and diet
- Conducted psycho-educational assessments concerning emotional, behavioral, and cognitive difficulties: common tests included the WAIS-IV, MMPI-2, MCMI, BDI, and BAI
- Referred clients' for medication evaluations as needed to address chronic and severe symptoms of

mental illness

- Attended and presented case material in weekly dyad and group supervision

Related Professional Experience

University of Minnesota Department of Child and Adolescent Psychiatry,
Early Risers Child Development Project **Minneapolis, Minnesota**
Research Project Manager/Community Program Specialist 1994–1998

- Assisted in identification and recruitment of research subjects, the coordination of subject screening process and the implementation of experimental treatments.
- Hired and trained assessment technicians and secondary counselors
- Evaluated program and fidelity of program implementation
- Tracked study participants as they participated in the various treatment tiers
- Directed the delivery of services including food, transportation, and recreation

Volunteer Professional Experience

LA Biomedical Research Institute at Harbor-UCLA Medical Center **Los Angeles, California**
Research Assistant September 2013–August 2015

Building Resiliency & Increasing Community Hope (B-RICH) Study & Patient Centered Outcomes Research Institute (PCORI)Study B-RICH is a randomized study being conducted Harbor-UCLA Medical Center LA Biomedical Research Institute and the David Geffen School of Medicine at UCLA in partnership with community-based organizations Healthy African American Families II and First African Presbyterian Church.

PCORI is authorized by Congress to conduct research to provide information about the best available evidence to help patients and their health care providers make more informed decisions. PCORI's research is intended to give patients a better understanding of the prevention, treatment and care options available, and the science that supports those options.

- Assisted in the implementation of community partnered, participatory research project with two treatment groups or the wait-list group who were offered two case management calls and referrals to community social support services. The study group participated in seven weekly sessions of a 90-120 minute Resiliency Class.
- Taught 7-week Cognitive Behavioral Therapy Resiliency Class.
- Conducted screening surveys, initial interviews, and three-month follow-up interviews after the Resiliency Class
- Conducted qualitative phone interviews to utilize the African American and Latino clients stratified by intervention status to determine priorities for outcomes and services to address them

Green Dot Public Charter Schools/Locke High Schools **Los Angeles, California**
School Psychology Intern August 2009–June 2010

- Conducted assessments concerning emotional, behavioral, and cognitive difficulties. Common tests

included *Curriculum-Based Measures of Reading Fluency, Reading Comprehension, Writing, and Math; BASC=2, B-VAT, CAS, TAPS=3, TVPS, VABS-II*

- Developed and monitored academic and behavioral interventions within a Response to Interventions (RtI) model
- Participated on the Student Success Team (SST) process on a levels of intervention that included curriculum adaptation, modification, and referral for special education services
- Collaborated in developing in-service trainings, conducted in-service trainings, managed and conducted SST meetings, and consulted with staff
- Collected progress monitoring data using alternative assessment (Curriculum-Based Measurement and AIMsweb data inputting system to create progress monitoring graphs
- Provided individual counseling to 8 adolescents, who received special education services

Newport-Mesa Unified School District **Costa Mesa, California**

School Psychology Intern August 2007–May 2008

- Conducted assessments concerning emotional, behavioral, and cognitive difficulties. Common tests included *Curriculum-Based Measures of Reading Fluency, Reading Comprehension, Writing, and Math; BASC-2, BRIEF, B- VAT*, CASL, Conner's Rating Scales (Parent, Teacher), CASL, CTONI, EOWPVT, KABC-II, MVPT-3, PPVT 4, *TAPS-3*, TOLD-3, *TVPS*, WISC-IV, WJIII, VMI-Motor Integration, VMI-Visual Perception, WASI, and WRAML-2

Research Experience

Pepperdine University Harrell Research Group (HRG)

Research Assistant to Dr. Shelly Harrell September 2010 –*2014*

- The Harrell Research Group is committed to applied scholarship, based on the core values of cultural diversity and social justice, which informs real world concerns and leads to actions that enhance wellness and empower individuals, groups, and communities. Research centers on projects relevant to (1) Well-Being & Diversity, (2) Intervention Development and Implementation, and (3) Community-Based Program Partnerships.

Culture & Trauma Lab, Pepperdine University

Research Assistant to Dr. Thema Bryant-Davis September 2010–August 2013

The Culture and Trauma Research Lab conducts qualitative and quantitative research on the cultural context of interpersonal trauma recovery. Projects, including critical analyses of the literature, focused on partner abuse, sexual assault, human trafficking, genocide, and the societal trauma of racism.

Publications

Bryant-Davis, T., Ellis, M. U., Burke-Maynard, E., Moon, N., Counts, P. A., & Anderson, G. (2012). *Religiosity, spirituality, and trauma recovery in the lives of children and adolescents. Professional Psychology*: Research AndPractice, 43(4), 306-314. doi:10.1037/a0029282

Bryant-Davis, T., Ullman, S., Tsong, Y., Anderson, G., Counts, P., & Tillman, S. (accepted). *Healing pathways: Religious coping and social support among African America sexual assault survivors. Pepperdine University.*

Professional Presentations

Ellis, M., **Anderson, G.**, Rogers, G. & Bryant-Davis, T. (2013, October).*"Neuropsychological Manifestations of Child Sexual Abuse and Pathways to Recovery."* Los Angeles County Psychological Association Convention: Los Angeles, California.(Poster).

Anderson, G. (2013, July). "*A Mile in Child Moccasins: Traditional Ways of Healing Sexual Abuse.*" American Psychological Association Annual Convention: Honolulu, Hawaii. (Poster).

Anderson, G. (2013, June)."Positively Different: Experiences and Expressions of Well-being in the Context of Culture andDiversity- *More than Gangs, Drugs, and Rap Music: Urban African American Youth and Well-being."*Third World Congress onPositive Psychology: Los Angeles, California.

Anderson, G., Counts, P., Bellete, N., & Gutierrez, R. (2013, March). "A National and International Look at Gender-BasedViolence" - *Sexual assault and intimate partner violence with Native American/American Indian (NA/AI) women*."Association for Women in Psychology Conference: Salt Lake City, Utah.

Anderson, G. (2012, October). *Well Being Among African American Youth in South Central Los Angeles: Validation of the Multidimensional Well-Being Assessment (MWA).* Pepperdine Multicultural Research and Training Lab Fourth Biennual Conference: Los Angeles, California.
Anderson, G., Cassidy-Clark, K., & Harrell, S. (2012, August). *What's Good in the Hood?: Youth prevention programs in South LosAngeles and implications for evidence-based practice.* American Psychological Association Convention: Orlando, Florida. (Poster).

Anderson, G., Counts, P., & Bellete, N. (2012, July). *Shattering the Scilence: Clinical Approaches to Issues in the Community.* 44th ABPsi Annula International Convention: Los Angeles, California.

Counts, P., **Anderson, G.**, Yessi, J., & Bryant-Davis, T. (2012, March). *Strength and Resilience: Adolescent Girls Exiting Trafficking.* Association of Women in Psychology Conference: Palm Springs,

CA. (Poster).

Anderson, G., Counts, P., & Harrell, S. (2012, January). *I Am Because We Are: Community support and the positive development of Black youth.* Association of Black Psychologists General Assembly Mid-year Conference: Prairie View, Texas. (Poster).

Counts, P., **Anderson, G.**, & Bryant-Davis, T. (2011, September). *Counseling approaches to positive outcomes among child trafficking survivors.* International Conference on Violence, Abuse, and Trauma: San Diego, California (Poster).

Anderson G., Counts, P., & Bryant-Davis, T. (2011, January). *Coping and surviving: African American women and the aftermath of sexual assault.* The Association of Black Psychologists Mid-Year General Assembly Conference: New Orleans, Louisiana (Poster).

Training and Certifications

Advocate Training Program, 9-month training, California Black Women's Health Project, 2012- 2013
APA Advanced Training Institute Participant, 5-day training, "Research Methods with Diverse Racial and Ethnic Groups" Michigan State University, East Lansing, 2011
Dialectical Behavior Therapy "Nuts and Bolts", 1-day skills training, Loma Linda Medical Center, 2012
Trauma Focused-Cognitive Behavioral Training (TF-CBT), 1-day training, Pepperdine University, 2010

Professional Service

Strategic Planning Chair–Association of Black Psychologists Student Circle Board, *present*
Assistant Coordinator–National Multicultural Conference Summit 2013 Planning Committee, 2011–2013
Planning Committee–Black Graduate Student Conference in Psychology, 2012
Planning Committee–Association of Black Psychologists Annual Convention, 2011–2012
President, Africana Students in Psychology and Education Association (ASPEA), 2011–2012
Co-founder and coordinator–Pepperdine Diversity Symposium, 2011–2013
Chair, Southern California Chapter Student Circle, Association of Black Psychologist, 2010-present
Student Leader, National Association of School Psychology (NASP), 2006

Awarded Grants and Fellowships

Conrad N. Hilton Foundation Fellowship, Union Rescue Mission, 2012
Psy.D. Contribution to Diversity Scholarship, Pepperdine University, 2010, 2011, & 2012
Center for Faith and Learning Pepperdine Service Learning Internship Grant, 2011 & 2012
APA Advanced Training Institute Scholarship, 2011
Colleague Diversity Grant, Pepperdine University, 2010 & 2012
Award for Professional Promise in Graduate School Psychology, Argosy University, 2007

Honors and Professional Memberships

Alternate, American Psychological Association Minority Fellowship Program, 2011

Campus Representative, Advocacy Coordinating Team (ACT), American Psychological Association of Graduate Students (APAGS), 2012–2014

California Psychological Association, Graduate Students, 2010–2012

Association of Black Psychologists (ABPsi), since 2010

American Psychological Association, Graduate Students, 2010–2014

Los Angeles County Psychological Association of Graduate Students, 2010–2011

Africana Students in Psychological and Education, 2011–2015

Association of Black Women in Higher Education (ABWHE), 2011–2015

Association of Pan African Doctoral Scholars (APADS), since 2012–2015

ABSTRACT

Existing models and measures of well-being tend to be based on an individualistic, western worldview. In addition, when cross-cultural comparisons are made, diverse cultural groups within the same national border are typically not examined. The Multidimensional Well-Being Assessment (MWA) was developed because of the absence of a culturally relevant measure to assess the well-being of those whose worldview is more consistent with collectivism. Although much attention has been given to detrimental forces in the lives of African Americans, less consideration has been given to assessing well-being in this population. In this study, a nonrandom sample was used to examine the validity of the MWA. In addition, several demographic variables were considered to explore the relationship of the dimensions of well-being contained on the MWA. A total of the 169 persons who identified as African American or as a Black person with African ancestry participated in the study. The MWA showed strong reliability on nearly all dimensional subscales, as well as a pattern of expected significant positive and negative correlations with multiple validation measures. Significant correlations between demographic variables (i.e., age, education, income, and gender) and several dimensions on the MWA were also found. This study has implications for future research and the MWA shows promising results with regard to its psychometric properties. It is a potentially useful instrument to utilize in research that seeks to deepen understanding of life satisfaction and wellness in diverse populations, with particular attention to unique findings within the African

American population.

Introduction

How does the culture and context of African Americans influence their perception and meaning of what makes a good life? This concept is encompassed in the complex construct of positive psychology's study of well-being, a critical component in optimal functioning (Ryan & Deci, 2001). It has become evident that positive aspects of human behavior and psychological health, not just psychopathology, should be defined and explored (Simonton & Baumeister, 2005). In the last 30 years, well-being has become an increasingly visible topic, particularly burgeoning in positive psychology literature since 2000 (Rich, 2001; Seligman & Csikszentmihalyi, 2000). However, some ethnic minority populations have been significantly overlooked in studies of well-being.

While cross-cultural differences in well-being between countries have indeed received some attention, less literature is available examining racial and ethnic diversity within a particular nation (Arrindell et al., 1997). Furthermore, relatively little qualitative research has been conducted examining how well-being is expressed and experienced in the context of having a racial or ethnic minority status (Nathan, 2010). African Americans in the United States are one of the ethnic minority populations that have been marginalized and pathologized within mental health literature in general, and ignored in the well-being literature in particular, as normative behavior and well-being have been primarily defined from a Eurocentric male perspective (Harrell, 2014). Because culture has not been taken into consideration in research on well-being among ethnic minority populations, a large gap in the literature remains on the cultural informants of well-being and correlates of well-being (Christopher, 1999). It is important that the construct of well-being be understood and measured with consideration of cultural diversity in order to determine the enhancement of psychological and physical resilience across cultures and

to inform researchers and clinicians on how best to aid persons from underrepresented cultural groups towards achieving optimal functioning.

The Multidimensional Well-Being Assessment (MWA; Harrell, 2013) was developed because systems and measures of well-being have lacked integration of values important to diverse racial and ethnic groups, such as urban African Americans. Harrell's underlying multidimensional well-being framework has the primary purpose of being more inclusive and incorporating contexts of well-being that may be more relevant to populations who are more collectivistic and do not hold a dominant, western, or Eurocentric worldview. The Multidimensional Well-Being Assessment integrates the transformational, transcendent, and collective aspects of well-being that emerge from the literature in multicultural psychology in which the themes of collectivism, spirituality, and overcoming adversity are prominent (Jackson, 2006). The literature reviewed discusses the limitations of current conceptualizations of well-being and explore the construct of well-being in the African American population. The larger historical, sociopolitical, and cultural context will be considered in how they help to understand the experience of well-being. The primary goal of this research study is to examine well-being in a sample of African Americans as measured by the MWA. More specifically, this study aims to examine the psychometric properties of the MWA as a culturally valid instrument for evaluating the well-being of African Americans.

Review of the Literature

The following literature review includes a discussion of the construct of well-being, including its history and definitional issues. Issues relevant to the measurement of well-being will also be discussed. Finally, research findings on the relationship of well-being to culture, with particular attention to the African American community, will be reviewed.

Current Conceptualizations of Well-being

Although the literature on well-being has increased, there is little agreement about a standard definition of the construct (Deci & Ryan, 2006; Kahn & Juster, 2002; McGillivray, 2007; Mizohata & Jadoul, 2013). Some theorists and researchers believe that concepts such as happiness, good life or life satisfaction are synonymous with well-being, while others argue that fundamental differences exist between these terms (Diener, 1984; Hayborn, 2008; Keyes, Shmotkin, & Ryff, 2002; Veenhoven, 2008). Well-being has also been examined through a number of theoretical frameworks that may focus on objective indicators, such as income or biological theories, that point to genetic predisposition (Binder, 2013; Diener & Ryan, 2009; Frey & Stutzer, 2002; Gasper, 2005; Sointu, 2005). These indicators are typically divided into socio-demographic (e.g., age or marital status), economic (e.g., type of work), situational (e.g., health or social relationships), individual determinants (e.g., personality traits), or institutional factors (e.g., privilege or discrimination).

The research on well-being has generally been divided into two philosophical traditions or perspectives that are suggested to be distinct empirically but conceptually related (Keyes et al., 2002; Lent, 2004; Ryan & Deci, 2001). The literature also suggests that these two philosophical views overlap as well as highly correlate, as both approaches essentially revolve around subjective accounts of well-being but examine differing features and derive differing

operational definitions (Keyes et al., 2002; Ryff, 1995). The two perspectives are usually referred to as hedonic and eudaimonic well-being or respectively, as subjective and psychological well-being. These specific approaches within which well-being has been explored will be examined.

The hedonic view of well-being emphasizes pleasurable and preferable experiences and feelings (Hayborn, 2008; Kahneman, Diener, & Schwarz, 1999; Kubovy, 1999). Its focus is on the experience of positive affective states while avoiding pain. The idea of happiness has been emphasized, which not only encompasses physical pleasure in the individual's immediate experience, but also the attainment of goals (Diener, Sapyta, & Suh, 1998; Keyes et al., 2002). Hedonic well-being is based on an individual's feelings about his or her overall life (Diener, 1984; Diener, Suh, Lucas, & Smith, 1999; Ryan & Deci, 2001; Waterman, 2007a). Yet, some believe that the explanation of hedonic well-being is too narrowly focused (Diener & Lucas, 2000; Ryan & Deci, 2001).

The term subjective well-being is often used interchangeably with hedonic psychology; in fact, most of the research in the hedonic psychology field assesses the construct through measures of subjective well-being (SWB; Diener, 1984; Diener & Lucas, 2000). Associated with the general term "happiness," subjective well-being traditionally followed a hedonic approach and referred to the extent to which one subjectively experiences high levels of positive affect and low levels of negative affect (Diener, Lucas, Schimmack, & Helliwell, 2009; Ryan & Deci, 2001; Waterman, 2007b). SWB is also regarded as an outcome measure by which to judge successful living (Diener & Suh, 1999). Cognitive evaluations or appraisals of life satisfaction as whole and emotional reactions to life events were later integrated into the definition of subjective well-being (Diener & Diener, 1995; Diener, 2006; Ryan & Deci, 2001; Seligman &

Csikszentmihalyi, 2000). Therefore, subjective well-being includes affective and cognitive elements. It is composed of three components: affective evaluations or emotional responses; domain satisfaction or satisfaction in regards to work, family life, and other areas; and cognitive evaluations of life satisfaction (Ryan & Deci, 2001).

Unlike SWB, psychological well-being is commonly understood in terms of existential challenges of life (Keyes et al., 2002). Psychological well-being is sometimes used synonymously in the literature with the idea of eudaimonic well-being, an approach which proposes that if people experience a purpose in life, along with challenges and opportunities for growth, they will feel fulfilled and experience greater well-being (Deci & Ryan, 2000; Keyes et al., 2002; Waterman, 2007a). Thus, it integrates actualized potential and pursuit of intrinsic goals, such as career, close relationships, personal growth and community involvement (Camfield & Skevington, 2008; Waterman, 1993). The concept of psychological well-being has been constructed and defined by researchers using factors believed to be the principal contributions to the quality of life (Waterman, 2007a). Ryff's (1989) early efforts to understand psychological well-being integrated existing literature and offered the following characteristics: the acceptance of oneself; the ability to choose or create appropriate contexts; warm and trusting relations with others; having goals, intentions, and a sense of direction; the opportunity for personal growth, and the ability to be autonomous. Consequently, Ryff and her colleague (1989; Ryff & Singer, 1998a) operationalized the term psychological well-being and proposed a multi-dimensional model according to six characteristics: autonomy, environmental mastery, personal growth, positive relationships with others, purpose in life, and self-acceptance.

Waterman (2007a) highlights important distinctions between Ryff's conceptualization of psychological well-being and the construct of eudaimonic well-being. Although these two

perspectives towards well-being have considerable overlaps, such as focus on purpose in life and personal growth, other elements of psychological well-being, such as autonomy, environmental mastery, and positive relationships with others are not part of the eudaimonic construct or the reconceptualization of Aristotle's philosophy concerning realization of one's daimon or true nature (Diener & Suh, 1999; Ryan & Deci, 2001; Waterman, 1993). The eudaimonic approach conceptualizes well-being as occurring in the actualization of human potentials and the fulfillment, not happiness (Ryan & Deci; Waterman). It emphasizes meaning, purpose, and self-actualization or the extent to which individuals derive satisfaction from the belief that they have identified and are functioning at their highest potentials (Lent, 2004; Ryan & Deci, 2001; Waterman, 2007a; Waterman, 1993).

In addition to subjective and psychological aspects, social well-being has also been examined as a significant concept in the general understanding of positive mental health. Keyes (1998) defines social well-being as the evaluation of one's circumstance and functioning in society, which includes the dimensions of coherence, integration, acceptance, contribution, and actualization. Social coherence consists of an individual's ability to organize, make sense of, and understand their social world. Individuals high in this aspect are able to better handle the inevitable tragedies and disappointments of life. Social integration involves the extent to which one feels a commonality with others. It emphasizes collective membership and the degree to which one feels a sense of belonging in their community. Social acceptance stems from self-acceptance and involves an individual's ability to trust and be kind to others. Next, social contribution consists of the evaluation of one's social value and ability to contribute to society. Lastly, social actualization describes the belief in the evolution of society and the ability to hope that society is able to reach its potential. This approach to well-being may have particular

importance to culturally-diverse populations with a more non-western and collectivistic worldview.

Multicultural well-being. Universalist and uniqueness are two positions that have been articulated in the multicultural well-being literature. Dimensional and identity approaches to well-being stem from the universalist position (Diener & Tov, 2009; Kahneman et al., 1999). The dimensional approach views the cause of well-being as the same for while the identity approach acknowledges that the causes of well-being may differ for individuals but suggests that everyone is attempting to attain the same level of subjective well-being, that it is global, and that the goal is happiness (Diener & Tov, 2009). On the other hand, as researchers discover that the idea of "the good life" differs from person to person and from place to place, norms and values molded by cultural traditions offer different sources and perspectives of subjective well-being and how to measure it (Kitayama, Markus, & Matsumoto, 1995; Uchida, Norasakkunkit, & Kitayama, 2004). With a growing body of literature on well-being, universalist positions are being revealed as inadequate when framing multicultural well-being. In response, researchers are now attempting to expound on conceptualizations of well-being to incorporate multicultural values, beliefs, and practices. As a result, the uniqueness approach emphasizes that the construction of well-being in any culture and community depends on a historical, socio-economic and subjective understanding of well-being that varies from group to group (Diener & Tov, 2009).

Another important element in conceptualizing well-being is the process and outcome distinction. Peterson, Park, and Seligman (2005) distinguish activities and orientations that may lead to the experience of well-being (the processes) from the actual experience of well-being (the outcome), which may include changes in mental health such as increased vitality and happiness.

It is thought that the processes are behaviors that allow an individual to see his or his functioning capabilities that can lead them to find positive outcomes (Bhullar, Schutte, & Malouff, 2013).

Current Measurements of Well-being

Likely due to the lack of consensus on how to define well-being, as well as how to measure it, numerous well-being instruments have been developed (Diener & Seligman, 2004; Lent, 1994). As previously stated, ways to measure well-being can include self-reports, societal-level well-being indicators, biological measures, and objective measures of behavior (Binder, 2013; Zou, Schimmack, & Gere, 2013). Currently, well-being inventories are divided into theory-driven construct areas (e.g., subjective well-being and psychological well-being) and specific life domain areas (e.g., relational well-being, religious/spiritual well-being, physical well-being, mental health well-being, etc.). Many of these inventories are self-reports. The two most common methods to measure subjective well-being are the Satisfaction with Life Scale (SWLS; Diener, Emmons, Larsen, & Griffin, 1985) and the Positive and Negative Affect Schedule (PANAS; Watson, Clark, & Tellegen, 1988). The most frequently used scale to assess psychological well-being is Ryff's (1989) Scales of Psychological Well-being. Positive affect, negative affect, and life satisfaction are the three factors that have received the most empirical support as means of operationalizing the concept of well-being (Arthaud-Day, Rode, Mooney, & Near, 2005). There are also numerous scales of specific aspects of well-being that may be relevant for African Americans, such as spirituality, sense of community, and social identity.

Conceptualization and Dimensions of Culture

Constructs that inform how well-being is defined, developed, and expressed emerge from culture in relationship to socialization processes, emotional norms, and cognitive biases (Diener & Lucas, 2000; Diener, Lucas, & Oishi, 2002; Eid & Diener, 2001; Lu, 2006; Suh, 2000, 2002).

Therefore, the impact of culture on well-being is indisputable, as well as highly significant in its role in the psychological outcomes of different groups (Kitayama & Markus 1995; Ryff & Singer, 1998a; Triandis 1996; Utsey, Adams, & Bolden, 2000).

Many definitions of culture exist; however, in general there is agreement that culture can be understood on an individual level, a demographical level (measured by demographic factors such as ethnicity or race), and a cultural level (measured by geographical proximity) (Matsumoto, 2002; Nobles, 1978; Triandis, 1994). Harrell (2015) suggests that culture is "dynamic while simultaneously being *embedded* in social and institutional contexts, *internalized* as patterns of meaning and identity, *expressed* through actions and relationships, and *interactive* with coexisting cultural systems that reflect the multiple dimensions of human diversity that carry culture" (p. 19). Harrell (2015) further indicates that culture is "carried in networks of knowledge, meanings, symbolic representations, values, and beliefs; and manifested through language, communication styles, emotional expression, interpersonal behaviors, social roles, health and healing practices, institutional structures, organizational policies and practices, ideologies, aesthetics, customs and normative behaviors, rituals, symbols, and physical artifacts" (p. 19). Harrell's approach conceptualizes culture as providing "the foundational frames for developing worldview, interpreting reality, and acting in the world for a group of people who share common ancestry, social location, group identity, or defining experiential context" (p. 19). Understanding culture in this comprehensive manner provides the foundation and rationale for looking more closely at the cultural aspects of well-being.

With respect to dimensions of culture, literature over the past several decades has suggested that that nationality and ethnocultural groups can be placed on an orientation continuum of from individualist (independence) to collectivist (interdependence; Kitayama &

Markus, 1995; Wilson, Moore, Boyd, Easley, & Russell 2008). More recently, researchers have proposed that these individualist-collectivist cultural orientations are not mutually exclusive but are multidimensional, which implies that individuals from all societies may endorse both individualistic and collectivistic tendencies although they may vary only in the degree to which they endorse or express specific cultural values (Komarraju & Cokley, 2008; Oyserman & Lee, 2008; Vargas & Kemmelmeier, 2013). These tendencies influence the expression of well-being.

Societies that value individualism place central emphasis on the person and tend to be more self-oriented when exploring well-being (Kitayama & Markus, 1995). The key factors of positive psychological functioning in individualistic societies are portrayed through independence, autonomy, and personal goals prioritized over in-group goals (Compton, 2003; Triandis, 1995). On the other hand, collectivistic cultures ascribe coping values or well-being based on the welfare of the group, harmonious relationships with other, and interdependent self-construal (Diener & Lucas, 2000; Uchida et al., 2004). The communalism emphasis within the broader collectivistic orientation is reflected in African cultural contexts and values spiritual interconnectedness, community interactions, and extended family connections as factors related to positive psychological outcomes (Cooper & Denner, 1998; Kambon 1998; Nobles, 1998). Cultural norms and the centrality of the group have more importance than individual attitudes in determining behavior for collectivistic societies. However, in recent literature, a hybrid model suggests that the sources of well-being come from both the self and the group's welfare (Cheng et al., 2011).

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may vary only in the degree to which they endorse or express specific cultural values (Komarraju & Cokley, 2008; Oyserman & Lee, 2008; Vargas & Kemmelmeier , 2013; Trumbull, Rothstein-Fisch, Greenfield, & Quiroz, 2001). With respect to dimensions of culture, literature over the past several decades has suggested that that nationality and ethnocultural groups can be placed on an orientation continuum of from individualist (independence) to collectivist (interdependence; Kitayama & Markus, 1995; Wilson et al., 2008). This hybrid model contrasts with the previous independence model (individualistic), which proposes that what constitutes the fundamental source of well-being is the self or independent self-construal, and the interdependent model (collectivistic), which postulates that the fundamental source of well-being is the welfare of the group (Diener & Lucas, 2000; Uchida et al., 2004). This hybrid model reflects a marriage of the individualistic and collectivistic conceptualizations of well-being, in which individuals are exposed to two sets of competing values. One set of values is related to the self, which emphasizes self-expression, achievement, and fulfillment of one's goals. Fulfillment of these self-oriented needs requires individuals to turn away from people, be one's own self, and break inherited rules. The other set of values is related to external standards, which emphasize responsibility and accountability. Fulfillment of these social-oriented needs require individuals to turn toward people, seek others' approval, and adhere to social norms (Diener & Lucas, 2000; Uchida et al., 2004).

Culture and Well-being

The relationship between culture and well-being is intricate because definitions of well-being are inherently culturally rooted judgments. Thus, definitions of happiness or well-being will always be formulated from a particular vantage point (Bauer, McAdams, & Pals, 2008; Christopher, 1999; Kitayama & Marcus, 2000; Tov & Diener, 2009). Since well-being is

dependent on values and cultures as well as individuals to convey the importance of those values, generalizing what will make all people happy and comparing well-being conceptualizations cross-culturally is difficult (Bech, 2012; Cheng et al., 2011; Tov & Diener, 2009). Current research on well-being across varying nationality groups has, however, revealed important considerations regarding the conceptualization of well-being (Diener & Diener, 1995; Diener & Suh, 1997; Diener & Suh, 1999; Diener, Suh, Lucas, & Smith, 1999; Suh et al., 1998). Some highlight the contribution of factors such as genetics, socioeconomic status, or personality, while others suggest that that the perception of well-being is best determined by the individualism-collectivism continuum that defines differences in operation and meaning between individualistic and collectivistic societies (Diener & Suh, 1999).

Cross-cultural and national literature has found that overall, individualistic nations report higher levels of subjective well-being (Diener & Diener, 1995; Diener & Suh, 1999). Oishi (2000) has found that the influence of personality on the affective or emotional component of subjective well-being appears to cut across many cultures. It has been suggested that understanding well-being as the individual's perceived balance between pleasant and unpleasant affect, the hedonic balance, is pancultural (Schimmack, Radhakrishnan, Oishi, Dzokoto, & Ahadi, 2002). In the cognitive component, culture has been suggested to moderate the influence of personality on an individual's subjective evaluation of his or her own life, or life satisfaction. At the individual level, the use of emotions to provide feedback about the fit between one's goals and one's reality has been found to predict judgment of life satisfaction far better than social approval of life satisfaction (norms) in individualistic cultures (Schimmack et al., 2002; Suh et al., 1998). In general, individual variables (e.g., self-esteem) are a stronger predictor of life satisfaction in individualistic cultures (Diener & Suh, 1999; Oishi, Diener, Lucas, & Suh, 1999).

For example, research on nations identifying strongly with an individualistic worldview have found to positive correlations between autonomy with well-being, while positive social relationships were found to be significantly correlated with well-being in both individualistic and collectivistic cultures (Oishi, 2000). Conceptualizations of well-being in the literature have traditionally reflected an individualistic worldview by measuring the good life in terms of one's level of happiness or positive emotional state. However, some contend that this premise of well-being may be less relevant to collectivist societies (Bauer et al., 2008**;** Christopher, 1999).

Psychological research on well-being from the collectivistic worldview has been notably absent in early writings on well-being. Existing conceptualizations of well-being in collectivist societies view well-being in the context of group welfare or interdependent self-construal and place more emphasis on social obligations and social membership than one's affective state. Asserting one's individualistic value contradicts with the collectivistic cultural value of interconnectedness between the self and significant others (Compton, 2001; Lent, 2004; Markus & Kitayama, 1991). A number of studies have found that family well-being, cultural-connectedness, and emotions stemming from evaluations of social approval were stronger predictors of life satisfaction than were individual variables (e.g., self-esteem; Diener & Suh 1999; Oishi et al., 1999; Lent, 2004). Accordingly, individuals in collectivistic societies rely more on social appraisals to judge life satisfaction and have higher subjective well-being when they displayed emotions or behaved according to the expected norms of their society (Diener & Suh 1999; Diener, Suh, & Oishi, 1997; Oishi et al., 1999; Suh et al., 1998). Other research has found that satisfaction with freedom is less predictive of SWB and self-esteem is less correlated with life satisfaction in collectivist than in individualist societies (Diener & Diener, 1995; Diener & Suh, 1999; Suh, 2000). It should also be noted that the focus of the research on collectivistic

cultures has chiefly been limited to East Asian groups. Other collectivistic cultures have received less attention in the literature on well-being that explores the complex, culturally shaped ways in which people experience wellness (Bauer et al., 2008**)**. It is also noteworthy that many cross-cultural studies of well-being utilize the hedonic framework and measure subjective well-being. The eudaimonic or psychological well-being approach has been less frequently studied outside of the United States and Europe. There is cross-cultural literature using dimensional measures of well-being such as the World Health Organization's Well-being Index-Five (WHO-5) and the International Well-being Index-Personal Well-being Index (PWI), which have been evaluated for validity and reliability in multiple languages and countries and used for international subjective well-being comparisons to assess multiple dimensions of well-being (Awata et al., 2007). Additionally, little of the well-being literature and research studies examine various demographic groups residing within the United States, including that of African Americans.

African American Culture and Context

In order to adequately understand the construct of well-being for the African American population of the United States, it is vitally important to first understand the history and the modern-day impact of that history. Psychological resilience and optimal functioning among African Americans are impacted by the long-term effects of the history of slavery and racism in the United States (Barden, 2013). Processes rooted in culture inform the ways in which individuals seek to improve or increase well-being.

History of African Americans. The first English colonies to have Africans imported to be slaves brought them to Virginia in 1619. Colonization of the Americas led to the birth of the Triangular Slave Trade and by the 18th century, chattel slavery had become widespread and completely racialized. Laws that made it acceptable to treat persons of African descent as

nothing more than property were in full effect (Rawley & Behrendt, 2005). Many processes were created to establish distance between slaves and their culture of origin. One was being forbidden to speak native languages. Another was assigning more favorable working condition based on skin tone or genetic proximity to the slave masters (Frazier, 2012). There were concerted efforts made to break the spirits of the slaves by erasing history, and stripping them of their culture or anything that could possibly result in unification. (Frazier, 2012).

Despite these attempts to separate African slaves from their culture, there is evidence to suggest that the African American experience in the United States represents a continuation of African history and culture. There continues to be an intergenerational legacy of family relationships, interdependence, and group solidarity. There is retention of a psychic orientation towards self in connection (Ivey, D'Andrea, Ivey, & Simek, 2007; Nobles, 1978). The worldview of African Americans is grounded in, among other things, extended familial and fictive kinship bonds and a collective social orientation (Grills, 2002; Nobles, 2015).

Akbar (1985), Nobles (1978), and other African-centered psychologists note that individuals from African cultures tend to view themselves as being mutually interdependent with those in their social identity communities. The meaning and expression of collectivism within the Afrocultural context is conceptualized in the literature as communalistic. Communalism in African cultures has been discussed in the literature examining African American experiences such as learning performance (Dill & Boykin, 2000), mental health (Harris & Molock, 2000), and coping strategies (Scott, 2003).

There are also three additional cultural outlooks that may apply to worldview of African Americans. These outlooks include improvisation, transcendence, and transformation. Improvisation involves an alternative plan if the original plan does not work. Transcendence

consists of rising above a particular situation by turning attention away from it. Lastly, transformation is the idea that you can take a negative element or entity and transform it into something positive. It is to take an experience that has been very negative for you and transform it into something where you learned something, grow, and prosper (Parham, White, Ajamu, & White, 2000; Nobles, 1978).

African Americans and Well-being

There is a paucity of literature investigating the influence of racial or ethnic minority status on well-being. Most of the research on well-being among African Americans has focused on low socioeconomic (SES), inner-city populations, or the deleterious environments in which they reside (Franklin et al., 2006; Major, Spencer, Schmader, Wolfe, & Crocker, 1998). Furthermore, the majority of empirical research examining well-being issues related to African Americans has tended to focus on comparisons with the white middle-class mainstream on differences in demographic characteristics, socioeconomic status, or stress-related factors, resulting in the minority or lower socioeconomic (SES) population appearing deviant or pathological (Parham et al., 2000; Williams, Takeuchi, & Adair, 1992). The notion of subjective well-being does not exist without considering how social elements are interrelated and the complex ways they may contribute to an individual's well-being across all life domains (Harrell, 2000; Prilleltensky, 2008). Negative life-events and traumatic experiences, such as racism and oppression, appear to impact the level of one's well-being and life satisfaction (Lucas & Diener, 2004; Prilleltensky, 2003; Brown & Gary, 1988). Literature documents the damage and significant psychological distress that incidences of racism and oppression can create upon the well-being of individuals, particularly ethnic minorities (Bryant-Davis & Ocampo, 2005; French & Chavez, 2010; Harrell, 2000; Prilleltensky, 2003). Findings suggest that perceived racial

discrimination is significantly related to poorer mental health and well-being, including in depressive symptoms, lower self-esteem and lower levels of psychological functioning (Seaton, Caldwell, Sellers, & Jackson, 2010; Sellers & Shelton, 2003). Because prescribed privileges are not equally distributed or afforded, variations within culture would exist based on an individual's identification with a racial or ethnic group. This is certainly true for African Americans, who experience a minority status and a lesser social status or access to resources, opportunities, and privilege (Diener & Suh, 1999: Harrell, 2000; Ryff & Singer, 1998a).

African Americans have been the focus of the majority of the empirical research examining the negative effects of race-related or ethnicity-related stressors, much of which has examined the impact of racial discrimination on psychological well-being (Safi, 2010). Overall, for African Americans it has been found that the significance of racial identity to one's self-concept as well as one's own affective and evaluative judgments of one's racial-ethnic group act as a buffer against the effects of perceived discrimination on psychological distress (Hughes et al., 2006; Sellers, Copeland-Linder, Martin, & Lewis, 2006; Sellers & Shelton, 2003).

Racism and adverse socioeconomic circumstances in which an individual is embedded are influenced by the structural arrangements and have the potential for long-lasting psychological and emotional damage in the form of chronic strain (Fitzpatrick & LaGory, 2000; Miller & MacIntosh, 1999; Pearlin, 1989; Turner, Lloyd, & Wheaton, 1995). Despite the increased likelihood of African Americans to be exposed to risk factors such as poverty, community violence, and inadequate access to financial resources, many African Americans have displayed the ability to have positive well-being and thrive in the context of adversity (Cauce, Cruz, Corona, & Conger, 2011; Masten & Obradovic, 2006; U.S. Department of Health and Human Services, 1999). There is empirical evidence linking the cultural beliefs, behaviors,

and practices of African Americans to effective coping strategies that result in positive adaptive outcomes in situations of risk and adversity (Harvey & Hill, 2004; Taylor, Chatters, & Levin, 2004; Utsey et al., 2000). Research has found that African Americans preferred group-centered coping strategies (e.g., family, community, kinship networks) to deal with adversity and found that collective coping was related to positive self-esteem (Constantine, Donnelly, & Myers, 2002; Daly, Jennings, Beckett, & Leashore, 1995). Conceptually, collective coping is derived from an African-based cultural value system that places the group's interest above that of the individual. In this system, African Americans rely on group-centered activities (e.g., got a group of family or friends together) for coping with adversity (Boykin, Jagers, Ellison, & Albury, 1997). Overall, the literature suggests that variables such as kin networks, religiosity, and positive racial identity may be important sources of well-being for African Americans.

Kin networks. The ability to thrive, notwithstanding what may be viewed as a position of disadvantage, may partially dependent on African American's development of alternate strategies of social support (Jackson, & Adams, 1992; Schieman, 2005). A combination of cultural influences affects the social cohesion in the kin networks of African Americans, including "fictive kin," or social ties that are not based on bloodlines or marriage. Social cohesion and social embeddedness are experienced by African American residents of more segregated neighborhoods than those of more diverse communities. These residents are more likely to participate in neighborhood activities when living within more segregated communities. It is also of note that African American preferences in maintaining residential segregation play a major role the preservation of Black institutions (Krysan & Farley, 2002). Both participation of in neighborhood activities and Black institutions enhance well-being for African Americans (McGrath, Brennan, Dolan, & Barnett, 2009).

Religion-spirituality. It is not a new idea that spirituality, faith, or prayer may have a strong relationship to well-being. For many people, religion imbues a sense of meaning in one's life, reduces psycholgocial distress, and instills active coping mechanisms. Research has also indicated cultural context mediates the pattern in the relationship between religiosity and psychological well-being (Ciarrochi & Deneke, 2004; Lavric & Flere, 2008; McIntosh, Silver, & Wortman, 1993; Myers, 2008; Tarakeshwar et al., 2006). Religiosity appeared to be more salient among African American youth than among other racial or cultural groups (Benson, Leffert, Scales, & Blyth, 2012; Benson & Scales, 2009). It appears that religious practices, rituals, and beliefs may provide specific coping resources for African Americans because lifestyles promoted by religious involvement may minimize stressors. Findings revealed a significant interaction between religiosity, adherence to traditional African American culture, and psychological well-being. Also, a significant interaction has been found between religiosity and adherence to African American culture that is positively related to life satisfaction (Jang, Borenstein, Chiriboga, Phillips, & Mortimer, 2006).

Positive racial identity. Ethnic identification, defined as the degree that individuals identify themselves as a part of an ethnic group and that group's culture, has been shown to be more strongly affiliated with positive well-being than with compromised well-being (Smith & Silva, 2011). Positive ethnic identity can be a resilience factor that enhances well-being for cultural groups who are also ethnic minority group members. It is assumed that greater self-esteem, self-confidence, and purpose in life are linked to higher levels of commitment to one's ethnic identity as part of an achieved identity (Seaton, Scottham, & Sellers, 2006). Some scholars suggest the impossibility of separating a strong personal identity from collective or racial group identity in African Americans with a healthy sense of well-being and self because people of

African descent view the self as an extension of the collective and derive their sense of self through an identification with African and African American culture (Azibo, 1998; Townsend & Belgrave, 2000). The findings in one study indicated that the relationship between stressful events and internalizing behavior was moderated by ethnic identity whereas externalizing behavior was moderated by Afrocentric values, such that African American adolescents who experienced the least amount of stress were the ones who had positive attitudes about African Americans. (Jackson, 2006; Wakefield & Hudley, 2005). Some researchers have suggested that ethnic identity only serves as a protective factor when African Americans are in a setting in which they are at risk for threats to their group identity, which may be the case when they are the minority in numbers (Bowman, Prelow, & Weaver, 2007).

There is evidence that developing a strong, positive ethnic or racial identity is beneficial to well-being against the deleterious effects of prejudice and discrimination and that it plays an important role in healthy adjustment in terms of psychological functioning (Martinez & Dukes, 1997; Phinney, 1996; Wakefield & Hudley, 2005). Furthermore, Sellers and colleagues (2006) and Sellers and Shelton (2003) found that both centrality, or the significance of racial identity to one's self-concept, and public regard, or one's beliefs about the affective and evaluative judgments others make of one's racial-ethnic group, buffered the effects of perceived discrimination on the psychological distress of African Americans.

Well-being and Sociodemographic Variables

Although there are no conclusive findings on the relationship of sociodemographic variables to well-being (Lucas & Gohm, 2000), it has been suggested in the literature that well-being may be influenced by sociodemographic as well as psychological factors (McLeod & Kessler, 1990; Mcleod & Owens, 2004; Moody-Ayers, Lindquist, Sen, & Covinsky, 2007).

Therefore, it is also important to explore well-being in relationship to variables such as gender, education, socioeconomic status, and age.

Gender. There are many hypotheses and explanations relevant to gender differences in well-being (Diener, Suh, Lucas, & Smith, 1999; Lucas & Gohm, 2000; Nolen-Hoeksema & Rusting, 1999). One possible explanation is that gender roles mitigate psychological and biological factors and play a part in the reduction or promotion of well-being (Rusting & Nolen-Hoeksema, 1998). For example, studies about gender differences suggests that African American men may adopt a view of masculinity that makes them more likely to adopt health behaviors that put them at increased risk for chronic health conditions as compared with African American women (Courtenay, 2000; Gibbs, 1988; Wade, 2009). Cultural factors that moderate any gender differences in other conceptualizations of well-being need to be further explored.

Education. The literature has mixed findings regarding the relationship between education and well-being. Some studies have found that higher levels of well-being are associated with higher levels of education, and education has been found to be more significant as an influence on well-being when level of income fell below a critical threshold (Ryff & Singer, 1998b). However, other literature states that there is not a consistent correlation between well-being and education (Desjardins, 2008; Veenhoven, 2008).

Socioeconomic status. Above very low incomes, it is a common assertion that income and happiness are not linked and that once basic needs are met, people move to self-fulfillment (Cummins, 2006; Diener & Oishi, 2005; Diener, Sandvik, Seidlitz, & Diener, 1993; Pinquart & Sorensen, 2000). However, those who have more socioeconomic advantage are able to buffer against some of the life stressors that would put aspects of their well-being at risk (e.g., physical health) or assist them in recovering quicker when they do occur (Hayborn, 2008; Lucas, Clark,

Georgellis, & Diener, 2004; McLoed & Kessler, 1990). Lastly, when accounting for the emotional components of SWB, such as happiness, people with greater access to recreational activities, comfortable living situations, and high-quality food appear to benefit from the rewards of their wealth (Biswas-Diener, 2010; Diener, 1984).

Age. Literature on the impact of age differences on well-being provides conflicting evidence. Varied researchers argue that well-being increases with age, decreases with age, is stable across age, or that correlates of subjective well-being vary between young adults and those that are older, depending on the component or measure used to examine the relationship between age and well-being (Diener, & Suh, 1998; Lucas & Gohm, 2000).

Limitation of Current Measures and Rationale

Existing models and measures of well-being tend to have an individual western cultural bias that fails to integrate many dimensions that may be of importance to those from collectivistic cultures, such as communal, cultural, and spiritual processes (Pedrotti, 2011). Research that measures and compares well-being across groups has often had a limited conceptualization of well-being by failing to recognize the unique cultural dynamics and binding experiences of diverse groups and individuals (Christopher & Hickinbottom, 2008). Furthermore, cultural variability described by such studies typically involves the observation and comparison of national samples of predominantly white, affluent, university students (Greenfield, Keller, Fuligni, & Maynard, 2003). When attempts to gain cross-cultural validity have been made, they have done so internationally, rather than using within nation diversity. Furthermore, the cross-cultural well-being literature has not explicitly incorporated cultural variability and contextual influences with respect to item content or scale structure in the measurement tools. Fox and Prilleltensky (1997) noted that that the values of well-being should

be explored across all communities. At present, conceptualizations of well-being that account for cultural variety and dynamics are lacking, as are comprehensive and multiculturally validated measures of well-being. There continues to be a need to understand the well-being of a variety of nonmainstream populations.

The primary aim of this study was to examine multiple dimensions of well-being in a sample of African Americans as assessed by a new measure. The Multidimensional Well-Being Assessment (MWA) was created with a foremost purpose of being more inclusive of aspects of well-being that may be particularly relevant to racial and ethnic minority groups and those of lower socioeconomic status. Another rationale for the creation of the MWA is that other measures of well-being tend to be unidimensional. There is currently not a unified multidimensional measure of well-being that considers aspects that may be of relevance to diverse cultural groups. The MWA recognizes that well-being is a both psychological and subjective; therefore, it includes the more traditionally measured affective, cognitive, and behavioral aspects while incorporating related constructs such as spirituality, sense of community, transformational growth, and social identity. The multidimensional constructs in a single integrated instrument are another unique contribution of the MWA.

Research Questions

Two primary research questions and two descriptive questions were generated to guide the study.

Research Question 1: Does the MWA demonstrate internal consistency reliability in a sample of African American adults?

Hypothesis 1: There will be acceptable internal consistency reliability of at least .70 on all context areas and dimensional subscales of the MWA in the African American sample.

Research Question 2: Does the MWA demonstrate construct validity in a sample of African American adults?

Hypothesis 2a: The MWA contexts and subscales will show positive and statistically significant convergent validity coefficients with existing measures of well-being including the Satisfaction With Life Scale (SWLS)**;** the Scale of Positive and Negative Experience (SPANE) for positive feelings only; the Flourishing Scale; and the International Well-being Index-Personal Well-being Index-Adults (PWI-A).

Hypothesis 2b: The MWA contexts and subscales will show negative and statistically significant convergent validity coefficients with psychological distress as measured by the Broad Assessment of Distress and Dysfunction (BADD) and the Scale of Positive and Negative Experience (SPANE) for negative feelings only.

Hypothesis 2c: The MWA contexts and subscales will not be significantly related to social desirability, a measure of discriminant validity.

The following additional descriptive research questions were offered to gain further information about the nature of well-being in an African American sample:

Descriptive Question 1: What are the top five important dimensional indicators of well-being for African Americans overall?

Descriptive Question 2: What demographic differences are observed on the contexts and subscales of the MWA in an African American sample?

Descriptive Question 2a: What gender differences are observed on the contexts and subscales of the MWA in an African American sample?

Descriptive Question 2b. What educational differences are observed in the contexts and subscales of the MWA in an African American sample?

Descriptive Question 2c: What socioeconomic status differences are observed in the contexts and subscales of the MWA in an African American sample?

Descriptive Question 2d: What age differences are observed in the contexts and subscales of the MWA in an African American sample?

Methodology

The current research was designed to examine well-being in an African American adult sample. The study was conducted as a part of a larger ongoing psychometric study of the Multidimensional Well-Being Assessment (Harrell, 2013; Harrell et al., 2012).

Participants

Based on power tables by developed by Cohen (1992), using a power set at .80, and a medium effect size with a significance level of .05, it was determined that in order to conduct correlational statistics that the minimum sample size should be 85. The inclusion criteria for the sample included a minimum of 85 male and female adults over 18 years of age, who self-identify on the demographic section of the Background Questionnaire as "African-American," or "Biracial-Multicultural" (with "African American" listed) as their primary racial identification. The study also included biracial and multiracial individuals who described their racial identity as African American in a text response. There were no exclusion criteria.

Participant demographics. A total of the 169 persons who identified as African American or persons with African Ancestry participated in the study. Ninety-four participants completed only the MWA (55.6%). Seventy five people completed some portion of the validation scales (44.4%), with 46 of those individuals ($N = 46$) completing the entire study, including selected validation scales (27%). Participants who completed the MWA consisted of 135 females (79.9.5%) and 34 males (20.1%). Ages of participants ranged from 18 to 85 years with a mean age of 41.67. A majority of the participants endorsed a Christian affiliation, with 37.9% identifying as some type of Protestant Christian (Methodist, Baptist, Lutheran, etc.), 25.4% identifying as nondenominational Christian, and 9.5% identifying as Catholic. Another 22.5% identified as either spiritual with no specific religious belief system, some other spiritual

or belief system, agnostic, or atheist. The majority of participants had obtained a college or university degree or higher (22.5% college or university degree; 56.2% graduate or professional degree), while 11.8% had obtained a community college/vocational/trade school degree, and 9.5% had a high school degree, a high school equivalent, or less. Most participants listed an annual income of less than $25,000 (34.1%), 25% fell in the $25,000–$50,000 range, while 22.5% made $50,000–$100,000 and 16.5% had an annual income of over $100,000. Only 5.4% of participants noted that their basic needs were not being met, while 21% of participants noted that solely their basic needs were being met (with no extras). Forty percent had everything they needed plus a few extras, 20% were able to purchase many of the things they wanted, and 14% were able to buy luxury items or buy nearly anything they wanted.

Recruitment and Procedures

Participants were recruited in multiple ways. One strategy involved research staff identifying organizations with African American membership and gaining permission from the manager or head of the organization to make announcements and distribute flyers that directed participants to the online questionnaire. In some instances, pencil-and-paper administrations of the questionnaire occurred during meetings or gatherings. In addition, snowball methods (i.e., distribution of recruitment materials to networks known to the researcher) were used to recruit participants. In this case, potential participants were directed to the project website to complete the questionnaire. The online questionnaire could be completed from any device where an internet connection was available. All online participants had the option of entering a weekly prize drawing for a chance to win a $30 gift certificate valid for a wide variety of merchants. When the questionnaires were administered in-person, a prize drawing was conducted after questionnaires were completed and the winner received a gift card to a department store.

Measures

Multidimensional Well-Being Assessment (MWA). The MWA (Harrell, 2013; See Appendix A) was developed for the purpose of establishing a more inclusive, culturally informed, and comprehensive measure of well-being that takes into account the multiple contexts of living and different values between and within cultures. Its attempt at greater inclusivity primarily includes aspects of well-being that may be particularly relevant to racial-ethnic minority groups and individuals of lower socioeconomic status. Moreover, it is the first well-being measurement to incorporate important aspects of well-being previously given minimal attention by other comprehensive scales, namely transformational well-being, collective well-being and transcendent well-being within a comprehensive assessment of subjective and psychological well-being. These aspects of well-being emerge from the literature in multicultural psychology, feminist psychology, and humanistic psychology where themes of collectivism, spirituality, and overcoming adversity are prominent (Jackson, 2006). Conceptualizing well-being that is inclusive of these ideas and measuring the resulting multidimensional construct in a single instrument is the unique contribution of the MWA.

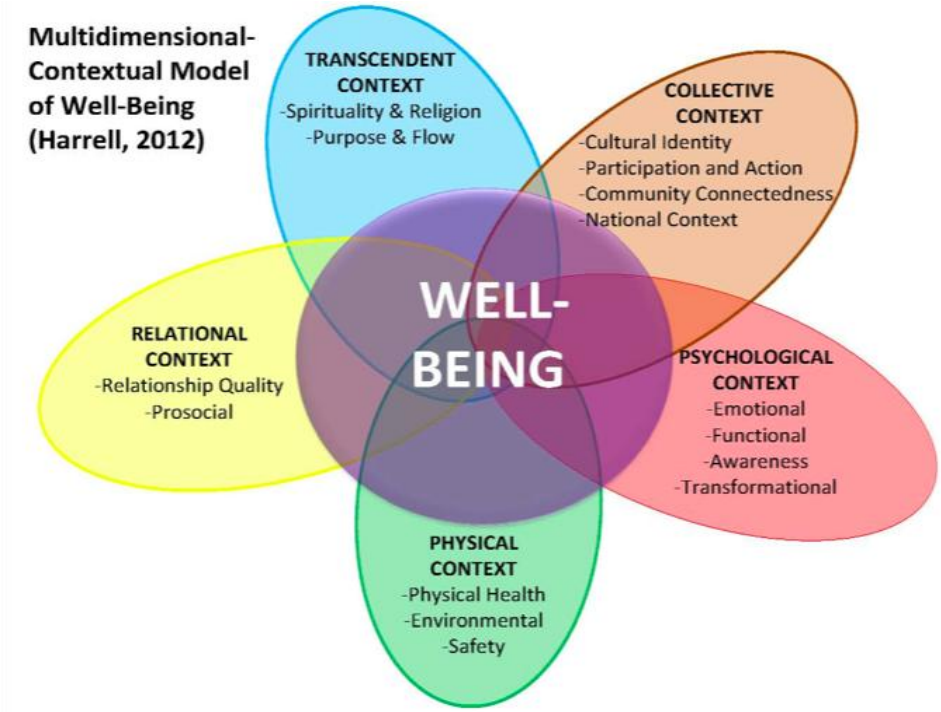

Figure 1. Visual representation of the five scales of the MWA. This figure illustrates the interconnectedness of contexts and the relationship of well-being to these contexts.

The next step in the development of the MWA is to establish the reliability and validity of the instruments through the collection of data from a large number of respondents. Therefore, the central goal of the larger study is to examine the psychometric properties of the Multidimensional Well-being Assessment. The specific objectives of the larger Well-being Project include the following: (a) to assess the structure of positive well-being as measured by the MWA; (b) to examine the internal consistency reliability of the MWA; (c) to examine the construct validity, both convergent and discriminant, of the MWA; and (d) to examine the criterion validity of the MWA.

Conceptualizing well-being inclusive of these ideas and measuring the resulting multidimensional construct in a single efficient instrument is the unique contribution of the MWA. It is a 160-item scale assessing five general wellness contexts, with 2 to 4 dimensions of well-being within each context for a total of 15 Well-being Dimensions. These include the

Psychological Wellness context comprised of four dimensions of well-being (Emotional, Functional, Transformational, and Awareness); the Physical Wellness context comprised of three dimensions of well-being (Health and Body, Environmental, and Safety); the Relational Wellness context comprised of two dimensions of well-being (Prosocial and Relationship Quality); the Collective Wellness context comprised of four dimensions of well-being (Community, Sociocultural Identity, Participatory, and National Context); and the Transcendent Wellness context comprised of two dimensions of well-being (Meaning-Purpose-Flow and Spiritual-Religious). Items are rated on a 5-point Likert-type scale; responses range from "Never/Not at all" to "Always/Extremely." The respondent is asked to rate each item based on how much the statement has been true for them over a specific time frame (e.g., past week, past two weeks, past month). Scores are calculated for each Wellness Context, as well as for each dimension of well-being by adding ratings and dividing by the number of items so that scores are comparable across domains and dimensions.

The first 94 participants, who participated in the psychometric study and filled out demographic questions for the MWA online, were used to examine preliminary data (Harrell et al., 2013). Of these initial participants, 63 also completed a set of validation instruments. The mean age for this initial sample was 36.68 years (SD = 13.08). The initial sample consisted of 72 women (76.6%) and 22 men (23.4%). Forty-four (44) self-identified racially as White, which comprised 46.8% of the sample, with 50 participants (53.2%) identifying as people of color. The majority of the participants (71.7%) were born in the United States of America, and most (80.9%) had obtained a college degree or higher. The initial finding of note and most relevant to the current study is that people of color had significantly lower subjective well-being (t (63) = 2.45, $p < .05$), lower total Physical Well-Being (t (92) = 2.12, $p < .05$), and higher negative

emotions than Whites (t (61) = -2.86, p < .01). For the total initial sample, the dimensions rated as the top five most important contributors to overall well-being were:

- "The quality of my relationships with the people closest to me," (rated by 71%);
- "Having positive emotions and feelings," (rated by 60%);
- "My physical health," (rated by 55%);
- "My daily activities and achievements," (rated by 51%);
- "Have a sense of meaning and purpose," (rated by 48%).

The Background Questionnaire. The Background Questionnaire (Harrell et al., 2012; See Appendix B) is a basic 15-item demographic questionnaire developed by the investigator to obtain descriptive information about the research participants. Thirteen questions request information regarding the participant's gender, age, race-ethnicity, country of birth and residence, postal zip code, education, employment, relationship status, parental status, and financial situation. Two additional questions ask if the past two weeks had been particularly impacted by an illness or stress.

The instruments used to measure convergent construct validity include the Personal Well-being Index (PWI; Lau, Cummins, & McPherson, 2005), Satisfaction with Life Scale (SWLS), and the Flourishing Scale (Diener et al., 2009). The principal researcher was given permission for use of each of these measures in the larger study. Three additional instruments are included: the Broad Assessment of Distress and Dysfunction (BADD; Harrell et al., 2013) and Scale for Positive and Negative Emotions (SPANE; Diener et al., 2009) to assess criterion validity, and the Crown-Marlowe Social Desirability Scale (Crowne & Marlowe, 1960) to assess divergent validity. The Crown-Marlowe is in the public domain and available for use without prior permission.

The Satisfaction With Life Scale (SWLS). The SWLS is a common measure used to assess global life satisfaction or judgmental aspects of subjective well-being (Diener et al., 1985). This scale does not include items pertaining to affective or emotional components of subjective well-being. It consists of the average of five related items, each of which is rated on a 7-point scale from Strongly Disagree (1) to Strongly Agree (7), allowing the individual to integrate and weigh the items at their discretion (Diener et al., 1985; Pavot & Diener, 1993; Pavot & Diener, 2008). With a relatively small number of items, the SWLS has been one of the most widely used measurements for assessment of subjective well-being and has been translated into over 25 different languages. The psychometric properties of the SWLS were established in diverse populations including non-psychiatric medical outpatients (Arrindell, Meeuwesen, & Huyse, 1991) and adolescents (Neto, 1993), as well as in different countries such as Brazil (Gouveia, Milfont, da Fonseca, & de Miranda Coelho, 2009), the Netherlands (Arindell, Heesink, & Fegi, 1999), China (Bai, Wu, Zheng, & Ren, 2011), and Turkey (Durak, Senol-Durak, & Gencoz, 2010).

Flourishing scale. The Flourishing Scale is a self-reported measure of psychological and social functioning, which has a theoretical basis in psychological and social well-being (Diener et al., 2010). It consists of eight items pertaining to positive relationships, feelings of competence, and a sense of purpose. High scores indicate psychological strengths and optimistic view of self and future. Internal consistency of the Flourishing scale was statistically substantial (Cronbach's alpha = .87), and the convergence with Satisfaction with Life Scale was .62 (Diener et al., 2010). In addition, the Flourishing scale has been demonstrated to correlate at significant levels with other well-being measures, such as Ryff scales of Psychological Well-being and Deci and Ryan's Basic Need Satisfaction in General Scale.

International Well-being Index-Personal Well-being Index-Adults (PWI-A). Also known as the Australian Unity Well-being Index within Australia, the PWI-A is a seven-item measure that purports to measure a subjective dimension of quality of life. Creators made items consistent with SWB research and indicators to be theory-driven and maintain high construct validity, yet the semi-broad nature of domain areas were chosen to increase cross-cultural validity. Participants rate items on a scale of 0 to 10, with 0 being completely dissatisfied and 10 being completely satisfied, in the following domains: standard of living, health, achieving in life, relationships, safety, community-connectedness, and future security. The PWI-A has been utilized by more than 150 researchers from 50 countries and provinces. Construct validity was verified using the criterion that each domain must contribute unique variance when the domains are collectively regressed against satisfaction with life as a whole (Lau et al., 2005).

The Scale of Positive and Negative Experience (SPANE). The SPANE is a 12-item questionnaire includes six items to assess positive feelings and six items to assess negative feelings. For both the positive and negative items, three of the items are general (e.g., positive, negative) and three per subscale are more specific (e.g., joyful, sad). In particular, the scale assesses with a few items a broad range of negative and positive experiences and feelings, not just those of a certain type, and is based on the frequency of feelings during the past month. The SPANE brief name is followed by a P, N, or B to indicate the scales for Positive Experience, Negative Experience, and the Balance between the two (Diener et al., 2009).

Broad Assessment of Distress and Dysfunction (BADD). Harrell et al. (2013) developed the revised BADD to measure level of general psychological distress and symptomatology not specific to a particular diagnostic category. It is a 36-item scale that integrates common language and expressions regarding psychological distress (e.g., “I felt like I

was going to have a nervous breakdown"; "I felt like I was going crazy, like I was losing my mind"; "I felt like a failure or a loser"). Items are rated on a 5-point Likert-type scale on how much the statement has been true for them over a specific time frame (e.g., past week, past two weeks, past month). Responses ranged from "Never true for me" to "Always true for me." The total score is calculated as a sum of ratings across the 36 items. In the preliminary analysis of data from the psychometric study (Harrell et al., 2013), the BADD demonstrated strong internal consistency reliability with an alpha reliability of .86, as well as good construct validity as evidenced in its pattern of correlations with measures of positive well-being and social desirability.

Crown-Marlowe Social Desirability Scale. Originally developed in 1960 by Crowe and Marlowe, the scale was designed to measure the tendency of individuals to project favorable images of themselves during social interactions. Crown-Marlowe contains 13 true-false items that describe socially desirable but improbable behaviors, as well as socially undesirable but probable behaviors. Findings suggested that individuals who score high on this measure tend to overreport socially desirable information while underreporting socially undesirable information about themselves.

Results

The SPSS version 22.0 was utilized to analyze the data in this study. Participant responses were coded and entered into the SPSS database. The data analysis process involved descriptive analyses, internal consistency reliability analysis, correlational analyses to examine validity, and a series of *t*-tests, correlations, and multivariate one-way analysis of variance (MANOVAs) to determine relationships and the significance of mean group differences between demographic groups on the five contexts and 15 dimensions of well-being within the sample of adults of African American descent.

The first step of analysis consisted of cleaning the data by assessing missing data, frequencies, means, modes, and measures of error for each item. Missing data was replaced with a mean substitution process for that item. This process led to any necessary corrections of data entry errors and the identification of any outlier scores. Next, a descriptive analysis of the demographic variables as well as the scores for the well-being contexts and dimensions were computed. The frequencies, range, means, and standard deviations were obtained for all demographic variables and scores on the MWA dimensions and items, BADD, PWI, SPANE, Flourishing, and SWLS.

In order to observe patterns of relationships and any potential implications for exploring the research questions, Pearson's *r* correlations were conducted among all the variables. Correlations were also performed between the MWA, BADD, PWI, SPANE, Flourishing, and SWLS to examine the validity of the MWA.

Internal Consistency Reliability Analysis of the MWA

Internal consistency reliability analyses were conducted and Cronbach's alphas were determined for each context and dimension of the MWA. Table 1 presents the results for the

MWA contexts and dimensions. All of the five MWA Contexts demonstrated strong reliability (ranging from .917- .963). The MWA Dimensions also demonstrated strong reliability (ranging from .798 to .924). These results provide support for Hypothesis 1 with all reliability coefficients being greater than .70.

Table 1

Reliability Coefficients and Mean Values for the MWA Contexts and Dimensions

Context and Dimension	# Of Items	Cronbach's Alpha	Mean (*SD*)
Physical (PWB)	31	.917	4.35 (.68)
Health	12	.859	4.24 (.85)
Environment	11	.817	4.46 (.79)
Safety	8	.840	4.86 (.82)
Psychological (YWB)	40	.963	4.18 (.80)
Emotional	12	.924	4.20 (.92)
Functional	10	.876	4.18 (.84)
Awareness	6	.798	4.35 (.86)
Transformative	12	.890	4.07 (.89)
Relational (RWB)	27	.919	4.40 (.80)
Relationship Quality	15	.858	4.30 (.86)
Prosocial	12	.895	4.24 (.74)
Collective (CWB)	35	.948	3.73 (.94)
Identity	12	.885	4.20 (.94)
Community	10	.866	3.85 (1.0)
Participatory	8	.868	3.52 (1.2)
National	5	.841	3.62 (1.3)
Transcendent (TWB)	27	.931	3.98 (.89)
Meaning	14	.901	4.11(.93)
Spirituality	13	.893	4.20 (1.1)

Interscale correlations of the MWA. Most contexts and dimensions on the MWA were significantly correlated with one another ($p < .05$), with the exception of the Physical-Safety Dimension and Collective-Participatory Dimension (see Table 2). The Physical-Safety dimension also did not significantly correlate with the Transcendent-Spirituality dimension.

Table 2

Intercorrelations of MWA Context Domains and Dimensions

	PWB-E	PWB-H	PWB-S	YWB	YWB-A	YWB-E	YWB-F	YWB-T	RWB	RWB-P	RWB-Q	CWB	CWB-I	CWB-C	CWB-P	CWB-N	TWB	TWB-M	TWB-S
PWB	.919**	.833**.	.778**	.748*	.695**	.721**	.694**	.632**	.640**	.534**	.624**	.600**	.608**	.580**	.382**	.462**	.524**	.591**	.384**
PWB-E		.651**	.671**	.683**	.638**	.639**	.653**	.580**	.603**	.522**	.571**	.564**	.612**	.494**	.353**	.448**	.473**	.515**	.359**
PWB-H			.402**	.782**	.677**	.767**	.680**	.707**	.640**	.549**	.614**	.652**	.615**	.646**	.486**	.465**	.596**	.667**	.438**
PWB-S				.370**	.408**	.374**	.371**	.242**	.360**	.250**	.393**	.240**	.271**	.282**	.047	.218**	.203**	.252**	.136
YWB					.862**	.946**	.917**	.906**	.835**	.784**	.743**	.824**	.741**	.765**	.712**	.595**	.757**	.881**	.524**
YWB-A						.802**	.749**	.703**	.742**	.672**	.681**	.755**	.701**	.695**	.596**	.599**	.629**	.773**	.402**
YWB-E							.839**	.776**	.766**	.656**	.735**	.735**	.654**	.728**	.597**	.531**	.686**	.820**	.465**
YWB-F								.755**	.754**	.705**	.672**	.738**	.660**	.686**	.636**	.555**	.614**	.748**	.399**
YWB-T									.779**	.809**	.626**	.784**	.705**	.683**	.746**	.523**	.791**	.852**	.594**
RWB										.896**	.925**	.817**	.791**	.711**	.682**	.583**	.734**	.820**	.535**
RWB-P											.659**	.799**	.773**	.631**	.745**	.549**	.747**	.802**	.566**
RWB-Q												.698**	.678**	.664**	.516**	.516**	.604**	.700**	.424**
CWB													.901**	.862**	.885**	.758**	.774**	.846**	.574**
CWB -I														.677**	.721**	.596**	.709**	.760**	.541**
CWB -C															.693**	.575**	.621**	.720**	.428**
CWB -P																.580**	.761**	.804**	.582**
CWB -N																	.533**	.587**	.385**
TWB																		.887**	.923**
TWB-M																			.644**

Note. *$p < .05$; **$p < .01$;

Scale Validity Analyses

Tables 3 and 4 present the validity coefficients for the MWA contexts and dimensions. Significant positive correlations were found between all the MWA contexts and dimensions and the PWI. In addition, except for Physical-Safety dimension, significant positive correlations were found between all the MWA contexts and dimensions and the SWLS, the SPANE (positive) and the Flourishing scales. This supports the hypothesis that the MWA positively correlates with the PWI, SWLS, the Flourishing scale, and the positive items of the SPANE.

Table 3

Validity Coefficients for the MWA Contexts and Dimensions With Alternate Measures of Well-Being

Context and Dimension	PWI	SPANEpos	SWLS	FLOURISHING
Physical	.530**	.455**	.441**	.275*
Environment	.502**	.389**	.469**	.290*
Health	.525**	.604**	.548**	.375**
Safety	.291*	.141	.067	.005
Psychological	.601**	.740**	.703**	.694**
Awareness	.481**	.637**	.524**	.568**
Emotional	.677**	.838**	.730**	.718**
Functional	.532**	.588**	.628**	.520**
Transformative	.431**	.534**	.571**	.619**
Relational	.530**	.592**	.582 **	.659**
Prosocial	.388**	.481**	.426**	.635**
Relationship Quality	.550**	.564**	.591**	.546**
Collective	.528**	.578**	.475**	.564**
Identity	.534**	.488**	.389**	.463**
Community	.542**	.592**	.449**	.506**
Participatory	.333**	.473**	.352**	.565**
National	.282*	.289*	.371**	.304*
Transcendent	.473*	.594**	.404**	.685**
Meaning	.544**	.661**	.480**	.791**
Spirituality	.342**	.448**	.285*	.509**

Note. *$p < .05$; **$p < .01$

Significant negative correlations were found between the following the MWA contexts and dimensions and the BADD: Physical Context, Physical- Environment, Physical Health, Physical Safety, Psychological Context, Psychological-Emotional, Psychological-Functional, Psychological Awareness, and the Relational Context. Significant negative correlations were also found between the following MWA contexts and dimensions and the SPANE (negative): Physical Context, Physical Environment, Physical Health, Psychological Context, Psychological-Emotional, Psychological-Functional, and Psychological Awareness. These results support the hypothesis that the MWA dimensions and subscales would negatively correlate with the BADD, and the negative items of the SPANE. The pattern of relationships between the MWA and known

measures is as would be expected, which supports its construct validity in an African American sample, with the exception being the mixed results for the Crown-Marlowe social desirability measure. While most of the MWA contexts and dimensions performed as expected in discriminant validity, they were not significantly correlated with social desirability and this sample of African Americans as a whole was low on social desirability. In particular, a significant negative correlation was found between the Crown-Marlowe and the following the MWA contexts and dimensions: Physical Context, Physical- Environment dimension, Physical Health, Physical Safety, Psychological-Functional, and Psychological Awareness. This seems to indicate that this sample in this study did not have much interest in social desirability, despite the fact that certain aspects of well-being appeared to be reported more negatively when social desirability was higher. With regard to social desirability, the correlations ranged from -.300 to .111 with the MWA contexts and dimensions. Additionally, the fact that the BADD did not correlate with the transformative and collective dimensions of the MWA suggests that those dimensions may be accessing constructs that may be relatively independent of the intensity of distressing symptoms.

Highest Rated Contexts and Dimensions on the MWA

When examining mean scores across MWA contexts, the results indicate (Table 5) this sample scored highest on the Relational Wellness Context (M = 4.40), followed by the Physical Wellness Context (M = 4.35), the Psychological Wellness Context (M = 4.18), the Transcendent Wellness Context (M = 3.98), and the Collective Wellness Context (M = 3.73). Asked to rate the five most important areas (indicators of the well-being dimensions; Table 6) for determining their well-being, the five highest rated choices included meaning and purpose (81.5%), having positive emotions and feelings (69.7%), improving themselves and their lives

Table 4

Validity Coefficients for the MWA Contexts and Dimensions for Measures of Distress and Social Desirability

Context and Dimension	BADD	SPANEneg	Crown-Marlowe
Physical	-.555**	-.423**	-.322**
Environment	-.406**	-.295**	-.234**
Health	-.513**	-.474**	-.300**
Safety	-.440**	-.260	-.255*
Psychological	-.412 **	-.493**	-.171
Awareness	-.456**	-.488**	-.233*
Emotional	-.528**	-.624**	-.195
Functional	-.416 **	-.424 **	-.285*
Transformative	-.117	-.230	.035
Relational	-.262*	-.280	-.054
Prosocial	-.044	-.037	.044
Relationship Quality	-.392**	-.419**	-.127
Collective	-.128	-.197	-.034
Identity	-.105	-.149	-.019
Community	.057	-.099	-.034
Participatory	-.022	-.034	-.013
National	-.056	-.047	.111
Transcendent	-.044	-.228	-.002
Meaning	-.171	-.320	-.047
Spirituality	.038	-.134	.025

Note. *$p < .05$; **$p < .01$

(66.4%), physical living environment (63.4%), and relationships with those closest to them (59.1%).

Demographic Differences on Well-Being

A series of MANOVAs were conducted to compare the effect of gender, age, annual income, financial situation, and level of education on the MWA contexts and dimensions to determine if there were any differences in these areas. A MANOVA was conducted for each of the five contexts with the corresponding dimensional scales as the dependent variables in each analysis. Pearson *r* correlations were computed to assess bivariate relationships between

Table 5

MWA Dimensions: Importance to Wellbeing and Frequency Rated in Top Five

	MWB Dimension	*N*	Frequency	% ranked in top 5	Mean (*SD*)
Having a sense of meaning and purpose.	Meaning and purpose	119	97	81.5	3.71(.62)
Having positive emotions and feelings.	Emotional	122	85	69.7	3.74(.57)
Improving myself and my life.	Transformative	113	75	66.4	3.57(.90)
My physical living environment.	Environmental	82	52	63.4	3.40(.81)
The quality of my relationships with the people closest to me.	Relationship quality	132	78	59.1	3.75(.60)
My physical health and functioning.	Body and Health	129	75	58.1	3.79(.45)
Being safe from harm or danger.	Safety	90	52	57.8	3.59(.84)
My spirituality or religious experience.	Spiritual-Religious	114	65	57.0	3.34(1.0)
Having a strong awareness of myself, my thoughts and feelings.	Awareness	98	46	46.9	3.76(.55)
Doing good things for other people.	Prosocial behavior	124	56	45.2	3.51(.61)
My daily activities and achievements.	Functional-behavioral	126	56	44.4	3.57(.64)
A strong identity and connection to my culture (or other group in society central to my identity, such as religion, sexual orientation, or ability/disability status, etc.).	Sociocultural identity	80	33	41.3	3.29(.85)
Participating in positive social/community change.	Participatory	74	27	36.5	3.13(.85)
How things are going in my home country.	National context	70	12	17.1	3.06(.92)
Having a strong sense of belonging and connection to my neighborhood, work, or school community.	Community connectedness	71	12	16.9	3.19(.78)

Table 6

Well-Being Dimensions Rated Highest in Importance

	Rated Highest in Importance
1	My physical health and functioning.
2	Having a strong awareness of myself, my thoughts and feelings.
3	The quality of my relationships with the people closest to me.
4	Having positive emotions and feelings.
5	Having a sense of meaning and purpose.

age and the MWA contexts and dimensions and validity scales. Nonparametic Spearman's rho

correlations were conducted to determine the correlation coefficients between levels of education, less than high school diploma, community college degree or vocational school, college-university degree (i.e., B.A., B.S., etc.), or graduate/professional degree (e.g., M.B.A., Ph.D., M.D., etc.), and the MWA contexts and dimensions. Spearman's rho correlations were also conducted to compare the effect of annual income in those who made less than $25,000, $25,000–$50,000, $50,000–$100,000, and over $100,000, on the MWA contexts and dimensions. To determine if there were differences on any of the MWA contexts and dimensions and gender, an independent sample *t* test was conducted.

Table 7

Correlations of the MWA With Age, Education, Financial Situation, and Income

	Age (Pearson Correlation)	Education (Spearman's rho)	Financial Situation (Spearman's rho)	Income (Spearman's rho)
Physical	-.012	-.044	-.032	.138
Environment	.003	.022	-.016	.138
Health	.004	-.150	-.012	.029
Safety	-.056	.058	-.033	.203**
Psychological	.035	-.112	.006	.009
Awareness	.065	-.077	-.013	-.026
Emotional	-.006	-.199**	.004	.025
Functional	.049	-.115	.042	.117
Transformative	.042	-.005	.012	-.064
Relational	.031	-.116	.069	-.081
Prosocial	.061	.010	.056	-.121
Relationship Quality	.005	-.222**	.083	-.048
Collective	.087	-.086	.033	-.102
Identity	.182*	-.034	.037	-.033
Community	.182*	-.171*	.031	-.076
Participatory	.173*	.071	.027	-.125
National	.143	-.188*	.037	-.146
Transcendent	.072	-.009	-.031	-.092
Meaning	.566	-.058	.005	-.119
Spirituality	.080	.031	-.058	-.055

Note. *$p < .05$; **$p < .01$

Correlational results indicate that age is significantly and positively correlated with three dimensions of Collective Well-Being (Identity, Community, and Participatory) suggesting that well-being in these areas increase as African American get older (Table 9). Significant negative correlations were found between educational level and multiple dimensions of well-being including Emotional, Relationship Quality, Community, and National indicating the people with lower education reported higher well-being in these areas (Table 10). There were no significant correlations between well-being and financial situation and only one significant correlation with income. African Americans with higher incomes reported greater Safety-related Well-Being.

Gender. In the *t*-test analysis, gender differences were found on the Transcendent and Collective Context Domains and the Transformational, Religious-Spiritual, and Community Well-Being Dimensions with women reporting higher well-being in each area (see Table 8). The MANOVA results indicated significant gender differences on Transcendent and Psychological well-being with females having higher well-being than males (see Table 10). In particular, females reported more well-being than males on the spiritual dimension of Transcendent well-being and on the transformative dimension of Psychological well-being (see Table 9). No significant differences were found between the two groups on the Physical, Collective, and Relational contexts.

Level of education. The MANOVA results indicated significant differences by education level on all contexts of well-being except for Transcendent, with those who had an education level of completing community college or vocational school having higher levels overall. In addition, this educational grouping reported more well-being than those in other educational

categories on the participatory dimension of Collective well-being and on the safety dimension of Physical well-being (see Table 11).

Table 8

Gender differences on MWA Context Domains and Dimensions

	Male Mean (*SD*)	Female Mean (*SD*)	*T* Equal-Not Equal
Physical	4.24 (.61)	4.37 (.69)	-.999/-1.08
Environment	4.30 (.71)	4.50 (.81)	-1.26/-1.36
Health	4.07 (.79)	4.29 (.86)	-1.34/-1.41
Safety	4.91 (.80)	4.85 (.83)	.399 (.409)
Psychological	4.04 (.72)	4.21 (.82)	-1.14/-1.24
Awareness	4.35 (.82)	4.35 (.87)	.001/.001
Emotional	4.08 (.085)	4.22 (.93)	-.788/-.821
Functional	4.15 (.65)	4.18 (.88)	-.191/-.227
Transformative	3.73 (.89)	4.15 (.87)	-2.50/-2.48
Relational	4.16 (.74)	4.41 (.76)	-1.69/-1.72
Prosocial	4.06 (.92)	4.37 (.84)	-1.85/-1.76
Relationship Quality	4.24 (.74)	4.44 (.82)	-1.30/-1.39
Collective	3.46 (.78)	3.81 (.96)	-1.94/-2.19
Identity	3.93 (.94)	4.26 (1.0)	-1.72/-1.80
Community	3.54 (.91)	3.93 (1.1)	-1.95/-2.14
Participatory	3.26 (1.1)	3.59 (1.3)	-1.39/-1.47
National	3.34 (1.4)	3.69 (1.3)	-1.42/-1.37
Transcendent	3.59 (.92)	4.07 (.87)	-2.84/-2.75
Meaning	3.97 (.93)	4.14 (.93)	-.960/-.962
Spirituality	3.54 (1.2)	4.36 (1.0)	-3.98/-3.67

Note. $*p < .05$; $**p < .01$

Table 9

MANOVA results for Gender

	Wilkes Lambda	*F*	*p*
TRANS	.88	.622	.000
TRANSs	—	15.956	.000
PSYCH	.914	3.369	.011
PSYCHt	—	5.582	.019

Table 10

Means and Standard Deviations for Significant Gender Differences

	Females Mean (*SD*)	Males Mean (*SD*)
Transcendent	4.07 (.87)	3.59 (.92)
Spiritual	4.36 (1.0)	3.54 (1.2)
Psychological	4.21 (.82)	4.04 (.72)
Tranformative	4.07 (.87)	3.73 (.89)

Table 11

MANOVA Results for Level of Education

	Wilkes Lambda	*F*	*p*
COLL	.838	3.330	.001
COLLp	—	2.774	.043
REL	.903	2.855	.010
PHY	.898	1.975	.041
PHYs	—	2.607	.054
PSYCH	.771	1.775	.013

Table 12

Means and Standard Deviations for Significant Education Differences

	≤ high school Mean (*SD*)	community college or vocational Mean (*SD*)	College Mean (*SD*)	graduate or professional school Mean (*SD*)
Collective	3.76 (1.0)	4.21 (.84)	3.56 (.95)	3.71 (.92)
Collective-Participatory	3.02 (1.5)	4.02 (1,1)	3.26 (1.2)	3.61 (1.2)
Relational	4.41 (.86)	4.67 (.81)	4.30 (.70)	4.30 (.74)
	≤ high school Mean (*SD*)	community college or vocational Mean (*SD*)	College Mean (*SD*)	graduate or professional school Mean (*SD*)
Physical	4.34 (.87)	4.42 (.59)	4.27 (.62)	4.35 (.69)
Physical-safety	4.91 (1.2)	4.60 (.64)	4.86 (.74)	4.90 (.83)
Psychological	4.17 (.90)	4.51 (.88)	4.15 (.73)	4.12 (.80)

Income and financial situation. There were no significant effects of annual income on the context or dimensional scales. However, significant well-being differences were found on ratings of financial situation for the Relational and Psychological contexts. Specifically, those

who rated themselves as not having all of their needs met had lower levels of well-being in the area of Relational well-being and those who are able to purchase everything they want and more reported higher Psychological well-being.

Table 13

MANOVA Results for Financial Situation

	Wilkes Lambda	*F*	*p*
REL	.866	1.960	.027
PSYCH	.771	1.775	.013

Table 14

Means and Standard Deviations for Financial Situation

	My basic needs like food and shelter are not always met.	My basic needs are met (food, shelter, clothing) but no extras.	I have everything I need and a few extras.	I am able to purchase many of the things I want.	Within limits, I am able to have luxury items like internationa l vacations, new cars, etc.	I can buy nearly anything I want, anytime I want.
Psychological	3.99 (.97)	3.93 (.73)	4.12 (.85)	4.35 (.69)	4.48 (.64)	4.74 (1.0)
Relational	4.00 (.90)	4.24 (.65)	4.29 (.79)	4.52 (.64)	4.66 (.67)	4.53 (1.2)

While 33% of the sample reported an income of under $25,000, only 5% stated that their financial situation was such that their basic needs were not met.

Age. The MANOVA results indicated significant age group in differences on the Collective Context and Psychological well-being with those persons ages 71 or older reporting higher well-being than those in other age ranges (see Table 13). In particular, a higher level of well-being was reported on the national dimension of Collective well-being (see Table 15).

Table 15

MANOVA Results for Age

	Wilkes Lambda	*F*	*p*
REL	.866	1.960	.027
COLL	.809	1.935	.012
COLLn	—	1.558	.032
PHYs	—	2.607	.054
PSYCH	.870	1.928	.030

Table 16

Means and Standard Deviations for Significant Age Differences

	18–20 yrs Mean (*SD*)	21–30 yrs Mean (*SD*)	31–40 yrs Mean (*SD*)	41–50 yrs Mean (*SD*)	51–60 yrs Mean (*SD*)	61–70 yrs Mean (*SD*)	71+ years Mean (*SD*)
Relational	4.30(.67)	4.37(.76)	4.41(.65)	4.15(.63)	4.28(.99)	4.37(.80)	4.69(.66)
Collective	3.57(.74)	3.62(.99)	3.65(.84)	3.66(.75)	3.74(1.1)	3.91(.94)	4.34(.90)
Collective-National	3.47(1.0)	3.56(1.3)	3.24(1.2)	3.97(1.2)	3.57(1.4)	3.54(1.3)	4.76(.93)
Physcial-Safety	5.30(.80)	4.75(.73)	5.04(1.0)	4.95(.78)	4.80(.82)	4.64(.83)	4.89(.84)
Psychological	4.13(.80)	4.18(.86)	4.20(.72)	3.96(.72)	4.26(.80)	4.05(.82)	4.60(.82)

Discussion

This study focused on examining the reliability and validity of the Multidimensional Well-being Assessment (MWA), a comprehensive and culturally-inclusive measure of well-being, in a sample of African American adults. Research on the measurement of well-being among African Americans has been lacking (Perry, Pullen, & Oser, 2012; Thomas Witherspoon, & Speight, 2008) and the MWA was developed in response to the need for a measure of well-being that assessed dimensions relevant to diverse racial-ethnic groups.

Reliability and Validity of the MWA

Reliability and validity analysis of the MWA in an African American sample revealed the scale as a reliable measure of well-being for this population overall, as Cronbach's alpha reliability coefficients ranged from .798 to .963 across all five MWA Wellness Contexts (Psychological, Physical, Relational, Collective, and Transcendent) and all dimensions of well-being within the contexts. With regards to validity, as hypothesized, most MWA contexts and dimensions were found to be significantly correlated in expected directions with the multiple validation scales utilized in the study. However, utilizing a measure of social desirability, discriminant validity was only partially found as some dimensions within the Physical and Psychological Contexts of well-being were negatively correlated with scores on the Crowne-Marlowe at a significant level, demonstrating that social desirability is associated with lower well-being for African Americans.

Rating and Importance of MWA Contexts

African Americans included in this study rated physical health and functioning, strong awareness of self, relationships with those closest to them, having positive emotions and feelings, and having meaning and purpose as the five highest rated contributors to their overall

well-being and life satisfaction. These finding are consistent with studies in which satisfaction concerning health and family emerged as significant predictors of general life satisfaction for African Americans (Adams, 1999).

When compared to preliminary results of the larger MWA psychometric study, African Americans in this sample scored similarly on the five highest rated dimensions of overall well-being (Harrell et al., 2013). One exception was found, however, as those who participated in the preliminary psychometric study (an ethnically diverse but predominantly White sample) did not rate a strong self-awareness as one of their top rated dimensions. Instead, daily activities and achievements were rated as most important. One possible explanation is that African Americans may rate awareness of one's thoughts and feelings over the importance of their activities or what they have achieved in life because there is more control over the former. Linking one's well-being to achievements may be less reliable when factors such as racial discrimination and daily microaggressions can potentially affect the nature of a person's activities in the world. It should be noted that some of the participants in the current study were also represented in the data analyzed in the preliminary analysis of the larger study database.

Demographic Variables Contributing to Well-Being in African Americans

Research has suggested that it is important to consider intragroup variability when examining psychological factors among African Americans in order to avoid overgeneralization and pay attention to intersectionality issues (Charles, Kramer, Torres, & Brunn-Bevel, 2015; Dressler, 1991; Williams, Mohammed, Leavell, & Collins, 2010). The results of the current study suggest that well-being does vary within African American based on demographic variables such as age, education, income, and gender.

There was a great deal of variability in age within the study sample; however, more than half fell between 20 and 40 years of age and almost 80% were 60 years old or younger. A majority of participants (73%) identified as some denomination of Christian. The African Americans in this sample were highly educated, with 90% having some college and 56% having a graduate or professional degree. Forty percent of the sample reported an income of $50,000 or above, and 95% of the participants have at least their basic needs met. Overall, the sample is middle income.

Age. Studies conducted on life span and overall well-being have shown that age accounts for very little of the variance in life satisfaction, and that age does not have a negative relationship with life satisfaction, but is moderated by health (Diener & Suh, 1998). This is supported in the current study in that significant age differences were found for only one dimension of well-being—the Collective National dimension. Specifically, participants 71 and older reported higher well-being in the dimension than those in other age groupings. There are several possible ways to understand this result. Men in this age group may have been more likely to have served in the military at a time of war (e.g., Korean, Vietnam). There are indications that attitudes towards veterans have changed for the better, thus potentially giving these individuals a sense of national pride for having fought for their country (Alliano & Lester, 1994). Older African Americans have lived through changes in history, from the civil rights movement to the election of a black president, such that they have seen a decrease in day-to-day racism and greater opportunities for African Americans. This may account for their increased sense of national pride over others who have not witnessed these changes. It has been suggested that elders are respected, obeyed, and considered a source of wisdom in the African American community, as surviving to old age is considered an accomplishment that reflects personal

strength, resourcefulness and faith (Myerhoff, 1984). Studies show that in communities in which elders are accorded great respect, life satisfaction is highest among those over 65 (Donovan & Halpern, 2002).

Level of education. The findings of the current study suggest that those who completed junior college or vocational training reported higher Collective-Participatory well-being, with a trend toward greater Physical-Safety well-being. In contrast to international studies reporting that less education is correlated to higher rates of spirituality and faith (WHOQOL SRPB Group, 2006), this finding was not apparent in the current sample of African Americans as no significant differences were found on religious-spiritual well-being by education. This may mean that level of education does not make a difference in religious-spiritual well-being in the lives of African Americans.

Junior college-vocational school graduates reported greater participatory well-being than those in other educational groups. As most community colleges and vocational schools are commuter schools and more likely to reflect the communities in which they are located participants who attended these types of institutions may have lived and attended school in a more segregated environment than if they had attended a four-year university or college (Cox, 2016). For African Americans, neighborhood and community participation in is higher in segregated communities than when they reside in more diverse communities (Haxton, & Harknett, 2009; Mitchell & LaGory, 2002). Those who attended two-year or vocational schools may have remained in their neighborhood of origin, thus giving them a sense of familiarity and safety. It is also interesting to consider that early proponents of the junior colleges created a movement to democratize higher education and the students who attended these institutions (Brint & Karabel 1989; Gleazer 1994). It may be possible that junior colleges foster more

engagement and civic participation in their students so that they are more likely to derive a sense of well-being from participatory activities (Franco, 2002).

As previously stated, the African Americans in this sample are highly educated, which may not be a reflective of the nationwide African American population. As African Americans obtain higher levels of education, their context changes and they are more likely to be isolated and experience higher levels of social distance in their social relations with other African Americans, as well as non-African Americans. The level of isolation some African Americans experience may affect their levels of well-being in some dimensions, in particular, relational well-being.

Income and socioeconomic status. The results of this study indicate that individuals who reported their financial situation as not having all their needs met have lower levels of wellness with regard to relational well-being than those who assess their financial situation in other ways. In low income families, kin support is negatively associated with internalizing problems such as depression and is thought to enhance well-being (Thompson & Peebles-Wilkins, 1992). However, because these results do not demonstrate causation, the barriers to individuals in accessing this resource are unknown. Overall, socioeconomic status and levels of wealth have increased for African Americans (Stevenson, & Wolfers, 2013). Existing research suggests that SES contributes to well-being by improving quality of life, ability to engage in leisure activity, and protection from adverse consequences of life stressors (George, 1992; George, 1996; Pearlin, Menaghan, Lieberman, & Mullan, 1981; Wong & Watt, 1991). However, national studies have also found that once basic needs are met, income does not strongly predict subjective well-being (Diener et al., 1999). This is consistent with the current study that found no differences in well-being according to income.

Gender. The data suggests that gender may relate to different experiences with well-being. Significant gender differences were found on the spiritual and transformative dimensions of well-being with females scoring higher on these scales. This finding is similar to other studies that have found that females usually report higher subjective well-being (Diener et al., 1999).

Research also suggests that women continue to be involved spiritually throughout their lives, which may result in better mental health and more satisfaction with their lives (Reed, & Neville, 2014). There has been some suggestion in the literature that African American males are less likely to have religious affiliation and attend religious services less frequently (or not at all) than African American females. Thus, they may not benefit from the social, psychological, and coping resources that religiousity-spirituality provides, nor rate this area as an important source of well-being (Brown & Gary, 1994).

Although negative stereotypes, concealed and overt discrimination and prejudice affect African Americans in general, it is particularly impactful on African American males with regard to incarceration rates, and educational and employment opportunities. African American males are some of the most stigmatized individuals in the United States (Blake & Darling, 2000; Courtney, 2000). It follows that the well-being of African American males would be lower than that of African American females. Further research is needed to better understand these gender differences.

African Americans and Well-being in This Study

The MWA was created in part to respond to the needs of populations that might have alternative or additional values to the Western worldview and sources of well-being. The sample in this study had high well-being with respect to their cultural identity, and over 40% of the sample rated the Identity dimension in their top five. These findings of this study support the

assertion that African Americans have retained remnants of their traditional African communal orientation (Levin, Chatters, & Taylor, 1995; Musick, 1996). However, the individuals in this sample did not rate cultural identity as important to determining their overall well-being as other dimensions. For the total sample, Collective Well-being was rated as the content of least importance and no dimensions of Collective Well-being were highest rated or ranked in the top five. In fact, dimensions of Collective Well-being were lowest ranked in importance and the least rated in percentages of participants the top five areas of importance. This, however, may not negate the fact that, although not viewed as important, African Americans with a positive racial identity have higher well-being and happiness (Yap, Settles, & Pratt-Hyatt, 2011).

However, at least for the female gender, the results are consistent with the literature that states spirituality buffers the impact of negative events and conditions of distress among African Americans and contribute positively to well-being (Brown & Gary, 1994; Ellison, 1992; Ellison & Gay, 1990). The results also support that kin networks are important to individuals in the African American community (Schieman, 2005), as the Relational Well-being Context was the highest rated and the item "The quality of my relationships with the people closest to me" (Harrell, 2013, p. 2) was rated and ranked in the top five of importance.

Methodological Limitations

Several limitations revolve around the design and method included in this study. First, the results are discussed with caution, as the nature of the design used in this study limits the generalizability of the results. The present study was limited by potential threats to internal and external validity. Threats to internal validity were possible as a result of participant characteristics and data collection procedures.

Participants comprised a voluntary, non-random, convenience, and non-clinical sample

from individuals and organizations. Only those who volunteered to participate in this study were included in the sample, such that participant subjects may have been curious, willing to cooperative to the research, and/or enticed by the possibility of winning a prize in the prize drawing. An additional limitation of the study is volunteer sample bias, as those who are members of organizations centered around African Americans may be more connected to their culture than those who are not. Most participants included in this study resided in Southern California, which may also limit the generalizability. The overall sample was highly educated and may not be representative of the general African American population as a whole. Furthermore, the sample was gender-biased and overrepresented by females. Future studies should seek to include a more representative sample of the African American population in aspects of randomness, gender, geographic location, and clinical status. It is possible that a wider representation of African Americans may have different ways of understanding and experiencing well-being. Last, it must be noted that the construct of well-being in this measure continues to be slanted towards a western understanding of well-being.

Data collection procedures might also have posed some threat to internal validity. The set of questionnaires administered were based on self-report, with many taken on-line, thereby making it a possibility that questionnaire responses were not solely answered by the individual participant. Moreover, because this study was correlational in nature, causality cannot be assumed as relationships may be confounded by other factors.

Potential Contributions of the Present Study

Despite its limitations, this study was able to provide preliminary psychometric data on the Multidimensional Well-being Assessment and potentially contribute to a greater understanding of the mental health of African Americans and differences that may exist between

the many subpopulations that make up American society. This study has implications for mental health professionals who work with culturally or ethnically diverse populations have a clearer understanding of the principles that govern well-being and how these principles differ between groups. It is essential that clinicians as well as researchers know whether subjective well-being exhibits conceptual equivalence across racial groups, and, in particular, what is meant when African Americans report on their life quality. A central issue of the present research was whether subjective well-being is functioning the same for African Americans as it is for others, namely White Americans, for whom most of the existing models have been developed. The aim of this study was to enhance the understanding of well-being in the African American population, and to maximize the cultural relevance of care and the cultural competence of mental health professionals.

Research has not generated a coherent and comprehensive understanding of well-being for African Americans (Jackson, Chatters, & Neighbors, 1982). An additional goal of this study was to contribute to the psychological literature by examining the validity and reliability of a multicultural well-being assessment measure, and to expand the current conceptualizations of well-being and mental health for those of African American descent. These findings suggest that differences do exist between groups. It appears that, at least from a western frame or worldview of well-being, the MWA shows promising results with regards to reliability and validity in the deepening of our understanding of what brings a diversity of individuals' satisfaction and wellness.

The results of this study may have implications for examining intersectionality defined as "the interconnected nature of social categorizations" (Crenshaw, 1989, p. 140) among African Americans. Although the sample size in this study was not large enough to do so, the concept of

intersectionality among African Americans warrants further study. Implications for future research on well-being include investigating how ethnicity, gender, class, and sexual identity, as well as other variables, intersect to have an influence on well-being. An intersectional approach would extend beyond a conventional, categorically framed identification of a population to one that examines the complex identities of African Americans in the context of the way they experience well-being and provide an understanding of how various factors of their identity operate together to enhance or diminish well-being.

Clinical practitioners can go beyond conventional analysis and categorical thinking to examine individuals in the context of their historical, sociocultural and political contexts. Additionally, they can employ clinical practices that encourage cultural responsiveness, cultural awareness, and mutual empathy through clinical treatment plans that encourage strength, empowerment, and resiliency. Clinical practitioners can use an intersectional approach to identify the complexities of the African American experience when coping with such constructs as historical hostility, institutional racism, and microaggressions, in addition to highlighting their innate strengths and resiliencies. The clinical implications for work with African Americans, as well as other ethnic communities, include an understanding of how strong psychological well-being can be a buffer in coping with stress. Interventions in clinical practice could be grounded in an understanding of how the intersections of social identities of African American work together to influence mental health.

Future Directions for Research

The current study provides some insight into the expression and experience of well-being in the context of a racial-ethnic minority status. The inclusion of a racial identity scale, or better yet, a multidimensional social identity measure, could assess how individuals in interpret their

own personal identity, and the impact of multiple social identities on their well-being.

This study chose to examine the four demographic variables of age, education, income, and gender. However, differences in well-being on religious differences, parental status, marital status, as well as other demographic variables, could also be studied.

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APPENDIX A

Downloadable Version of Questionnaire

APPENDIX A

Downloadable Version of Questionnaire

<u>YOUR WELL-BEING</u>. This section includes 160 statements related to the experience of positive well-being. We understand that well-being means different things to different people so please answer as openly and honestly as possible about your own experience. There is no "correct" way to have well-being! Using the scale below, please select the response that indicates how much each statement has been true for you <u>DURING THE PAST TWO WEEKS</u>, including today.

0 = NEVER/NOT AT ALL= Never true for me during the past 2 weeks, not even once

1 = RARELY/A LITTLE= True for me only a few times during the past 2 weeks

2=SOMETIMES/SOMEWHAT= True for me about half the time

3 = PRETTY OFTEN/MOSTLY= True for me most days during the past 2 weeks

4 = VERY FREQUENTLY/VERY STRONGLY= True for me usually everyday

5 = ALWAYS/EXTREMELY= True for me nearly all day everyday (USE THIS SPARINGLY!)

N/A=DOES NOT APPLY TO ME= This statement doesn't relate to my life at all

NOTE: While we do provide a "Does not Apply" option, we ask that you ONLY use it for things that truly don't make sense for you. However, if it is something that just hasn't been true for you over the past two weeks, then the "Never" option would be more appropriate. *(Example: "I fed my bear chocolate cake". You would answer "DOES NOT APPLY" only if you DON'T actually <u>have</u> a bear. If you DO have a bear but would never feed her chocolate cake, then you would answer "NEVER/NOT AT ALL"-- even if feeding your bear chocolate cake is something that doesn't fit you at all).*

0 = NEVER/NOT AT ALL= Not true for me during the past 2 weeks, not even one time
1 = RARELY/A LITTLE= True for me only a few times during the past 2 weeks
2=SOMETIMES/SOMEWHAT= True for me about half the time
3 = PRETTY OFTEN/MOSTLY= True for me most days during the past 2 weeks
4 = VERY FREQUENTLY/ALMOST ALWAYS= True for me usually everyday
5 = ALWAYS/EXTREMELY= True for me nearly all day everyday (USE THIS SPARINGLY!)
N/A=DOES NOT APPLY TO ME= This statement doesn't relate to my life at all

	Never	Rarely	Sometimes	Mostly	Very Frequently	Always	N/A
1. I was satisfied with how things were going in my life.	0	1	2	3	4	5	N/A
2. I felt strong and empowered.	0	1	2	3	4	5	N/A
3. I handled my daily challenges well, coped effectively with everydaystress/problems.	0	1	2	3	4	5	N/A
4. I felt like my life had meaning, like I'm here for a purpose.	0	1	2	3	4	5	N/A

	Very Never	Rarely	Sometimes	Mostly	Frequently	Always	N/A
5. I was creative or had good ideas.	0	1	2	3	4	5	N/A
6. I did something to help make the world a better place.	0	1	2	3	4	5	N/A
7. I felt caring and loving feelings towards the people closest to me.	0	1	2	3	4	5	N/A
8. I was able to relax or calm myself when I needed to.	0	1	2	3	4	5	N/A
9. There was someone I could trust with my most personal/private thoughts and feelings	0	1	2	3	4	5	N/A
10. I was able to use or display my knowledge, skills, and/or talents.	0	1	2	3	4	5	N/A
11. I made good decisions.	0	1	2	3	4	5	N/A
12. I felt safe getting to and from the places I needed to go.	0	1	2	3	4	5	N/A
13. I felt physically healthy and strong enough to handle the demands of my daily activities.	0	1	2	3	4	5	N/A
14. There was someone who encouraged, supported, or motivated me.	0	1	2	3	4	5	N/A
15. I took time to “smell the roses”, really noticing and enjoying things from my senses (e.g., aromas, sounds, tastes).	0	1	2	3	4	5	N/A
16. I actively participated in an organization related to my culture or another community that is important to me.	0	1	2	3	4	5	N/A
17. I had positive interactions with people (neighbors, co-workers, salespersons, etc).	0	1	2	3	4	5	N/A
18. I spent time in places with lots of grass, flowers, trees, clean rivers, lakes, or beaches, etc.	0	1	2	3	4	5	N/A
19. I spent time doing my hobbies, special projects, or other activities that I enjoy.	0	1	2	3	4	5	N/A
20. I did some type of physical exercise for fitness, strength, endurance or fun.	0	1	2	3	4	5	N/A
21. I showed patience with a person or situation.	0	1	2	3	4	5	N/A
22. I was open to new things; willing to step out of my comfort zone.	0	1	2	3	4	5	N/A
23. I felt proud of my cultural heritage (or the history/background of another group in society important to my identity).	0	1	2	3	4	5	N/A
24. I was satisfied with my situation related to romance or intimacy.	0	1	2	3	4	5	N/A
25. I was comforted by the presence of a Higher Power/God in my life.	0	1	2	3	4	5	N/A
26. I had a positive event or activity to look forward to.	0	1	2	3	4	5	N/A
27. People in my neighborhood know each other and can depend on each other.	0	1	2	3	4	5	N/A
28. I felt safe from physical harm from people I know.	0	1	2	3	4	5	N/A
29. I felt compassion or sympathy for someone.	0	1	2	3	4	5	N/A
30. I was able to be myself, to be “real” with the people I care about (didn’t have to pretend or be fake).	0	1	2	3	4	5	N/A
31. I felt respected by others for my positive qualities or actions.	0	1	2	3	4	5	N/A
32. My faith or spirituality was strengthened through reading, classes or discussions.	0	1	2	3	4	5	N/A
33. I felt like I was “home” when I was with people from my culture (or another group in society important to my identity).	0	1	2	3	4	5	N/A
34. I bounced back or recovered from any disappointments or bad things that happened.	0	1	2	3	4	5	N/A
35. I listened to what my body needed in terms of rest, water, food, etc.	0	1	2	3	4	5	N/A

	Never	Rarely	Sometimes	Mostly	Very Frequently	Always	N/A
36. There was plenty of open space in my community; it was not overcrowded by people or traffic	0	1	2	3	4	5	N/A
37. My home country was strong and stable in terms of leadership and political matters.	0	1	2	3	4	5	N/A
38. My faith and spiritual beliefs were strong.	0	1	2	3	4	5	N/A
39. I had someone in my life who “has my back”, who is there for me when I need them.	0	1	2	3	4	5	N/A
40. I felt emotionally connected to my culture or another group in society that isimportant to me (e.g., religious, disability, sexual orientation, military, large extended family, etc.).	0	1	2	3	4	5	N/A
41. I gained a greater knowledge and understanding of a local, national, or global issue.	0	1	2	3	4	5	N/A
42. I was “moved” by creative expression, had a strong emotional connection or experience related to music, art, dance, etc.	0	1	2	3	4	5	N/A
43. I felt accepted and welcomed by people at my workplace, school, or other place where I spend a lot of time.	0	1	2	3	4	5	N/A
44. I felt joy and happiness inside.	0	1	2	3	4	5	N/A
45. I felt connected to a purpose larger than my personal life.	0	1	2	3	4	5	N/A
46. I was able to relieve (or didn’t experience any) symptoms of stress in my body (e.g., neck/back tension, headache, stomachache, dizziness, trouble breathing, etc.).	0	1	2	3	4	5	N/A
47. I supported someone in getting through a difficult situation.	0	1	2	3	4	5	N/A
48. I was satisfied with my sexual functioning and activity.	0	1	2	3	4	5	N/A
49. I had a network of people available to me that were important sources of help and support in my life.	0	1	2	3	4	5	N/A
50. I felt really “alive”, present and engaged with the here-and-nowmoments of my life.	0	1	2	3	4	5	N/A
51. I felt good about the direction my home country was going in.	0	1	2	3	4	5	N/A
52. I was a leader or took initiative to start some action for change in my community or organization.	0	1	2	3	4	5	N/A
53. I had a strong awareness of how I was feeling and what I needed.	0	1	2	3	4	5	N/A
54. I was confident in myself; my self-esteem was high.	0	1	2	3	4	5	N/A
55. The water, electricity, and plumbing worked fine where I was living.	0	1	2	3	4	5	N/A
56. I felt loved by and/or in a close relationship with a Higher Power/Godin my life.	0	1	2	3	4	5	N/A
57. I felt a strong sense of gratitude, an appreciation for both the ups and downs in my life.	0	1	2	3	4	5	N/A
58. I effectively managed any physical pain or health problems I was having.	0	1	2	3	4	5	N/A
59. I did something to try to resolve a conflict or improve a relationship.	0	1	2	3	4	5	N/A
60. I enjoyed special time with a pet or other animal.	0	1	2	3	4	5	N/A
61. I felt at peace inside of myself.	0	1	2	3	4	5	N/A
62. I worked together with others on an issue of mutual concern in my community, workplace, school, or other setting.	0	1	2	3	4	5	N/A
63. I felt guided by a vision or mission for my life.	0	1	2	3	4	5	N/A
64. I observed or learned something positive about my culture (or another group in society that is very important to my identity).	0	1	2	3	4	5	N/A

	Never	Rarely	Sometimes	Mostly	Very Frequently	Always	N/A
65. I showed kindness, did something nice for someone.	0	1	2	3	4	5	N/A
66. I felt like things were improving in my life.	0	1	2	3	4	5	N/A
67. I avoided things that are harmful or dangerous to my health (e.g., cigarettes, excessive alcohol, illegal drugs, driving recklessly, etc.).	0	1	2	3	4	5	N/A
68. How I lived my daily life was consistent with my spiritual or religious beliefs.	0	1	2	3	4	5	N/A
69. I enjoyed spending time in my neighborhood or local community.	0	1	2	3	4	5	N/A
70. I felt connected to the rhythms and patterns of nature (e.g., animals, trees, oceans, stars, mountains, or other living things).	0	1	2	3	4	5	N/A
in another group in society most important to me.	0	1	2	3	4	5	N/A
72. I did or said something to lift someone's spirits.	0	1	2	3	4	5	N/A
73. I felt safe from gang violence, terrorism, police (or military) violence.	0	1	2	3	4	5	N/A
74. I had an amazing or "peak" experience (e.g., heightened awareness, awe, intense connection with another person, a creative burst, a revelation).	0	1	2	3	4	5	N/A
75. I did a good job at work, school, or with my other responsibilities.	0	1	2	3	4	5	N/A
76. I spent time in meditation, personal reflection, or deep contemplation.	0	1	2	3	4	5	N/A
77. I intervened or stood up for someone in a situation involving injustice or unfairness.	0	1	2	3	4	5	N/A
78. I felt a strong sense of belonging in my neighborhood (e.g., it felt like home to me).	0	1	2	3	4	5	N/A
79. I assisted someone in need.	0	1	2	3	4	5	N/A
80. I enjoyed expressing and sharing my spirituality with other people or in a faith community.	0	1	2	3	4	5	N/A
81. I gave good advice or guidance to someone.	0	1	2	3	4	5	N/A
82. I lived with integrity, was true to myself and my values ("walked my talk").	0	1	2	3	4	5	N/A
83. My living environment was generally safe and healthy (e.g., freefrom mold, industrial pollution, dangerous chemicals, rodents, broken glass, peeling paint, etc.).	0	1	2	3	4	5	N/A
84. I felt supported by people at my workplace, school, or other place where I spend a lot of time.	0	1	2	3	4	5	N/A
85. I felt a greater understanding of myself (e.g., why I am the way that I am, why I do the things that I do).	0	1	2	3	4	5	N/A
86. I felt safe from hate crimes, violence, or discrimination based on something about me like my race, religion, gender, sexual orientation, disability, etc.	0	1	2	3	4	5	N/A
87. I had companionship or a good social life, people to talk to or do things with.	0	1	2	3	4	5	N/A
88. The beauty and miracles of nature made me feel closer toa Higher Power/God.	0	1	2	3	4	5	N/A
89. I felt safe from sexual violence or exploitation.	0	1	2	3	4	5	N/A
90. I was "in the zone", got totally lost or immersed in an activity that I enjoyed.	0	1	2	3	4	5	N/A
91. I felt better about something that had been bothering me.	0	1	2	3	4	5	N/A
92. I received valuable counsel from a minister, rabbi, imam, priest, guru, pastor, or other religious leader.	0	1	2	3	4	5	N/A
93. I stopped to pay attention to what I was feeling emotionally and/or physically.	0	1	2	3	4	5	N/A

	Never	Rarely	Sometimes	Mostly	Very Frequently	Always	N/A
94. I had a strong sense of my values, what is most important to me.	0	1	2	3	4	5	N/A
95. My spiritual/religious beliefs and activities gave mestrength and guidance through the challenges I faced.	0	1	2	3	4	5	N/A
96. I got along well with family members.	0	1	2	3	4	5	N/A
97. I was guided positively by my intuition about things.	0	1	2	3	4	5	N/A
98. The place where I live was mostly free from very loud noises such as traffic, trains, gunshots, sirens, etc.	0	1	2	3	4	5	N/A
99. I felt positively connected with the soul or spirit of another person (living or deceased).	0	1	2	3	4	5	N/A
100. I felt accepted by many people in my culture (or another group in society that is very important to me).	0	1	2	3	4	5	N/A
101. I had a feeling of wisdom, insight, or understanding about life.	0	1	2	3	4	5	N/A
102. My neighborhood or local community was an important part of my life.	0	1	2	3	4	5	N/A
103. I felt a lot of national pride in my home country.	0	1	2	3	4	5	N/A
104. I resisted temptation; said “no” to something that would have been bad for me.	0	1	2	3	4	5	N/A
105. I felt connected to all of humanity regardless of race, nationality, social class, etc.	0	1	2	3	4	5	N/A
106. I expressed gratitude or appreciation to someone.	0	1	2	3	4	5	N/A
107. I participated in or contributed topositive change on a socialjustice issue or cause.	0	1	2	3	4	5	N/A
108. I motivated, encouraged, or cheered someone on.	0	1	2	3	4	5	N/A
109. I displayed my identification with my culture or another important identity group (symbols, clothing, language, artwork, home décor, bumper stickers, etc.).	0	1	2	3	4	5	N/A
110. I felt safe from threats, verbal abuse, emotional abuse, or stalking.	0	1	2	3	4	5	N/A
111. My basic needs were met (e.g., shelter, food, clothing).	0	1	2	3	4	5	N/A
112. I felt a clear awareness of who I am, my identity.	0	1	2	3	4	5	N/A
113. I helped someone understand or learn something.	0	1	2	3	4	5	N/A
114. I volunteered my time in the service of people in need, animals, the environment, or another cause important to me.	0	1	2	3	4	5	N/A
115. I was valued and respected at my workplace, school, or other place where I spend a lot of time.	0	1	2	3	4	5	N/A
116. Someone prayed or said blessings for me.	0	1	2	3	4	5	N/A
117. I got enough hours of peaceful, uninterrupted sleep.	0	1	2	3	4	5	N/A
118. I made sure I was informed about things happening in my neighborhood community	0	1	2	3	4	5	N/A
119. I felt good about my friendships.	0	1	2	3	4	5	N/A
120. I was growing and learning important life lessons.	0	1	2	3	4	5	N/A
121. I felt secure and grounded by my roots in my culture or another group in society important to my identity.	0	1	2	3	4	5	N/A
122. I look forward to being at work, school, or another place where I spend a lot of time (other than where I live).	0	1	2	3	4	5	N/A

	Never	Rarely	Sometimes	Mostly	Very Frequently	Always	N/A
123. I learned something new, became more knowledgeable.	0	1	2	3	4	5	N/A
124. I extended forgiveness or let go of negative feelings that I was having toward someone.	0	1	2	3	4	5	N/A
125. I did something to move my life forward or head in the right direction.	0	1	2	3	4	5	N/A
126. I felt committed to making my home country a better place.	0	1	2	3	4	5	N/A
127. I was aware of the connection between my mind, my emotions, and what was going on in my body.	0	1	2	3	4	5	N/A
128. I felt loved.	0	1	2	3	4	5	N/A
129. I felt safe in the neighborhood where I live.	0	1	2	3	4	5	N/A
130. I spent time praying, reading religious/spiritual books, or listening to spiritual music.	0	1	2	3	4	5	N/A
131. I was productive, got things done.	0	1	2	3	4	5	N/A
132. I felt that my family was well-respected in our cultural community or another important community.	0	1	2	3	4	5	N/A
133. I was becoming a better person; something about me was changing for the good.	0	1	2	3	4	5	N/A
134. I felt like someone really understands me and knows me well.	0	1	2	3	4	5	N/A
135. I felt inspired or excited about something.	0	1	2	3	4	5	N/A
136. My loved ones were safe from violence, abuse, or harassment.	0	1	2	3	4	5	N/A
137. Something good happened or turned out the way I wanted it to.	0	1	2	3	4	5	N/A
138. I had smiles, fun, and laughter in my life.	0	1	2	3	4	5	N/A
139. I got plenty of fresh outdoor air.	0	1	2	3	4	5	N/A
140. I felt good putting the needs of my family, culture, or other group (most important to me) above my own personal needs and wants.	0	1	2	3	4	5	N/A
141. I made progress dealing with a problem or getting rid of a bad habit.	0	1	2	3	4	5	N/A
142. I followed through on something, kept my word, or did what I said I would do.	0	1	2	3	4	5	N/A
143. I felt hopeful and optimistic.	0	1	2	3	4	5	N/A
144. I took good care of my health.	0	1	2	3	4	5	N/A
145. I witnessed or experienced spiritual healing.	0	1	2	3	4	5	N/A
146. I did something with excellence, something to be proud of.	0	1	2	3	4	5	N/A
147. I was able to purchase most (or all) of the material things that I wanted.	0	1	2	3	4	5	N/A
148. I did things during my free time (e.g., movies, music, books, Web sites, social activities) that reflected my culture or another group in society very important to my identity.	0	1	2	3	4	5	N/A
149. I was able to make something positive out of a negative situation.	0	1	2	3	4	5	N/A
150. Buildings and public areas in my neighborhood were kept in good condition.	0	1	2	3	4	5	N/A
151. I had a positive attitude, was in a good mood.	0	1	2	3	4	5	N/A
152. I enjoyed the physical comforts of home like my bed, my kitchen,or my bathroom.	0	1	2	3	4	5	N/A
153. I felt a strong sense of belonging at my workplace, school, or another place where I spend a lot of time.	0	1	2	3	4	5	N/A
154. I felt comfortable with my sexuality.	0	1	2	3	4	5	N/A

	Never	Rarely	Sometimes	Mostly	Very Frequently	Always	N/A
155. I had positive feelings about my home country.	0	1	2	3	4	5	N/A
156. I had enough privacy where I was living.	0	1	2	3	4	5	N/A
157. I took special care of my grooming or physical appearance (e.g., hair, clothing, face, body).	0	1	2	3	4	5	N/A
158. I had self-control.	0	1	2	3	4	5	N/A
159. I was a respectable member of my culture (or another group in society that I most identify with) and represented it well.	0	1	2	3	4	5	N/A
160. I ate mostly healthy and nutritious foods.	0	1	2	3	4	5	N/A

Next, please indicate the importance of each of the following in determining your well-being at this time in your life. Specifically: If what is going on in that area, positive or negative, affects how satisfied you are with your life then it would considered MORE important to your well-being. If what is going on in that area of your life doesn't make much of a difference to how satisfied you are with your life then it would be considered LESS important to your well-being.

	Not at all Important	A little Important	Somewhat Important	Very Important
1. My daily activities and achievements.	1	2	3	4
2. Doing good things for other people.	1	2	3	4
3. Having positive emotions and feelings.	1	2	3	4
4. Having a sense of belonging to a strong community (e.g., workplace, neighborhood, school, or other organization).	1	2	3	4
5. Having strong self-awareness—being aware of what I am feeling, sensing, thinking.	1	2	3	4
6. My physical health and functioning.	1	2	3	4
7. My spirituality or religious experience.	1	2	3	4
8. Having a sense of meaning and purpose.	1	2	3	4
9. Being safe from harm or danger.	1	2	3	4
10. Improving myself and making progress on changes I'm working on.	1	2	3	4
11. Participating in positive social/community change.	1	2	3	4
12. A strong identity and connection to my culture (or another group in society central to my identity such as my religion, sexual orientation, or ability/disability status).	1	2	3	4
13. The physical environment where I am living.	1	2	3	4
14. The quality of my relationships with the people closest to me.	1	2	3	4
15. How things are going in the country I consider home.	1	2	3	4

Finally, BEFORE YOU LEAVE THIS PAGE,
using the 15 areas of life listed above, please CIRCLE THE THE FIVE (5) MOST IMPORTANT areas for determining your well-being at this time in your life.

APPENDIX B

Demographic Information

APPENDIX B

Demographic Information

FIRST, JUST A BIT ABOUT YOU: The purpose of this first section is to provide us with an overall description of the people who have participated in our research project. We appreciate your openness in sharing this information so that we can look at diverse experiences of well-being. Please remember that we have no way of identifying you personally. Our research will only accurately inform a greater understanding of well-being if participants respond honestly. Thank you for your participation!

1. Your Gender: _____Male _____ Female

2. Your current age in years: _____

3a. Your Country of

Birth:_____

3b. Your Mother's Country of Birth:

_____

3c. Your Father's Country of

Birth:_____

4. Your Country of Current Residence:

_____

5. Length of time in your current country of residence (# of years): _____

6. Your current zip or postal code: _____

7a. Which ONE of the following broad categories BEST describes your general racial-ethnic group identification at this time in your life?

O Native American/American Indian/First Nations

O North American White

O Other White (European, South African, Australian, Russian, etc.)

O White Multiethnic—Please specify:

O Multiracial/Multiethnic Minority—Please specify:

O Black African (continental)

O African/Black American

O Afro-Caribbean (Jamaican, Haitian, Trinidadian, etc.)

O Afro-Latino (Dominican, Puerto Rican,Cuban, etc.)

O Mexican/Mexican American

O Latino/Hispanic/Central or South American (El Salvadorian, Guatamalan, Brazilian, Peruvian, Colombian, etc.)

O White Latino/Hispanic

O Middle Eastern/Arab descent

O Persian/Iranian descent

O Pacific Islander (Tongan, Samoan, etc.)

O South Asian/Indian/Pakistani

O Chinese/Chinese American

O Korean/Korean American

O Japanese/Japanese American

O Southeast Asian (Vietnamese, Cambodian, Laotian, etc.)

O Other—please specify:

7b. In your own words, please describe your racial-ethnic-cultural identity: (please be specific; Examples: "Afro Brazilian born and raised in the United States," "Southern White American," "Chinese Canadian," "Multiracial with Black and Korean," "Iranian American identifying primarily Jewish," "United States born White living in Japan for over 30 years and identifying

primarily with Japanese culture," etc.

_____

8a. Which <u>one</u> of the following BEST describes your <u>general</u> religious/spiritual affiliation at this time in your life? (Please CIRCLE only ONE response)

- o Jewish / Judaism
- o Catholic / Catholicism
- o Protestant Christianity (Methodist, Baptist, Lutheran, Episcopalian, etc.)
- o Nondenominational or Other

  Christianity:_____
- o Unitarian, Universalist
- o Muslim / Islam
- o Baha'i
- o Buddhism
- o Hinduism
- o Indigenous / Culture-Centered Religious Belief System
- o Religious Science
- o New Age or New Thought Spirituality
- o Wiccan or Other Pagan Religion
- o Other Spiritual or Religious Belief System (please specify):

  _____
- o Spiritual with no specific religious belief system
- o Agnostic
- o Atheist
- o None of the Above

8b. In your own words, please more specifically describe your religious/spiritual identification and/or belief system (e.g., non-practicing cultural Jew, African Methodist Episcopal, Progressive Christianity, Eastern Orthodox Christianity, Sunni Muslim, etc.):

_____

_____

_____

9. What is the highest level of education that you have achieved?

- ❍ Some High School or Less
- ❍ High School Degree or Equivalent
- ❍ Community College, Vocational or Trade School Graduate (e.g., Cosmetology, Electrician, etc.)
- ❍ College/University Degree (B.A., B.S., etc.)
- ❍ Graduate or Professional Degree (e.g., MBA, M.D., Ph.D.)

10. Are you currently in school or a training program?

- ❍ Yes, full-time
- ❍ Yes, part-time
- ❍ No

11. Are you currently working for pay?

- ❍ Working full-time for pay
- ❍ Working part-time for pay
- ❍ Not working for pay currently but looking for a job
- ❍ Not currently working for pay by choice

12. What is your profession, occupation, or vocation?

13. Which of the following BEST describes your relationship status over the PAST TWO WEEKS?

- ❍ Not currently dating at all
- ❍ Dating or going out casually
- ❍ In an intimate relationship with a boyfriend or girlfriend
- ❍ In a permanent relationship with my life partner

14. Please check any or all of the following that apply to you:

- ❑ Single, never married
- ❑ Currently married
- ❑ Living together with my spouse or life partner
- ❑ Separated from my current spouse or life partner
- ❑ Divorced
- ❑ Widowed

15. Which of the following best describes your sexual orientation identity at this time?

- ❍ Heterosexual
- ❍ Bisexual
- ❍ Gay or Lesbian (Homosexual)
- ❍ Questioning
- ❍ Other (please describe): _____

16. Are you currently a primary caregiver (physical, legal, financial responsibility) for an elderly person or dependent adult (older than 18 years)?

- ❍ Yes
- ❍ No

17a. Are you currently a parent or legal guardian of a child (birth-18 years)?

- ❍ Yes

- ❍ No

17b. If yes, how many children (birth-18 years old) currently live with you? _____

18a. Which of the following best describes your financial situation at this time?

- ❍ My basic needs like food and shelter are <u>not</u> always met.
- ❍ My basic needs are met (food, shelter, clothing) but no extras
- ❍ I have everything I need and a few extras.
- ❍ I am able to purchase many of the things I want.
- ❍ Within limits, I am able to have luxury items like international vacations, new cars, etc.
- ❍ I can buy nearly anything I want, anytime I want.

18b. In US Dollars, what was your approximate annual household income during the past year?

- ❍ Less than $25,000
- ❍ $25,000-$50,000
- ❍ $50,000-$100,000
- ❍ $100,000-$250,000
- ❍ $250,000-$500,000
- ❍ More than $500,000

19. During the PAST TWO WEEKS, how much stress have you experienced?

- ❍ Less than usual
- ❍ About the same as usual
- ❍ More than usual

20a. During the PAST TWO WEEKS, have you been negatively affected by an illness or condition that interfered with your regular lifestyle?

- ❍ Yes
- ❍ No

20b. Which, if any, of the following health conditions have you experienced over the <u>PAST TWO WEEKS</u>? (please check <u>ALL</u> that apply)

- ❑ Flu/Influenza or Severe Cold
- ❑ Moderate to Severe Allergic Reaction/Allergies
- ❑ Anemia
- ❑ Obesity
- ❑ Migraines or Chronic Headaches
- ❑ Chronic Back Pain
- ❑ Significant Cut or Wound from an injury
- ❑ Concussion or other Head Injury
- ❑ Musculoskeletal Injury (broken bones, torn ligaments, sprains, dislocations, Carpal Tunnel, etc.)
- ❑ Gastrointestinal Problem (diarrhea, constipation, food poisoning, etc.)
- ❑ Hernia
- ❑ Appendicitis, Kidney Stones, or other Acute Health Problem
- ❑ Pre-Diabetes or Insulin Resistance
- ❑ Diabetes
- ❑ High Blood Pressure (Hypertension)
- ❑ High Cholesterol
- ❑ Heart / Cardiovascular Disease
- ❑ Depression, Anxiety, Phobia, or PTSD
- ❑ Adult ADHD
- ❑ Cerebrovascular Disease (Stroke, TIAs)
- ❑ Musculoskeletal Disease (Lupus, Fibromyalgia, etc.)
- ❑ Gastrointestinal Disease (Ulcerative Colitis, Irritable Bowel Syndrome, Crohn's Disease,

etc.)

- ❑ Neurological Disease (Epilepsy, Parkinson's, Multiple Sclerosis, Huntington's Disease, etc.)
- ❑ Alzheimer's Disease or other Memory Problem
- ❑ Cancer, Malignant Tumor, or Blood Disease
- ❑ Endocrine or Thyroid Disease
- ❑ Asthma or Other Respiratory Disease
- ❑ Arthritis
- ❑ Alcohol/Drug Abuse or Addiction
- ❑ Anorexia, Bulimia, or Binge Eating Disorder
- ❑ HIV / AIDS
- ❑ Epstein-Barr / Chronic Fatigue Syndrome
- ❑ Reproductive Problem
- ❑ Sleep Disorder
- ❑ Limited Mobility requiring an assistive device such as a walker or wheelchair
- ❑ Deafness or Hearing Problem
- ❑ Blindness or Vision Problem
- ❑ Other Physical or Mental Health Condition or Addiction that has been diagnosed by a health care professional (please specify):

  _____

  _____

21. Finally, please feel free to indicate below <u>any important aspect of your identity or background</u> (relevant to your well-being) that we have not included in the questions so far:_____

APPENDIX C

Agreement to Participate in Research Activities

APPENDIX C

Agreement to Participate in Research Activities

AGREEMENT TO PARTICIPATE IN RESEARCH ACTIVITIES

Harrell Research Group Well-being Projects - Pepperdine University Graduate School of Education and Psychology

Dear Dr. Harrell and Pepperdine University Institutional Review Board,

After reviewing the "Information for Research Participants", the research questionnaires, and having my questions answered, I am agreeing to cooperate with the Harrell Research Group in the collection of data for their Well-being Projects. I understand that the participation of any individual in this research is entirely voluntary and that potential participants should not be required to participate or experience any pressure or negative consequences related to research participation. I am granting permission for the following research activities to be conducted with the named organization, business, or group.

(Please check all that apply)
_____ Post and/or place announcements in designated locations that are part of my organization, business, or group.
_____ Pass out research announcements to individuals attending an event or activity sponsored by my organization, business, or group.
_____ Place a stack of questionnaires in designated locations that are part of my organization, business, or group.
_____ Place a box for returning completed questionnaires in one or more designated locations that are a part of my organization, business, or group.
_____ Make an announcement describing the research at events and meetings to be specified.
_____ Place an announcement about the research project in our newsletter, newspaper, magazine, electronic resource, or Web site.
_____ Send an email describing the research to a membership list that I will provide.
_____ Collect data involving completion of a 45" questionnaire during a meeting that is part of my organization, business, or group.

I affirm that I am authorized to give permission for the research activities indicated above to be conducted with the organization, business, or group named below.

Name of Organization/Business/Group: _____
Name of Person Granting Authorization:_____
Title of Authorized Person Named Above: _____
Signature of Authorized Person: _____
Date: _____

****

Contact Person for making specific arrangements: _____
Contact Telephone #:_____ Alternate #:_____
Contact email addresses: _____

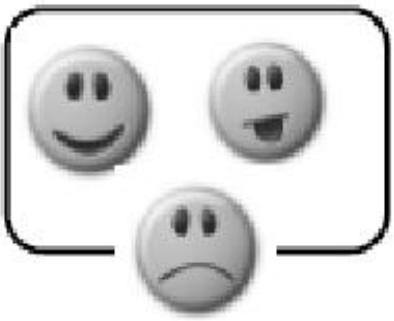
THIS FORM MAY BE RETURNED BY:
FAX: 888-380-7835
EMAIL: wellbeing@harrellresearchgroup.org (as a scanned attachment)
POSTAL MAIL: Dr. Shelly Harrell, Pepperdine University, 6100 Center Drive, 5th floor, Los Angeles, CA 90045

APPENDIX D

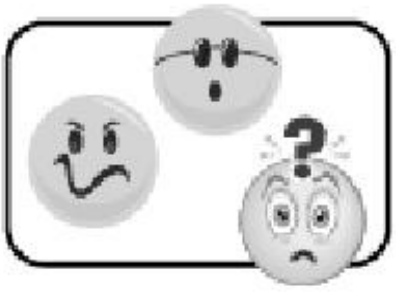
Recruitment Flyers

APPENDIX D

Recruitment Flyers



How have YOU been doing lately?



We'd like to know!

The Harrell Research Group at Pepperdine University is conducting a research study to better understand wellness and well-being...and we need your HELP!

Participate to WIN A $30 GIFT CERTIFICATE in our WEEKLY PRIZE DRAWING!

Scan the QR Code below to do the questionnaire NOW!

It is EASY to do our online questionnaire from your desktop, laptop, tablet or smartphone! OR you can print it out from our website!

You can do the questionnaire when you are somewhere just waiting for something! ...like while you're waiting in line at the store, at the auto shop, at the doctor's office, at the hair salon or barber shop!

Participate anywhere, anytime!

Visit us at www.wellbeingresearch.net for more info!

APPENDIX E

GPS IRB Approval Notice

APPENDIX E

PEPPERDINE UNIVERSITY

GPS IRB Approval Notice

Graduate & Professional Schools Institutional Review Board

May 14, 2013

Dr. Shelly
Harrell 6100
Center Drive
Los Angeles, CA 90045

Protocol #: P0313F07
Project Title: Psychometric Validation of the Multidimensional Well-Being Assessment (MWA) and Broad Assessment of Distress and Dysfunction (BADD) in Diverse Populations

Dear Dr. Harrell,

Thank you for submitting your application, Psychometric Validation of the Multidimensional Well-Being Assessment (MWA) and Broad Assessment of Distress and Dysfunction (BADD) in Diverse Populations, for expedited review to Pepperdine University's Graduate and Professional Schools Institutional Review Board (GPS IRB). The IRB appreciates the work you have done on the proposal. The IRB has reviewed your submitted IRB application and all ancillary materials. As the nature of the research met the requirements for expedited review under provision Title 45 CFR 46.110 (Research Category 7) of the federal Protection of Human Subjects Act, the IRB conducted a formal, but expedited, review of your application materials.

I am pleased to inform you that your application for your study was granted **Approval.** The IRB approval begins today, **May 14, 2013,** and terminates on **May 14, 2014.** In addition, your application to waive documentation of informed consent, as indicated in your **Application for Waiver or Alteration of Informed Consent Procedures** form has been **approved.**

Please note that your research must be conducted according to the proposal that was submitted to the GPS IRB. If changes to the approved protocol occur, a revised protocol must be reviewed and approved by the IRB before implementation. For ***any*** proposed changes in your research protocol, please submit a Request for Modification form to the GPS IRB. Please be aware that changes to your protocol may prevent the research from qualifying for expedited review and require submission of a new IRB application or other materials to the GPS IRB. If contact with subjects will extend beyond **May 14, 2014**, a **Continuation or Completion of Review Form** must be submitted at least one month prior to the expiration date of study approval to avoid a lapse in approval.

A goal of the IRB is to prevent negative occurrences during any research study. However, despite ourbest intent, unforeseen circumstances or events may arise during the research. If an unexpected situation or adverse event happens during your investigation, please notify the GPS IRB as soon as possible. We will ask for a complete explanation of the event and your response. Other actions also maybe required depending on the nature of the event. Details regarding the timeframe in which adverse events must be reported to the GPS IRB and the appropriate form to be used to report this

information can be found in the *Pepperdine University Protection of Human Participants in Research: Policies and Procedures Manual* (see link to "policy material" at http://www.pepperdine.edu/irb/graduate/). Please refer to the protocol number denoted above in all further communication or correspondencerelated to this approval. Should you have additional questions, please contact me. On behalf of the GPSIRB, I wish you success in this scholarly pursuit.

Sincerely,

Doug Leigh, Ph.D.
Chair, Graduate and Professional Schools IRB
Pepperdine University
Graduate School of Education & Psychology
6100 Center Dr. 5th Floor
Los Angeles, CA 90045
Doug.Leigh@pepperdine.edu
W: 310-568-2389
F: 310-568-5755

cc: Dr. Lee Kats, Vice Provost for Research and Strategic Initiatives
Ms. Alexandra Roosa, Director Research and Sponsored Programs