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Social Well-Being*

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The proposal of five dimensions of social well-being, social integration, social contribution, social coherence, social actualization, and social acceptance, is theoretically substantiated. The theoretical structure, construct validity, and the social structural sources of the dimensions of social well-being are investigated in two studies. Item and confirmatory factor analyses in both studies corroborate the theoretical model of social well-being. The new scales correlate convergently with measures of anomie, generativity, perceived social constraints, community involvement and neighborhood quality. The new scales correlate discriminantly with measures of dysphoria, global well-being, physical health and optimism. Multivariate analyses in both studies substantiate the claim that social well-being is an achievement, facilitated by educational attainment and age. The state and direction of the study of adult functioning are discussed.

What is the nature of a well-lived life? Does positive mental health include social challenges and criteria? Inquiry into the nature of well-being should embrace the division of life into public and private tasks, a distinction that has pervaded social psychological theory.

The self, for example, is both a public process and a private product (James 1890; Mead 1934). Individual differences in neuroticism and extraversion (Costa and McCrea 1980), self-awareness (Duval and Wicklund 1972; Fenigstein, Scheier and Buss 1975), self-conception (Greenwald and Pratkanis 1984; Trafimow, Triandis and Goto 1991; Triandis 1989) and esteem (Luhtanen and Crocker 1992) characterize people as either attentive to situational or internal exi-

gencies and information.

Role theories and concepts delineate the strains and incongruities between personal and social expectations (Biddle 1986; Heiss 1981) or focus on the ways in which people manage the incongruity between private and public life and images (Goffman 1959; also see Shaw and Costanzo 1982).

Finally, as adults age they purportedly encounter tasks that force them to choose to adapt through private resignation or public social involvement (i.e., generativity) (Erikson 1950; also see Adler 1979). The private and the public sides of life are two potential sources of life's challenges, with possibly distinct consequences for judging a well-lived life.

Despite the distinctions between public and private life, the leading conceptions of adult functioning portray well-being as a primarily private phenomenon. The clinical tradition tends to operationalize well-being through measures of depression, distress, anxiety, or substance abuse (see, e.g., Thoits 1992). Well-being therefore is the absence of negative conditions and feelings, the result of adjustment and adaptation to a hazardous world. The psychological tradition operationalizes well-being as the subjective evaluation of life via satisfaction and affect (e.g., Andrews and Withey 1976; Bradburn 1969; Campbell 1981; Campbell, Converse, and Rodgers 1976; Diener 1984; Gurin, Veroff, and Feld 1960) or personal functioning (Ryff

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1989; Ryff and Keyes 1995). According to this view, emotional well-being is an excess of positive over negative feelings; personal psychological functioning is the presence of more positive than negative perceived self-attributes such as personal growth. Although the existing models emphasize private features of well-being, individuals remain embedded in social structures and communities, and face countless social tasks and challenges. To understand optimal functioning and mental health, social scientists also should investigate adults' social well-being (also see Larson 1992, 1996).

The purpose of this study is to substantiate and test a social model of well-being that reflects positive social health. Therefore I discuss the social nature of life and its challenges, because such challenges might be criteria that individuals use to assess the quality of their lives. I propose operational definitions and indicators of social well-being. In two representative samples, I examine the theoretical structure and validity of each scale, as well as some of the social structural origins of each dimension of social well-being.

Symptoms of Life's Social Challenges

Social health, or at least its absence, is a preeminent concern in classic sociological theory. Despite the importance of anomie and alienation, Durkheim and Marx also discussed several dimensions of positive social health. Among the potential benefits of public life are social integration and cohesion, a sense of belonging and interdependence, and a sense of shared consciousness and collective fate (Durkheim 1951). The benefits of social life provide a foundation for a global definition of a social version of well-being.

Social well-being is the appraisal of one's circumstance and functioning in society. Below I propose and describe several social challenges that constitute possible dimensions of social wellness.

Social integration is the evaluation of the quality of one's relationship to society and community. Healthy individuals feel that they are a part of society. Integration is therefore the extent to which people feel they have something in common with others who constitute their social reality (e.g., their neighborhood), as well as the degree to which they feel that they belong to their communities and society. Social integration draws on conceptions of social cohesion (Durkheim), cultural estrangement and social isolation (Seeman), and class consciousness (Marx). In Durkheim's view, social coordination and health reflect individuals' connections to each other through norms and indicate their fondness for society. According to Seeman (1959, 1983, 1991; also see Merton 1949), cultural estrangement is the cleavage of self from society. Estrangement is the rejection of society or the realization that society does not reflect one's own values and lifestyle. Social isolation is the breakdown of personal relationships that provide meaning and support. Like Marx's conception of class consciousness, social integration entails the construal of collective membership and fate.

Social acceptance is the construal of society through the character and qualities of other people as a generalized category. Individuals who illustrate social acceptance trust others, think that others are capable of kindness, and believe that people can be industrious. Socially accepting people hold favorable views of human nature (see Wrightsman 1991) and feel comfortable with others (Horney 1945). Social acceptance is the social analogue to personal acceptance: People who feel good about their personalities and accept both the good and the bad aspects of their lives exemplify good mental health (Fey 1955; Ryff 1989). Therefore social acceptance of others might be the social counterpart to self-acceptance.

Social contribution is the evaluation of one's social value. It includes the belief that one is a vital member of society, with something of value to give to the world. Social contribution resembles the concepts of efficacy and responsibility. Self-efficacy is the belief that one can perform certain behaviors (Bandura 1977) and can accomplish specific objectives (Gecas 1989). Social responsibility is the designation of personal obligations that ostensibly contribute to society. Social contribution reflects whether, and to what degree, people feel that whatever they do in the world is valued by society and contributes to the commonweal. This construct

is consistent with Marx's thesis that people are naturally productive (Israel 1971).

Alienation is the economic counterpart to the diminution of the perceived value of one's life and everyday activities. The developmental analogue of social contribution is generative motives and behavior. Midlife, according to Erikson (1950), is a period when adults can act on their desire to contribute to society by molding the next generation into productive members of society (for example, by mentoring).

Social actualization is the evaluation of the potential and the trajectory of society. This is the belief in the evolution of society and the sense that society has potential which is being realized through its institutions and citizens. Healthier people are hopeful about the condition and future of society, and they can recognize society's potential. Socially healthier people can envision that they, and people like them, are potential beneficiaries of social growth. The evaluation of social progress is consistent with Srole's (1956) interpretation of anomie as the evaluation of society's potential by the evaluation of the character of society's custodians (for example, public officials). Similarly, social actualization resembles fatalism (Lefcourt 1982) and powerlessness (Seeman 1991).

Parallel to self-determination, social actualization is the sense that society controls its destiny. The focus on the realization of social potential also is similar to the theme of potential and its development as self-realization (Maslow 1968), eudaimonic happiness (Waterman 1993), and personal growth (Ryff 1989). Optimal functioning, in part, is openness to experience and the desire and effort to grow continually. Social actualization captures these ideas of growth and development.

Social coherence is the perception of the quality, organization, and operation of the social world, and it includes a concern for knowing about the world. Healthier people not only care about the kind of world in which they live, but also feel that they can understand what is happening around them. Such people do not delude themselves that they live in a perfect world; they have maintained or promoted the desire to make sense of life.

Social coherence is analogous to meaninglessness in life (Mirowsky and Ross 1989; Seeman 1959, 1991), and involves appraisals that society is discernable, sensible, and predictable. Psychologically, healthier individuals see their personal lives as meaningful and coherent (Ryff 1989). The sense of personal coherence, according to Antonovsky (1994), may be a marker of health: individuals who have coherence attempt to maintain coherence when faced with unpredictable and traumatic life events.

In sum, perspectives rooted in philosophy, social psychological theory and cultural analysis argue cogently for emphasizing the social equally with the personal nature of well-being. Themes of integration, social involvement, and public consciousness in classical sociological theory, which are reiterated in social psychological conceptions of self in society, suggest the social challenges faced by adults.

Social Structural Sources of Social Well-Being

People do not begin or maintain the quest for social well-being with the same assets. Social structure should constrain or facilitate individuals' ability and opportunity to respond successfully to the social challenges of life. Social stratification and aging are prominent structural aspects of life and have been the subject of prior research on the sources of other dimensions of health and well-being. In particular, educational attainment and processes of aging generally affect instrumental resources and self-conceptions.

Educational attainment launches young adults into specific occupations, affecting what they earn and the conditions and people they encounter daily. Indirectly, through monetary sequelae, education determines the quality of one's housing and neighborhood (Karabel and Halsey 1977; Kohn 1969; Kohn and Schooler 1982; Sewell and Hauser 1975). Lower socioeconomic status (SES) has been linked consistently to diminished physical and mental health (N. Adler et al. 1994), partially because life at lower socioeconomic levels appears to impair health-promoting self-conceptions (Mirowsky and Ross 1989).

Whereas higher levels of education

should promote social well-being, the relationship of age to social well-being is equivocal. Aging and age differences include numerous aspects that are not always consistent. For example, despite the apparent constriction of social positions and activity (Carstensen 1995; Riley, Kahn, and Foner 1994), and the decline in physical health with age, research illustrates how adults seem to age successfully through several mechanisms. (For a discussion of possible self-mechanisms, see Heidrich and Ryff 1996.) Moreover, while some self-conceptions (such as personal control) apparently decline with age (Mirowsky 1995), other studies find that adults, as they age, feel happier and more satisfied with their lives and report higher levels of some dimensions of psychological well-being (Heidrich and Ryff 1996; Ryff and Keyes 1995). The ability to age successfully suggests that some facets of social well-being, like psychological well-being, may increase with age.

In the two probability samples I investigate the hypothesis of the social nature of well-being and the hypothesis of the social structural sources of variation in social well-being, and subject these hypotheses to the standard of replication. I operationalize the dimensions in a local probability sample and replicate them in a larger, nationally representative sample of adults. Confirmatory factor analyses permit assessment of the utility of the hypothesized five-factor model of social well-being. I then correlate the new scales with extant indicators and scales of constructs and processes that reflect individuals' perceptions of positive social functioning. In the single exception I correlate the new scales with a scale of anomie, which measures the absence of social health. Insofar as all of the new scales measure social wellness, they should correlate negatively with appraisals of anomie.

In particular, social actualization and social acceptance should correlate strongly with anomie because the content of the Srole anomie scale focuses on the perceived quality of society (as does social actualization) and on the character of other people like public officials (as does social acceptance). Social contribution, on the other hand, should correlate strongly with a scale

(e.g., generativity) that measures how greatly individuals perceive that they are valued by others, are used as social resources (such as sources of advice), and contribute to others' well-being.

People who feel socially integrated, close to and deriving comfort from others in their community, should feel that they live in a vital and healthy neighborhood. Socially integrated individuals therefore should perceive their neighbors as trustworthy and their neighborhoods as safe. Adults integrated into society also should be likely to volunteer to maintain their neighborhood, perhaps because they feel their actions will be valued by others and because they want to maintain the quality of their neighborhood.

Finally, people who see life as socially coherent should also feel that their private life is coherent. Therefore individuals with higher scores on the social coherence scale should feel that their personal fives are more predicable, more controllable, and thus generally sensible and understandable.

In short, insofar as the new scales measure social well-being, socially healthier individuals should not regard society and its custodians as unsavory, should perceive themselves as social resources, should care for and feel safe in their communities, and should lead coherent personal lives.

Regression analysis of the disparities in social well-being, by education and age, permits investigation of the hypothesized structural sources of social well-being. Prior research on the structural sources of psychological aspects of mental health suggests that social well-being should increase as the level of education rises. Aging, however, involves losses and the ability to adapt and age successfully. Therefore, although social well-being may increase with age, I explore the possibility of a nonlinear relationship between age and social well-being. For example, some dimensions of social well-being could increase more rapidly because adults face the same social challenges that subside with age or adults adapt with age. However, social well-being could increase less quickly with age because the social challenges of life that might intensify cannot be offset by adults' attempts to age successfully.

METHODS

Samples

Study 1 is a random-digit-dialing sample (Waksberg 1978) of adults age 18 or older living in Dane County, Wisconsin. Madison is the seat of Dane County and the capital of the state. All interviews, utilizing computer-assisted technology, were conducted on the telephone by trained persons at the Letters and Science Survey Center at the University of Wisconsin, Madison. After the pretesting and interviewer training, interviews were conducted between April and June 1994. When determining household composition, interviewers selected the household member who had celebrated his or her birthday most recently (see O'Rourke and Blair 1983). The interview lasted 30 minutes on average. The sample includes 373 adults, for a response rate of 63%.

Study 2 is a random-digit-dialing sample of noninstitutionalized English-speaking adults age 25 to 74, living in the 48 contiguous states, whose household included at least one telephone.[1] In the first stage of the multistage sampling design, the investigators selected households with equal probability via telephone numbers. At the second stage, they used disproportionate stratified sampling to select respondents. The sample was stratified by age and sex; males between ages 65 and 74 were oversampled.

Field procedures were initiated in January 1995 and lasted approximately 13 months. The respondents were contacted by professional personnel; those who agreed to participate in the entire study took part in a computer-assisted telephone interview lasting 30 minutes on average. Respondents then were mailed two questionnaire booklets requiring about 1.5 hours on average to complete. As incentives for participation in the complete study, each respondent was offered $20, a commemorative pen, periodic reports of study findings, and a copy of a monograph on the study. The sample consists of 3,032 adults, with a 70% response rate for the telephone phase and an 87% response rate for the self-administered questionnaire phase, or a combined response rate of 61%.

Table 1 reports the demographic characteristics of each sample. The data from the national sample data are weighted to adjust for unequal probabilities of household selection and unequal probabilities of respondent selection within households. The sample weight also poststratifies the sample to match the October 1995 Current Population Survey proportions of adults on the basis of gender, age, race, education, and marital status, as well as the proportions of adults living in metropolitan (nonmetro) areas and various regions (northeast, midwest, south and west) of the United States. The mean age of the Dane County sample is 43.6 (SD = 15.9), compared with a mean age of 45.3 (SD = 13.5) in the national sample. In the Dane County sample, fewer respondents are married and more have attained slightly higher levels of education. Moreover, the Dane County sample is mostly Caucasian, and more households report slightly higher household incomes than in the national sample.

Measures

Social well-being. Theoretical conceptions in Study 1 (Dane County) promoted operational definitions that guided the creation of indicators (Appendix A). On the basis of linguistic clarity and face validity, I retained 10 items (five positive and five negative) per scale and placed them in a random sequence. After six background questions were asked, the 50 items were administered at the beginning of the telephone interview. Through the unfolding technique (Groves 1989), respondents stated whether they agreed or disagreed, and then judged how much (strongly, moderately, or slightly). The response options therefore range from 1, strongly disagree, to 7, strongly agree.

Interviewers were trained to refrain from converting voluntary expressions of uncertainty (i.e., "don't know" and "neither agree nor disagree") into substantive answers. A total of 87 respondents expressed uncertainty at least once in response to the items retained in Study 1. Expressions of "neither agree nor disagree" are coded to the midpoint of the scale; "don't know" expressions are assigned

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[1] This sample was assembled by MIDMAC, the John D. and Catherine T. MacArthur Foundation Research Network on Successful Midlife Development.

Table 1. Characteristics and Comparison of Specific Samples from the MacArthur Foundation's Studies of Successful Midlife (Percentages)

	Study 1 Dane County Sample (N = 373)	Study 2 National (Weighted)Sample (N = 3,032)
Age[a]		
Young	44.2	40.5
Midlife	38.9	40.3
Older	16.9	19.2
Gender		
Male	41.2	43.5
Female	58.8	56.5
Marital Status		
Married	51.5	68.1
Never married	27.9	8.6
Other	20.6	23.3
Race		
Caucasian	92.2	83.8
African-American	3.0	11.4
Other	4.8	5.7
Education		
Up to 12 years	30.0	51.5
13 to 15 years	30.5	25.5
16 years or more	39.4	23.0
Income		
$14,999 or less	12.4	18.3
$15,000 to $24,999	19.3	16.3
$25,000 to $34,999	15.7	12.2
·$35,000 to $49,999	16.0	19.5
$50,000 or more	36.6	33.6

[a]Dane County sample: Young = 18-39; midlife = 40-59; older = 60-89. National sample: Young = 25-39; midlife = 40-59; older = 60-74.

the mean of a respondent's existing items on a scale. In cases in which they agreed or disagreed but did not report the strength of their feelings, respondents are assigned the mean of the "agree" or "disagree" side of the response scale. Thus, for example, respondents who agreed with an item but did not know how strongly they felt were imputed the mean of the "agree" (strongly, moderately or slightly) side of the response scale.

Each scale in Study 2 consists of only three items. (Because of concern about respondents' fatigue, I did not include all items.) In keeping with the self-administered format, all pronouns are first person (in contrast to second person in Study 1). The response format ranges from 1, strongly disagree, to 7, strongly agree. Respondents were given a midpoint option labeled "don't know." The social well-being items were ordered randomly and embedded in a section of questions inquiring about social par-

ticipation, social responsibility, and social networks.

Validation criteria, Study 1. I measured anomie (Srole 1956) with a scale consisting of three items used in the General Social Survey (GSS) (Davis and Smith 1994). Respondents indicated whether they agree or disagree that (1) "Most public officials are not really interested in the problems of the average person," (2) "The lot of the average person is getting worse, not better," and (3) "It is not fair to bring children into the world with the way things look for the future." The internal (alpha) consistency of the anomie scale is .57, which is identical to the average reliability ($M\alpha = .57$, SD = .04) of the same scale over six years of the GSS.[2]

Two indicators measure aspects of global psychological well-being. Respondents indicated whether they felt very, somewhat, a lit-

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[2] GSS data are taken from 1984, 1985, 1987, 1988, 1989, and 1990.

tle, to not at all, satisfied with their lives right now. On the same scale, respondents were instructed to pretend for a moment that they knew their life would end next week, and then to indicate how happy they felt about the life they had been able to live. Finally, respondents indicated whether they had ever worked with other people in their community to solve a problem in their community. Respondents who had been involved then indicated whether their community activity occurred during the past 12 months.

Validation criteria, Study 2. Respondents indicated whether six indicators of generativity described them a lot, somewhat, a little, or not at all. The internal (alpha) reliability of the modified Loyola Generativity Scale (based on McAdams and de St. Aubin 1992) is .84. Higher scores reveal individuals who feel that they have made contributions to society, have imparted skills or advice to others, like to teach things to others, have had a good influence on others, and feel needed by others. A scale measuring perceived neighborhood health consists of four indicators intended to measure feelings of neighborhood trust and safety. Respondents indicated whether the following statements describe their situations a lot, some, a little, or not at all: (1) "I feel safe being out alone in my neighborhood during the daytime," (2) "I feel safe being out alone in my neighborhood during the night," (3) "I could call on a neighbor for help if I needed it," and (4) "People in my neighborhood trust each other." The internal (alpha) reliability of the neighborhood health scale is .66; a higher score indicates a stronger feeling of neighborhood trust and safety.

Respondents also completed a scale measuring perceived constraints, which reflects how much individuals perceive obstacles and unpredictable contingencies in their lives (see Lachman and Weaver Forthcoming). Respondents indicated whether they agree or disagree (strongly, somewhat, or a little) with eight self-descriptive statements, including the following as examples: (1) "There is little I can do to change the important things in my life," (2) "What happens in my life is often beyond my control," (3) "There are many things that interfere with what I want to do," and (4) "I

sometimes feel I am being pushed around in my life." The internal (alpha) reliability of the perceived constraint scale is .86.

Twelve items measured the experience of dysphoric symptoms. Respondents indicated how often, during the past 30 days, they experienced each symptom: "none of the time," "a little of the time," "some of the time," "most of the time," or "all of the time." The symptoms are feeling (1) "so sad nothing could cheer you up," (2) "nervous," (3) "restless or fidgety," (4) "hopeless," (5) "that everything was an effort," (6) "worthless," (7) "cheerful," (8) "in good spirits," (9) "extremely happy," (10) "calm and peaceful," (11) "satisfied," and (12) "full of life." The internal (alpha) reliability of the dysphoria scale is .92; a higher score indicates the experience of more negative and less positive symptoms.

Finally, during the telephone interview, respondents indicated their physical health as poor, fair, good, very good, or excellent. Also during the telephone interview, respondents indicated whether "being optimistic" described them a lot, somewhat, a little, or not at all.

RESULTS

In Study 1 I retained items with a corrected item-to-scale correlation of .30 or higher as indicators of their respective constructs. Similarly, in Study 2 I retained items (three per scale) that did not suppress the internal reliability estimate as indicators of the latent construct. One indicator of social coherence in Study 2 suppressed the scale internal consistency; therefore I omitted it from further analysis. The retained items functioned as indicators of their respective latent constructs in confirmatory factor-analytic models examining the relative explanatory power of the theoretical model of social well-being. I used PRELIS 2 (Joreskog and Sorbom 1993a) to create the variance and covariance matrix, and I estimated the parameters and indices of fit of the measurement models using LISREL 8 (Joreskog and Sorbom 1993b).

To assess indicator-to-construct overlap in Study 1, I fitted the five-factor theoretical model to the variance-covariance matrix and observed the completely standardized modification index (CSMI). When each indicator

and latent construct is standardized, the CSMI is the predicted correlation of each indicator with a latent construct other than its own. An indicator with a CSMI of .40 or higher is a potentially overlapping item.

Next I refitted the theoretical model estimating the effect of the unrelated construct on the potentially overlapping item to the variance-covariance matrix. One item purportedly indicating social actualization overlapped (.40, or > completely standardized loading); therefore I omitted it.

Examination of higher-order sample moments revealed univariate and multivariate skewness and kurtosis in both Study 1 and Study 2. Because of the small sample size in proportion to the number of indicators in Study 1, I identified item-distribution transformations that minimized the value of Mardia's multivariate test of skewness and kurtosis (see Bollen 1989:423). The conclusions were the same regardless of item transformations, but the transformations slightly enhanced the fit of each model. Consequently, I show the results of maximum likelihood (ML) estimation based on the exponential transformation, which caused the greatest reduction in multivariate skew and kurtosis.

Because the sample in Study 2 was large enough, I derived parameter estimates through weighted least squares (WLS). Using PRELIS 2 to estimate the asymptotic variance-covariance matrix, I then employed WLS to weight the variance-covariance matrix by the inverse of the asymptotic variance-covariance. As a result, I achieved (in theory) distribution-free, asymptotically unbiased, efficient parameter estimates. In other words, WLS produces more accurate estimates than ML as sample size increases, especially when the indicator distributions are highly nonnormal (see Bollen 1989; Browne 1984). Because of the large sample size, the multivariate skew of the indicator distributions proved highly influential. The fit of all models was substantially better with WLS than with ML, although these estimators produced identical conclusions. Therefore I show only the estimates based on WLS.

Validation: Structure

Table 2 presents the chi-square index of

fit and the descriptive indices of fit of a series of models fitted to the variance-covariance matrices from Study 1 and Study 2. As a rule of thumb, values of goodness of fit and adjusted goodness of fit indices at .90 or higher signify models that fit the data very closely. The critical N estimates the sample size needed to reject the null hypothesis for a given model at a given level of alpha (.05) (see Bollen 1989). Critical Ns exceeding 200 represent adequate models; increasingly larger Critical Ns represent even better-fitting models. I do not entertain theories about measurement error correlations; that is, measurement error is presumed to be random.

Models 1 through 3 serve as null hypotheses. Model 1 asserts that there are as many latent constructs as indicators (i.e., indicators are not correlated). In contrast, Model 2 postulates that the relationship among indicators is the result of a single factor, which means that all indicators intercorrelate at about the same level. Model 3, however, posits that the relationship among indicators is explained by a negative-item and a positive-item factor. Model 3 is artifactual, because it posits that people respond not to the content but to the valence of the scale items, agreeing with all positively phrased items and disagreeing with all negatively phrased items.

Models 4 through 7 represent tests of whether some of the proposed dimensions of social well-being are distinct. Model 4 posits two latent constructs: One causes the indicators of social integration and social contribution, and the other causes the indicators of social coherence, social acceptance and social actualization.[3] Model 5 posits three latent constructs to test the distinctness of social coherence indicators from social acceptance and social actualization indicators. Thus one of these constructs still causes social integration and social contribution, but another causes only social coherence, while the third construct causes social acceptance and social actualization. Model 6 posits four latent constructs to test the theory that social integra-

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[3] The reduced theoretical models do not exhaust all possible combinations. The reduced theoretical models, based on conceptual similarity, are the best theoretical hunches about what constructs might not be distinct.

Table 2. Fit Estimates of Alternative and Theoretical Confirmatory Models of Social Well-Being

	Study 1: Dane County Sample Telephone Interview (N = 373) Maximum Likelihood[a]			
Model	Chi-Square	df	GFI (AGFI)	CN
1. Independence	3,747	464	.36 (.27)	54
2. Single Factor	1,556	464	.73 (.69)	130
3. Two-Factor Artifacts	1,521	463	.73 (.69)	132
4. Two-Factor Reduced Theory	1,259	463	.79 (.76)	160
5. Three-Factor Reduced Theory	1,178	461	.81 (.78)	170
6. Four-Factor Reduced Theory	1,044	458	.84 (.81)	190
7. Five-Factor Theory	914	454	.86 (.84)	216
	Study 2: National (Unweighted) Sample Self-Administered Questionnaire (N = 2,887) Weighted Least Squares			
Model	Chi-Square	df	GFI (AGFI)	CN
1. Independence	3,372	77	.76 (.67)	94
2. Single Factor	1,677	77	.88 (.84)	188
3. Two-Factor Artifact	1,446	76	.90 (.86)	216
4. Two-Factor Reduced Theory	1,211	76	.91 (.88)	257
5. Three-Factor Reduced Theory	1,002	74	.93 (.90)	304
6. Four-Factor Reduced Theory	740	71	.95 (.92)	396
7. Five-Factor Theory	705	67	.95 (.92)	397

Note: GFI(AGFI) = Goodness of fit index (adjusted goodness of fit index); CN = critical N.
Analyses in both samples are based on imputation of mean from a respondent's own extant items.
[a]Analysis based on exponential transformation of item distribution.

tion is a latent construct distinct from social contribution. Model 7 investigates whether social acceptance and social actualization are distinct latent constructs. In other words, Model 7 is the proposed five-factor theoretical model of social well-being.

To examine how well a model fits the data, I compared each model with the immediately preceding model, using the chi-square contrast. The difference in chi-square values between models is distributed approximately chi-square; degrees of freedom are equal to the difference in the degrees of freedom between models.

In Study 1, all chi-square contrasts show that each successive and more complex model provides a better fit to the data. In fact, the theoretical Model 7 is the best-fitting model, with a chi-square contrast of 32.5 (p < .001) to Model 6. The descriptive

indices of fit suggest that the theoretical five-factor model in Study 1 fits the data only adequately. Simulation studies, however, suggest that the average values of many descriptive indices decrease as sample size decreases and as the number of indicators increases (see Bollen 1989:277). The theoretical model in Study 1 therefore fits well despite the smaller sample size (N = 373) and the large number of indicators (32).

Study 2 replicates the superior fit of the theoretical five-factor model. Again, chi-square contrasts illustrate that each successive and more complex model fits the data more closely. In the end, the theoretical five-factor model provides an excellent fit to the data. The chi-square contrast in the theoretical model, in comparison with Model 6, is 8.75 (p < .005). Moreover, the goodness of fit indices exceed .90 and the critical N is nearly 400.

The descriptive statistics of the indicators and the scales also reveal the quality of the theoretical model. Only one estimate of the correlation of the indicator with its standardized latent construct (i.e., validity coefficient) fails to satisfy the .40 rule of thumb (see Appendix B). Whereas the confirmatory factor analyses supported the theory of five distinct latent factors, the descriptive statistics for the observed scales displayed in Table 3 show that all scales intercorrelate positively. Moreover, nearly all scales, even the reduced-item scales in Study 2, exhibit relatively high internal consistency. The scale of social coherence exhibits lower internal reliability in Study 1 but relatively higher reliability in Study 2. On the other hand, the scale of social acceptance was internally consistent in Study 1 but the set of items did not cohere well in Study 2. These lower internal consistencies may be lower because of sampling variation and because I added a new item to the scale of social acceptance in Study 2 to achieve balance between negative and positive items.

Validation: Correlations

Table 4 displays the correlations of the new scales with validition criteria. I use the z-statistic to assess whether a particular scale of social well-being correlates more strongly, as hypothesized, with a validation criterion. When I employ the average sample size across all correlations in Study 1 (Mn = 360), the standard deviation is .075; therefore the difference between two z-transformed coefficients in Study 1 must be at least .15 to be statistically significant at the .05 alpha level.[4] In Study 2, the standard deviation of the z-statistic is .026; the z-ratio therefore must meet or exceed .052 to be statistically significant at the .05 alpha level. In the discussion of results, I focus only on whether the hypothesized validation correlations are confirmed.

In Study 1, all new scales correlate negatively with anomie, but social actualization and social acceptance correlate more strongly, as predicted, with the scale of anomie. As the evaluation of the quality of society, anomie relates to those dimensions of social well-being which indicate the evolution and potential of society and the perception of the character and qualities of generalized others. Feelings of social integration and social contribution in Study 1 are higher among individuals who have recently been involved in their communities (i.e., in community action) than among people who have never been involved. As expected, integration is associated with maintaining recent prosocial ties in one's community.

An unanticipated finding was the strength of the association of recent community action with social contribution. Viewed in retrospect, attempting to solve a problem in one's community also could be considered productive activity that should be connected with a sense of contribution. Study 2, however, reveals the distinction between integration and contribution. As expected, social contribution correlates strongly with generativity: People who feel that they are socially valued also feel that they possess the personal resources and qualities needed to guide others. Social integration, on the other hand, correlates more strongly with the perceived health of one's neighborhood. Thus people who feel close to others in their community also feel that their neighborhoods are safe and that their neighbors are trustworthy.

Finally, social coherence correlates strongly, as predicted, with the scale of perceived constraints. Individuals who find the social world more unpredictable, more complex, and more incoherent also tend to view their own lives as complex affairs, full of insurmountable obstacles and unpredictable contingencies.[5]

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[4] Sample size varies for the correlations of community action with the scales of social wellness. Particularly interesting is the correlation of recent community action, in which adults who were involved in their communities during the past month (N = 128) are contrasted with adults who have never been involved (N = 167). As a result, the standard deviation of the z-statistic is .082, and the z-ratio must equal or exceed .164 to be statistically significant at the .05 alpha level.

[5] Some new scales in Study 1 are unbalanced. The imbalance, however, does not appear to systematically influence the correlations. Social coherence is the most imbalanced scale, consisting of only one positive item; the anomie scale, for example, consists of three negatively phrased items. Social actualization, a balanced scale, correlates more strongly, however, than social coherence with the scale of anomie. Recall, too, that the confirmatory two-factor artifact model (negative and positive) did poorly in explaining the relationship between the items, compared with the series of theoretical models of social well-being.

Table 3. Descriptive Statistics (Study 1 in Upper Diagonal, Study 2 in Lower Diagonal)

	1	2	3	4	5
1. Social Coherence	—	.45	.25	.42	.45
2. Social Actualization	.45	—	.41	.40	.53
3. Social Integration	.23	.33	—	.57	.42
4. Social Contribution	.35	.31	.42	—	.20
5. Social Acceptance	.23	.48	.35	.23	—
Study 1: Dane County Sample					
M	25.0	32.1	33.0	30.3	28.3
SD	4.1	5.7	6.2	5.2	6.4
Number of Items	5	7	7	6	7
Alpha Reliability	.57	.69	.81	.75	.77
Study 2: National Sample					
M	8.9	11.8	14.0	15.5	13.0
SD	3.3	4.3	4.4	3.8	3.5
Number of Items	2	3	3	3	3
Alpha Reliability	.64	.64	.73	.66	.41

Note: For all rs, $p < .01$ (two-tailed)

The scales of social well-being correlate, but do not appear to overlap, with extant measures reflecting psychological conceptions of mental health. The social well-being scales correlate positively and modestly with the indicators of life satisfaction and life happiness in Study 1.

In Study 2, these scales exhibit consistently modest and positive correlations with the scale of dysphoria. Because of the sample size and statistical efficiency of Study 2, social integration correlates slightly stronger with dysphoria than does any other scale of social well-being. On the other hand, although dysphoria correlates relatively strongly with physical health, all scales of social well-being display small but positive correlations with the indicator of subjective physical health. The new scales of social wellness therefore appear to measure aspects of mental health and life quality related to, but distinct from, depressive feelings and physical health.

None of the social well-being scales correlates very strongly with the perception of oneself as optimistic (range of r = .17 to .23). This finding suggests that appraisals of social well-being are not unduly influenced by optimism or possibly the tendency to exaggerate positive qualities.[6]

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[6] Because physical health and optimism are ascertained during the initial telephone interview, the

Validation: Social Structural Sources

Table 5 presents the regressions of each scale of social well-being on age and education. Each model estimates a quadratic (and linear) parameter for age to investigate the possible acceleration or deceleration in the predicted increase of social well-being with age. (Only the statistically significant effects shown, however.) All models also adjust for gender, race, and marital status, which could structure educational outcomes and possibly social well-being. The remaining background variables (e.g., income) either follow from education or explain the hypothesized age differences, and therefore are omitted from these models. The intercept represents the predicted level of social well-being for the average 18-year-old (Study 1) or 25-year-old (Study 2).[7]

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small correlations with the social well-being scales may reflect, in part, the mode of administration as well as the effect of the time lag between the telephone interview and the self-administered questionnaire.

[7] In Study 2, I show the multivariate analyses based on unweighted data because the results are the same regardless of sample weighting. The components of the sample weights in Study 2 are not functions of the outcomes in this study. Therefore multivariate models based on the unweighted data should therefore be unbiased and efficient if the model is specified correctly (see Winship and Radbil 1994).

Table 4. Product-Moment Correlations of Social Well-Being Scales with Validation Criteria

	1	2	3	4	5	6
Study 1: Dane County Sample						
1. Anomie Scale	—	-.21	-.04ns	-.18	-.16	
2. Recent Community Action (Never=0)		—	0.0	.27	.08ns	
3. Community Action in Past (Never=0)			—	.04ns	-.06ns	
4. Global Life Satisfaction				—	.46	
5. Global Happiness with Life					—	
6. Social Actualization	-.55	.20	.05ns	.26	.16	
7. Social Acceptance	-.49	.15^a	.05ns	.21	.14	
8. Social Integration	-.33	.41	.14^a	.32	.31	
9. Social Contribution	-.28	.46	.22	.27	.20	
10. Social Coherence	-.28	.24	.02ns	.20	.16	
M	1.2	.43	.32	3.4	3.5	
SD	1.1	.50	.47	.74	.67	
Study 2: National Sample						
1. Generativity Scale	—	.14	-.23	.17	.10	.24
2. Health of Neighborhood Scale		—	-.21	-.24	.16	.14
3. Perceived Constraints Scale			—	.49	-.28	-.30
4. Dysphoria Symptoms Scale				—	-.40	-.30
5. Subjective Physical Health					—	.15
6. Self-Described Optimistic						—
7. Social Actualization	.17	.21	-.32	-.25	.16	.18
8. Social Acceptance	.12	.24	-.22	-.22	.13	.17
9. Social Integration	.28	.39	-.26	-.33	.19	.23
10. Social Contribution	.49	.16	-.36	-.22	.15	.16
11. Social Coherence	.18	.13	-.41	-.28	.15	.21
M	17.0	13.6	18.7	24.9	3.5	3.3
SD	3.8	2.2	8.0	7.1	1.0	.77

Notes: For all *r*s, $p < .01$ (two-tailed) unless noted. One-hundred and twenty-eight respondents engaged recently in community action, 78 engaged in community action in the past, and 167 never engaged in community action.
$^a p < .05$; ns = not significant at alpha = .05.

The replication of age and educational differences in social well-being strongly suggests that social well-being is shaped by prominent social forces. For the average adult, acquisition of education evidently paves the way for successful responses to social challenges of life. With more education, each dimension of social well-being increases. Thus social wellness, like all other aspects of health (N. Adler et al. 1994), is graded by processes of social stratification.

Each dimension of social well-being also is distributed by age. Four dimensions increase with age. Social coherence, however, decreases with age, perhaps in part because the intelligibility of the world in American society is skewed toward the celebration of youthful culture. Compared with older adults, younger adults may find the world coherent because they can view a world that tends to reflect their own popular culture. Insofar as age has a nonlinear relationship to social well-being, the evidence favors the "deceleration viewpoint": Although social actualization and contribution increase with age, the increase decelerates with each added year of life in both Study 1 and Study 2. In other words, social well-being is heterogeneous across ages. This finding is consistent with studies showing the diversity of psychological well-being across age groups. For example, older adults report more environmental mastery but less purpose in life than younger adults (Ryff and Keyes 1995).

DISCUSSION

Life is purportedly divided into private and public sides, each making its own demands and producing its own consequences. Although we recognize the public demands on individuals, social psychologists have not always translated social challenges into criteria that individuals use to evaluate their well-being. We have conceived of social health less as the presence of positive criteria than as the absence of negative conditions such as anomie and alienation. Moreover, the emphasis on social structure may skew attention toward the public side of life as a source of variation in social health rather than inspiring us to explore the social nature of the meaning of health. Ultimately, current research relies on and possibly reflects a bias toward psychological conceptions of well-being. Researchers either focus on clinical symptomatology such as depression or use global measures of life satisfaction and happiness. Multidimensional models (Ryff 1989) emerge from classic personality theories that conceive of the self as primarily private.

The studies reported here present evidence giving credibility to the theory that well-being includes social dimensions. I operationalized and validated five dimensions of social well-being grounded in classic sociological theory and current social psychological perspectives. Data from two studies involving cross-sections of adults and utilizing different modes of administration (telephone and self-administration) provide strong evidence for the replicability of the latent structure of the new scales and the social structural profiles of dimensions of social well-being.

Confirmatory factor analysis showed that the hypothesized five-factor model of social wellness fits the data best in both studies. The findings suggest that putative social challenges are manifold and distinct. The new scales in Study 1 correlate convergently with anomie and community involvement. In Study 2, the new scales correlate convergently with generativity, neighborhood health, and perceived constraints. In both studies, these scales correlate with global indicators of life satisfaction, happiness, and dysphoria. Thus the new scales clearly link, but do not overlap, with extant measures of mental health, which tend to reflect a psychological conception of well-being. Each scale of social well-being, even social actualization, which emphasizes society's potential and progress, correlates only minimally with self-defined optimism. In short, this study suggests that life includes numerous social challenges; therefore well-being includes social dimensions such as coherence, integration, actualization, contribution, and acceptance.

Society, too, is a source of variation in social wellness. Social structural profiles corroborate the theory that social wellness is an accomplishment. Social well-being increases with education and, in general, with age. Like other measures of mental health and well-being, it is graded by socioeconomic standing. It remains to be seen, however, whether the same processes (e.g., self-conception) and dimensions (e.g., agency) explain how each aspect of social structure affects each type of mental health and well-being.

The relatively strong association of prosocial community involvement with aspects of social well-being also supports the posited achievement of a well-lived life. Individuals involved in their communities during the past 12 months, but not people involved more than 12 months previously, reported feeling more socially integrated and socially contributive than people who had never been involved.

Despite the unity of measures of social wellness, it is also clear that social well-being, like psychological well-being, is related to age in diverse ways. Some aspects of social well-being decrease linearly; others increase linearly; still others increase, but at a decelerating rate. The results therefore suggest that the resources, skills, and experience gained through education and its sequelae, as well as through aging processes, are instrumental to negotiating the challenges of social life.

According to Nisbet (1953:15), and as quoted by Seeman (1959), the various synonyms for alienation testify to the importance of the construct of alienation. The social scientific conception of a well-lived life also relies on the image of the isolated

Table 5. OLS Regressions of Social Well-Being Scales on Age and Education

	Study 1 (N = 368) Dane County Sample		Study 2 (N = 2,977) National (Unweighted) Sample	
	b	β	b	β
Social Actualization				
Age	.17*	.49	.06**	.19
Age^2	-.003**	-.58	-.001**	-.18
Up to 12 years education	—	—	—	—
13 to 15 years education	2.2**	.18	.73**	.08
16 or more years education	3.1**	.27	1.7**	.19
Alpha	29.0		10.5	
Social Acceptance				
Age	.21*	.52	.04**	.16
Age^2	-.003*	-.43	.00	.00
Up to 12 years education	—	—	—	—
13 to 15 years education	2.2*	.16	.50**	.07
16 or more years education	2.5**	.19	1.2**	.15
Alpha	24.9		12.0	
Social Integration				
Age	.07**	.19	.06**	.17
Up to 12 years education	—	—	—	—
13 to 15 years education	2.3**	.17	.26	.03
16 or more years education	3.2**	.25	1.3**	.14
Alpha	30.7		12.9	
Social Contribution				
Age	.14*	.49	.05*	.17
Age^2	-.003*	-.49	-.002**	-.26
Up to 12 years education	—	—	—	—
13 to 15 years education	1.8**	.16	1.1**	.14
16 or more years education	3.4**	.32	2.9**	.35
Alpha	27.6		14.3	
Social Coherence				
Age	-.03*	-.13	-.03**	-.09
Up to 12 years education	—	—	—	—
13 to 15 years education	1.3**	.15	.90**	.13
16 or more years education	2.5**	.30	1.9**	.26
Alpha	24.7		8.0	

Note: Age = Age - lower age bound (age 18 in Study 1; age 25 in Study 2). All estimates adjusted by gender, race, and marital status.
* $p < .05$; ** $p < .01$ (two-tailed).

individual. That is, the paragons of the good life are happy and satisfied with their private lives, and they possess personal qualities indicative of psychological well-being. We are left to wonder, however, about the quality of such individuals' lives as lived with and for other people and for society. By operationalizing well-being through satisfaction in domains of life such as family and work, sociologists have implicitly questioned the conception of the individual as a disconnected social entity, but have not transformed this notion. Even anomie, the classic conception of the absence of social health, covers only the conceptual territory of social well-being that measures society's trajectory and potential (social actualization) and the character of society through people's character (social acceptance). As Nisbet states, life is a quest to belong. The quest for the good life, however, has many meanings, some of which are represented in the proposed five-factor model of social well-being.

In addition to exploring life for more social dimensions of well-being, future researchers on positive mental health and well-being face numerous tasks. An immediate task is to investigate the relationships

between measures of mental health and well-being that purportedly reflect distinct constructs. For example, are measures of psychological well-being truly distinct from measures of social well-being? At stake is the hypothesis that the challenges and labor of adulthood originate in the fundamental division of public and private life.

If life, in both its public and its private details, is the source of the dimensions of wellness, to what extent are the social and psychological challenges bound by culture? What, in turn, are the mediators and the various structural sources of each type of well-being? I repeat Thoits's (1995) call for the use of multiple outcome measures in studies of health and well-being. Progress depends, however, on the development and use of models of well-being that measure the array of human functions, ranging not only from negative to positive but also from psychological to social.

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Appendix A. Indicators of Social Well-Being Constructs

Social Integration
Study 1
2. You don't feel you belong to anything you'd call a community (-).
14. You feel like you're an important part of your community (+).
17. If you had something to say, you believe people in your community would listen to you (+).
27. You feel close to other people in your community (+).
30. You see your community as a source of comfort (+).
44. If you had something to say, you don't think your community would take you seriously (-).
50. You believe other people in society value you as a person (+).
Study 2
2. I don't feel I belong to anything I'd call a community (-).
6. I feel close to other people in my community (+).
11. My community is a source of comfort (+).

Social Acceptance
Study 1
7. You think that other people are unreliable (-).
9. You believe that people are kind (+).
18. You believe that people are self-centered (-).
26. You feel that people are not trustworthy (-).
33. You think that people live only for themselves (-).
41. You believe that people are more and more dishonest these days (-).
46. You think that people care about other people's problems (+).
Study 2:
3. People who do a favor expect nothing in return (+).
10. People do not care about other people's problems (-).
14. I believe that people are kind (+).

Social Contribution
Study 1
4. Your behavior has some impact on other people in your community (+).
5. You think you have something valuable to give to the world (+).
37. Your daily activities do not produce anything worthwhile for your community (-).
40. You don't have the time or energy to give anything to your community (-).
42. You think that your work provides an important product for society (+).
49. You feel you have nothing important to contribute to society (-).
Study 2
4. I have something valuable to give to the world (+).
7. My daily activities do not produce anything worthwhile for my community (-).
15. I have nothing important to contribute to society (-).

Social Actualization
Study 1
6. You believe that society has stopped making progress (-).
8. Society isn't improving for people like you (-).
19. You don't think social institutions like law and government make your life better (-).
21. You see society as continually evolving (+).
25. You think our society is a productive place for people to live in (+).
38. For you there's no such thing as social progress (-).
45. You think the world is becoming a better place for everyone (+).
Study 2
5. The world is becoming a better place for everyone (+).
9. Society has stopped making progress (-).
13. Society isn't improving for people like me (-).

Social Coherence
  Study 1
    3. The world is too complex for you (-).
    10. Scientists are the only people who can understand how the world works (-).
    13. You cannot make sense of what's going on in the world (-).
    15. Most cultures are so strange that you cannot understand them (-).
    20. You think it's worthwhile to understand the world you live in (+).
    29. You find it hard to predict what will happen next in society (-).
  Study 2
    1. The world is too complex for me (-).
    8. I cannot make sense of what's going on in the world (-).
    12. I find it easy to predict what will happen next in society (+).

Notes: A negative sign in parentheses indicates that the item is reverse scored, where response options range from strongly, moderately, or slightly disagree to slightly, moderately, or strongly agree. (2) The item numbers correspond to the item numbers and their measurement qualities reported in Table 2 (Appendix). In study 2, item 12 that indicates Social Coherence was omitted from Study 1 because it suppressed the internal reliability of the scale.

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Appendix B. Estimates of Parameters of Theoretical Social Well-Being Measurement Model

Construct	Item	Dane County Sample		National (Unweighted) Sample	
		Metric Loading	Validity Coefficient	Metric Loading	Validity Coefficient
Social	6	f1.0	.56	1.8	.46
Actualization	8	1.0	.62	1.4	.78
	45	.54	.48	f1.0	.62
	19	.74	.46		
	21	.75	.47		
	25	.89	.57		
	38	1.0	.62		
Social	7	f1.0	.56		
Acceptance	9	.99	.58	1.8	.41
	46	.84	.60	4.3	.70
	18	.62	.51		
	26	1.1	.68		
	33	1.1	.60		
	41	.80	.58		
	43[a]			f1.0	.18
Social	2	f1.0	.46	f1.0	.59
Integration	27	1.2	.66	1.2	.78
	30	1.1	.57	1.1	.74
	14	1.3	.65		
	17	1.2	.66		
	44	1.2	.64		
	50	1.1	.65		
Social	5	f1.0	.59	f1.0	.58
Contribution	37	1.2	.65	1.3	.57
	49	1.2	.74	1.5	.80
	40	1.1	.64		
	42	1.2	.60		
	4	.86	.49		
Social	3	f1.0	.43	f1.0	.61
Coherence	13	1.2	.47	1.3	.77
	15	1.3	.55		
	10	.90	.44		
	20	.92	.46		

Notes: f1.0 = indicator is used to fix the metric of the latent construct. The item number refers to the order of the item in the 50-item pool in Study 1; the item number also references the item in Appendix A.
[a]The indicator used to set the metric of Social Acceptance in Study 2 was not retained in Study 1, but was used in Study 2 in an attempt to achieve a more balanced scale.