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**Mental Health in the CDS Youth:  
Is America's Youth Flourishing?**

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## Abstract

A continuous assessment and a categorical diagnosis of the presence of mental health, described as flourishing, and the absence of mental health, characterized as languishing, are proposed and applied to data from the second wave of the Child Development Supplement (CDS-II) of the PSID, in which a comprehensive set of subjective well-being items were administered to youth ages 12 to 18. Youth indicated how frequently during the past month they experienced 3 symptoms of emotional well-being, 4 symptoms of psychological well-being, and 5 symptoms of social well-being. Keyes' (2002) criteria for the categorical diagnosis and continuous assessment of the mental health continuum were applied, and findings revealed that approximately 38 percent were flourishing, 56 percent were moderately mentally healthy, and 6 percent were languishing. Depressive symptoms decreased as mental health increased; languishing youth reported 10.9, moderately mentally healthy youth reported 3.4, while flourishing youth reported an average of 1.4 depressive symptoms. Prevalence of conduct problems (arrests, skipped school, alcohol use, cigarette smoking, and marijuana use) also decreased, and measures of psychosocial functioning (global self concept, self-determination, closeness to others, and school integration) increased as mental health increased. Findings suggest the importance of focusing on mental health as the presence of sufficient levels of subjective well-being in research on adolescent development.

### **Mental Health in the CDS Youth: Is America's Youth Flourishing?**

Depression—an exemplar of mental illness—appears to be prevalent in children and youth. Nearly one in every ten children has an episode of major depression before their 14<sup>th</sup> birthday (Garrison, Schluchter, Schoenbach, & Kaplan, 1989). By the time they can legally vote, drive a car, and drink alcohol in some states (i.e., roughly 16-17 years of age) as much as 20% of youth will have had some form of an anxiety or mood disorder or some form of a disruptive or substance use disorder (Lewinsohn, Hops, Roberts, & Seeley, 1993; Shaffer, Fisher, Dulcan, Davies, Piacentini, Schwab-Stone, Lahey, Bourdon, Jensen, Bird, Canino, & Regier, 1996). The onset of depression is routinely linked to downward spirals in behavior and quality of academic performance. That is, depressed youth are more likely to exhibit the markers of the “turbulent” adolescent than non-depressed youth. Depressed youth are more likely to smoke cigarettes, to report substance use and abuse, to exhibit conduct disorders, to experience academic problems, and ultimately to drop out of school (Angold & Costello, 1993; Berndt, Koran, Finkelstein, Glenberg, Kornstein, Miller, Thase, Trapp, & Keller, 2000; Covey, Glassman, & Stetner, 1998; Nolen-Hoeksema, Girgus, & Seligman, 1992; Rohde, Lewinsohn, & Seeley, 1991).

Research has aimed to assess the mental health of America's children and youth by focusing on the measurement of mental illness. While it is clear that children with depression are not mentally healthy, it is extremely dubious to assume that children without a mental illness are necessarily mentally healthy. Despite proclamations about health as a complete state (World Health Organization, 1948), research has equated the health and well-being of children, youth, as well as adults with the absence of disease,

illness, disability, and malfunctioning. Measures of subjective well-being were developed to assess the mental health and well-being in terms of the presence of positive feelings toward one's life and the level of functioning well in life (e.g., Diener, Emmons, Larsen, & Griffin, 1985; Keyes, 1998; Ryff, 1989).

Subjective well-being is the evaluation and declarations that individuals make about the quality of their lives that are based on the review, weighting, and summation of the quality of experiences, accomplishments, relationships, and other culturally relevant and valued ways of functioning in life (Diener, Suh, Lucas, & Smith, 1999; Keyes, Shmotkin, & Ryff, 2002). Subjective well-being research has been adult-centric and narrowly focused on happiness (e.g., Bradburn, 1969; Campbell, Converse, & Rodgers, 1976; Diener & Emmons, 1985; Diener et al., 1999; Kahneman, Diener, & Schwartz, 1999). Although subjective well-being seems to be synonymous with emotions like happiness, there is increasing recognition of the different theoretical streams of inquiry guiding this important domain of inquiry (Keyes et al., 2002; McGregor & Little, 1998; Ryan & Deci, 2001, Ryff, 1989; Waterman, 1993). Moreover, there is a growing body of research on the well-being of children and youth that is more inclusive (see Bornstein, Davison, Keyes, & Moore, 2003).

The study of subjective well-being has been divided into two streams of research, one that equates well-being with happiness and the other with human potential that, when realized, results in positive functioning in life. The streams of subjective well-being research grew from deeply ingrained, philosophically ancient, and fertile contemporary viewpoints that animate human thought and conduct. The first is the hedonic tradition that embodies human concerns with maximizing the amount or duration of positive,

pleasant feelings while minimizing the amount or duration of negative, unpleasant feelings. The hedonic tradition is reflected in the stream of research on *emotional* well-being, which consists of perceptions of avowed happiness and satisfaction with life, and the balance of positive to negative affect over a period of time. Whereas happiness is based upon spontaneous reflections of pleasant and unpleasant affects in one's immediate experience, life satisfaction represents a long-term assessment of one's life.

The second is the tradition of eudaimonia that animates human concerns with developing nascent abilities and capacities toward becoming a more fully functioning person and citizen. This tradition is reflected in the stream of research on *psychological* (Ryff, 1989) and *social* (Keyes, 1998) well-being that reflect how well individuals see themselves functioning in life. Ryff's (1989; Ryff & Keyes, 1995) multidimensional model includes six dimensions of psychological well-being indicates the challenges that individuals encounter as they strive to function fully and realize their unique talents. The six dimensions encompass a breadth of well-being: Positive evaluation of oneself and one's past life (i.e., self-acceptance), a sense of continued growth and development as a person (i.e., personal growth), the belief that one's life is purposeful and meaningful (i.e., purpose in life), the possession of intimate relationships (i.e., positive relations with others), the capacity to manage effectively one's life and surrounding world (i.e., environmental mastery), and a sense of self-determination (i.e., autonomy). Keyes' (1998) multidimensional model of social well-being consists of five dimensions that indicate whether and to what degree individuals are functioning well in their social world (Keyes, 1998). The measures assess individual's sense of belongingness (i.e., social integration), sense of value to society (i.e., social contribution), sensibility and

meaningfulness of the social world (i.e., social coherence), sense of potential for continued growth in social institutions and society (i.e., social actualization), and one's degree of comfort and acceptance of other people (i.e., social acceptance).

Though each dimension of subjective well-being represents an important domain of study in itself, Keyes (2002, 2003, 2004, 2005) has also proposed that these scales collectively measure the presence and absence of mental health. That is, mental health, like mental illness, is a syndrome of symptoms of subjective well-being. The diagnosis of states of mental health was modeled after the DSM-IV-TR (American Psychiatric Association, 2000) approach to the diagnosis of major depressive episode (MDE). That is, a diagnosis of depression is made when an individual's report of symptoms meet a diagnostic threshold, i.e., in this case, 5 of 9 symptoms experienced all the time or most of the time for a period of at least two consecutive weeks, at least one symptom represents depressed affect (i.e., depressed mood or anhedonia) and the remaining represent malfunctioning. Similarly, a diagnosis of mental health (i.e., flourishing in life) is made when an individual exhibits a high level on at least one symptom of hedonia and just over half of the symptoms of eudaimonia, i.e., positive functioning in life. Individuals are diagnosed as languishing in life when they exhibit a low level on at least one symptom of hedonia and low levels on just over half of the symptoms of positive functioning. Individuals who are neither flourishing nor languishing in life are diagnosed as moderately mentally healthy.

The items used to measure each facet of subjective well-being in adults were modified slightly to be appropriate for youth and included in the second wave of the Child Development Supplement (CDS-II). Factor analyses of the CDS-II subjective

well-being items support the aforementioned threefold distinction. That is, the three-factor model was the best-fitting model to these data, suggesting that measure of emotional well-being, psychological well-being, and social well-being reflect three distinct but correlated latent factors (Keyes, *in press*). The correlations between the latent factors, as well between the subjective well-being scales, were modest and ranged from .57 to .71.

The subjective well-being measures in the CDS-II showed excellent construct validity. The subjective well-being measures correlated relatively strongly and positively with the scale Marsh scale of global self concept, a scale that measured self-determination (a form of efficacy), and a scale that measure the child's sense of integration into their school integration. Each measure of subjective well-being also correlated modestly and negatively with the Kovacs child depression inventory, and modestly and positively with a measure of the child's perceived closeness to significant others (i.e., adults, family and friends) and with the child's self-rated overall health. Each measure of subjective well-being correlated positively but weakly with perceived level of math skill and perceived level of reading skill.

Thus, the CDS-II well-being items are used to replicate the mental health diagnosis proposed by Keyes (2002; 2005). Youth indicated how frequently during the past month they experienced 3 symptoms of emotional well-being, 4 symptoms of psychological well-being, and 5 symptoms of social well-being. Youth were diagnosed as flourishing if they experienced at least one of the three symptoms of emotional well-being and at least five of the nine symptoms of positive functioning “almost every day” or “every day” during the past 30 days. Youth were diagnosed as languishing if they

experienced at least one of the three symptoms of emotional well-being and at least five of the nine symptoms of positive functioning “once or twice” or “never” during the past 30 days. Youth who were neither languishing nor flourishing were diagnosed as moderately mentally healthy, meaning they experienced the symptoms of well-being “about once a week” or “two or three times a week” during the past 30 days. Using this diagnosis, the purpose of the present study is to (1) estimate the prevalence of mental health (i.e., flourishing) in the population of U.S. youth between the ages of 12 and 18, and (2) investigate the associations of level of mental health with depressive symptoms and conduct problems, and (3) investigate the associations of level of mental health with level of psychosocial functioning.

## Methods

### *Sample*

Data are from the Child Development Supplement (CDS) of the Panel Study of Income Dynamics (PSID), an ongoing national survey begun in 1968 that focuses on the transfer of social and economic capital within families. In 1997, all families participating in the PSID in 1997 with children between the ages of 0 and 12 years old were asked to complete the CDS, resulting in a sample of 3,563. Out of all CDS-I families, a total of 94% of the children had parents who had remained active in the PSID as of 2001 ( $n=3,271$ ), and these children were re-interviewed (i.e., CDS-II) during the fall of 2002 and spring of 2003, resulting in a sample of 2,907 children and youth ages 5-18. As such, the data collection response rate for the CDS-II is estimated at 91%.

The subjective well-being measures were administered for the first time in the CDS-II, and only to youth ages 12 or older. The measures of subjective well-being were

administered by audio-computer assisted self-interview, whereby youth listened to each question on a headphone and responded directly into a computer laptop that displayed the question and the response options. Descriptive analyses used population weights for the child data, provided by the PSID, to more accurately represent the nation's children. All multivariate analyses are conducted twice, once with the sample weighted and once without the sample weighted. Because conclusions of the multivariate analyses were unchanged by the sample weight, only the non-weighted findings are reported.

### *Measures*

The twelve subjective well-being items were adapted from the Midlife in the United States (MIDUS) study of adults (Keyes & Magyar-Moe, 2003), which comprehensively assessed adult well-being in terms of emotional, psychological, and social well-being. Emotional well-being in the CDS-II was measured with three items that asked youth how often during the past month they had felt (1) happy, (2) interested in life, and (3) satisfied. The response options for emotional as well as psychological and social well-being items were as follows: “never,” “once or twice,” “about once a week,” “two or three times a week,” “almost every day,” and “every day.”

Four of the six theoretical dimensions of psychological well-being were measured in the CDS-II: Environmental mastery, positive relations with others, personal growth, and autonomy. Purpose in life and self acceptance were not measured in the CDS-II because self esteem, a closely related measure of self acceptance was already part of the CDS, and purpose in life did not seem to be a pertinent question for pre-high school youth, and we wanted to obtain measures on all youth between the ages of 12 and 18. Environmental mastery was measured as “how often did you feel good at managing the

responsibilities of your daily life” in the past month. Positive relationships with others was measured as “how often did you feel that you have warm and trusting relationships with other kids?” in the past month. Personal growth was measured as “how often did you feel that you have experiences that challenge you to grow or become a better person?” in the past month. Autonomy was measured as “how often did you feel confident to think or express your own ideas and opinions?” in the past month.

The five dimensions of social well-being were measured in the CDS-II. However, and as with the measurement of psychological well-being, only a single item deemed most representative of the construct was chosen to measure social well-being. Social contribution was measured as “how often did you feel that you had something important to contribute to society?” in the past month. Social integration was measured as “how often did you feel that you belonged to a community like a social group, your school, or your neighborhood?” in the past month. Social actualization was measured as “how often did you feel that our society is becoming a better place?” in the past month. Social acceptance was measured as “how often did you feel that people are basically good?” in the past month. Social coherence was measured as “how often did you feel that the way our society works made sense to you?” in the past month.

*Depression and Conduct Problems.* Youth completed the Child Depression Inventory (CDI; Kovacs, 1992), which is a self-report instrument that is an extension of the Beck Depression Inventory (Kovacs & Beck, 1977), and it is designed to assess depression in youth ages 8 or older. The CDI contains 27 items, only 10 of which were used in the CDS-II. The 10-item CDI consists of items that have been shown to measure the latent factors of dysphoria, self-deprecation, and social problems in adolescents ages

13 to 17 (see e.g., Craighead, Smucker, Craighead, & Ilardi, 1998). Each CDI item consists of three statements that are graded in severity and are assigned numerical values from 0 to 2, and the scale is scored in the direction of more severe depressive symptoms. The 27-item CDI usually demonstrates high internal consistency (.80 or higher), and the internal (alpha) reliability of 10-item CDI in the CDS-II is .89. Conduct problems were measured with single items based on self-reports. Youth reported either the number of times or whether they had ever skipped school, been arrested, smoked cigarettes, drank alcohol, smoked marijuana, or used inhalants to get high.

*Psychosocial Functioning.* The global self concept scale (Marsh, 1990) is a 6-item scale involves items that measure the amount of time youth feel good about themselves. The six self descriptive statements are (1) “I have a lot to be proud of,” (2) “I can do things as well as most people,” (3) “I’m as good as most other people,” (4) “Other people think I am a good person,” (5) “When I do something, I do it well,” and (6) “A lot of things about me are good.” Youth indicate how much of the time—“never,” “rarely,” “sometimes,” “most of the time,” or “always”—each statement applies to them. The internal (alpha) reliability of the self concept scale is .84. Using the same response options, five items were used to measure youth’s self-determination. The self descriptive statements are (1) “I stay with a task until I solve it,” (2) “Even when a task is difficult, I want to solve it anyway,” (3) “I keep my things orderly,” (4) “I try to do my best on all my work,” and (5) “When I start something, I follow it through to the end.” The internal (alpha) reliability of the self-determination scale is .77.

Youth also were asked how close they felt toward six individuals—mother (or stepmother), father (or stepfather), sibling, friends, teacher, or other adults outside of

school. Respondents indicated whether they felt “extremely,” “quite,” “fairly,” or “not very” close to each of the six individuals. A total score was constructed by measuring the number of individuals of the six toward which a youth felt either “quite close” or “extremely close.” A higher score on this variable indicates a higher number of individuals toward which a youth feels close. In turn, a 4-item scale, with an internal (alpha) reliability of .70, measured perceived school integration and quality. The items measured how often youth felt (1) part of their school, (2) close to people at their school, (3) happy to be at their school, and (4) safe at their school. The response options included “never,” “once or twice in the last month,” “about once a week,” “two or three times a week,” “almost every day,” and “every day.”

### Results

Is America’s youth flourishing? Toward that end, the first research question investigates the prevalence of mental health among youth between the ages of 12 and 18. The categorical diagnosis and the continuous assessment yield very similar estimates of the prevalence of mental health; using the cut-point of an average score of 5 or 6 on the continuous assessment yields an estimate of 38.3%, compared with the categorical diagnostic estimate of 37.9%. In turn, the categorical diagnosis and the continuous assessment also yield very similar estimates of the prevalence of moderately mentally healthy; using the cut-point of an average score of 3 or 4 on the continuous assessment yields an estimate of 55.4%, compared with the categorical diagnostic estimate of 55.9%. Similarly, the categorical diagnosis and the continuous assessment yield almost identical estimates of the prevalence of languishing; using the cut-point of an average score of 1 or 2 on the continuous assessment yields an estimate of 6.3%, compared with the categorical

diagnostic estimate of 6.2%. Thus, findings suggest more youth—i.e., about one-half—are moderately mentally healthy than are mentally healthy (i.e., about 4 in 10 are flourishing), while a small portion (i.e., 6%) are languishing.

[Insert Figures 1a and 1b about Here]

To ascertain whether America's youth is flourishing, this paper also investigated the association of depression, conduct problems, and psychosocial functioning with the mental health diagnosis. In other words, are youth diagnosed as flourishing also more likely to be flourishing in life with less depression, fewer conduct problems, and better psychosocial functioning? Figures 1a and 1b report the mean level of depressive symptoms as measured by the CDI by the categorical diagnosis and the continuous assessment of mental health. Languishing youth reported an average of 10.4 (SD=13.6) symptoms of depression, moderately mentally healthy youth reported an average of 3.9 (SD=10.1) symptoms, and flourishing youth reported on average 1.4 (SD=3.1) depressive symptoms. Pairwise contrasts using the Tukey *Honestly Significant Difference* test revealed that all possible comparisons of mean-level depressive symptoms by mental health category were statistically significant at  $p < .001$  level. Thus, languishing youth reported 2.7 times as many depressive symptoms as moderately mentally healthy youth, and over 7.4 times as many depressive symptoms as flourishing youth. Moreover, moderately mentally healthy youth reported 2.8 times as many depressive symptoms as flourishing youth.

[Insert Table 1 about Here]

Table 1 reports the association of conduct problems with categorical diagnosis and continuous assessment of mental health. For simplicity, and because the findings are

comparable between each approach to mental health, the discussion will focus only on the categorical diagnosis. The findings indicate a consistent and linear relationship between conduct problems and level of mental health. All conduct problems—arrest, skipped school, smoking cigarettes or marijuana, alcohol or inhalant use—are more prevalent among languishing youth than moderately mentally healthy youth. In turn, all conduct problems other than the use of inhalants are more prevalent among moderately mentally youth than youth diagnosed as flourishing. Moreover, one-quarter of languishing youth reported three or more of the conduct problems, compared with 12.9% of moderately mentally healthy youth and only 6.5% of flourishing youth reported three or more conduct problems. In sum, flourishing youth are least likely to report conduct problems, while languishing youth are most likely to report any conduct problem as well as to report multiple conduct problems.

[Insert Table 2 about Here]

Table 2 reports the mean levels of measures of psychosocial functioning by level of mental health. Focusing again on the categorical diagnosis, the findings support the hypothesis that flourishing youth are functioning better than moderately mentally healthy or languishing youth. Youth diagnosed as flourishing report a higher level of global self concept (representative item: “A lot of things about me are good”) than moderately mentally healthy youth, who report a higher level of global self concept than languishing youth. Self-determination (representative item: “I try to do my best on all my work”) is highest among flourishing youth, followed by moderately mentally healthy youth, and lowest among youth diagnosed as languishing. Flourishing youth report feeling close to more people ( $M=4.2$ ;  $SD=1.4$ ) than moderately mentally healthy ( $M=3.3$ ;  $SD=1.4$ ), who

felt close to more people than languishing youth ( $M=2.6$ ;  $SD=1.4$ ). Youth diagnosed as flourishing report a higher level of school integration (i.e., feel more a part of their school, close to people at their school, happy to be at their school, and safe at their school) than moderately mentally healthy youth, who report a higher level of school integration than languishing youth. In sum, flourishing youth report the highest levels on all four measures of psychosocial functioning, while languishing youth report the lowest levels on all four measures.

### Discussion

Before the age of 18, the best-estimate of the population 2 in every 10 children and youth will have had some form of mental illness (Shaffer et al., 1996). Not only is mental illness common in youth, it is debilitating and hinders the social, emotional, and academic development of youth. While the focus on mental illness is unassailable, the presumption that children and youth who are not mentally ill must be mentally healthy is tenuous. Studies show that measures of common mental disorders such as depression and anxiety load on separate latent factors than measures of subjective well-being (Headey, Kelley, & Wearing, 1993; Keyes, 2005). Moreover, correlations among the measures of subjective well-being in the CDS-II and the CDI short form scale of depression were modest, ranging from  $-.23$  to  $-.33$  (Keyes, in press). In short, the absence of mental illness does not necessarily imply the presence of mental health.

The purpose of this study was to operationalize the diagnosis and assessment of the mental health continuum to CDS-II data to investigate whether America's youth ages 12 to 17 are flourishing. To that end, three descriptive research questions were explored. First, how many youth are mentally healthy, or flourishing, and how many are mentally

unhealthy, or languishing (i.e., prevalence)? Second, do flourishing youth report less depressive symptoms and fewer conduct problems than moderately mentally healthy or languishing youth? Third, are flourishing youth functioning better both psychologically and socially than moderately mentally healthy or languishing youth?

Findings suggests that fewer youth are mentally healthy—nearly 40%—than would be implied by taking the obverse of the best-estimate (i.e., Shaffer et al., 1996) of any mental disorder in youth, which would imply that about 80% of youth are free of a mental illness and therefore mentally healthy. Over one-half—i.e., 55%—of youth fit the criteria for moderate mental health, while 6% were mentally unhealthy, as they fit the criteria for languishing. Moreover, findings support the descriptive hypotheses that flourishing youth function better than moderately mentally healthy youth, who in turn function better than languishing youth. Flourishing youth had the *fewest* depressive symptoms and conduct problems, and the *highest levels* of global self-concept, self-determination, closeness to other people, and school integration. Languishing youth had the *highest number* of depressive symptoms and conduct problems, and the *lowest levels* of global self-concept, self-determination, closeness to other people, and school integration.

While results of this study suggest a promising line of future research on the mental health continuum in children and youth, caution is warranted in placing too much credence to the current prevalence estimates. Although the measures of subjective well-being exhibited construct validity, the data are nonetheless self-report and the diagnoses have not been corroborated by expert clinical judgments. Future research should investigate convergence of the child's and youth's reports of subjective well-being with

parent's and teacher's reports of the child's and youth's well-being. Moreover, research should investigate the degree of correspondence of the diagnoses with school counselor and clinical, psychiatric workup of mental health.

Although more clinical research is needed to examine the nosology of mental health, continued research on the epidemiology of children's mental health in the CDS-II can point toward new directions for prevention and for the study of resilience. Findings from the present study indicate that flourishing in youth is associated with developmentally desirable outcomes (e.g., low depression, few conduct problems, and high psychosocial functioning). What youth are most likely to be flourishing, what factors (intrapersonal, familial, educational, and community) explain how youth come to flourishing over time, could provide new insights for promoting positive development and resilience in youth and their transition into adulthood.

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Table 1  
*Prevalence and Association of Level of Mental Health with Conduct Problems (sample weighted)*

	Categorical Diagnosis			Continuous Assessment						Total (n=1,234)
	Mentally Unhealthy, <i>Languishing</i>	Moderately Mentally Healthy	Mentally Healthy, <i>Flourishing</i>	1 Never	2 Once or Twice	3 About Once a Week	4 Two or Three Times a Week	5 Almost Every Day	6 Every Day	
	6.2% (n=79)	55.9% (n=718)	37.9% (n=487)	1.3% (n=16)	5.0% (n=62)	19.8% (n=244)	35.6% (n=440)	33.8% (n=417)	4.5% (n=56)	
Ever Arrested	12.7% (10)	6.6% (46)	1.4% (7)	12.5% (2)	11.5% (7)	11.9% (29)	4.1% (18)	1.5% (6)	1.8% (1)	5.1% (63)
Ever Skipped School	29.3% (24)	21.0% (153)	11.2% (55)	29.4% (5)	27.7% (18)	24.6% (60)	18.8% (83)	11.9% (50)	7.0% (4)	17.7% (220)
Smoked Cigarettes	26.8% (22)	16.3% (119)	8.5% (42)	0 (0)	37.5% (24)	29.5% (72)	10.2% (45)	7.9% (33)	10.5% (6)	14.5% (180)
Drank Alcohol	47.6% (39)	48.7% (354)	36.8% (181)	25.0% (4)	57.8% (37)	58.2% (142)	43.7% (193)	40.0% (168)	32.1% (18)	45.2% (562)
Smoked Marijuana	19.5% (16)	10.9% (79)	6.1% (30)	0 (0)	21.9% (14)	18.9% (46)	7.9% (35)	6.0% (25)	7.0% (4)	10.0% (124)
Used Inhalants	7.3% (6)	0.3% (2)	0 (0)	0 (0)	9.4% (6)	0.4% (1)	0 (0)	0 (0)	0 (0)	0.6% (7)
Three or More Conduct Problems	25.3% (21)	12.9% (94)	6.5% (32)	0 (0)	26.2% (17)	23.4% (57)	9.0% (40)	6.4% (27)	7.1% (4)	11.7% (145)

Note: All  $\chi^2$  p < .001 (two-tailed).

Table 3

*Mean Levels of Psychosocial Functioning by Level of Mental Health (standard deviations in parentheses; sample weighted)*

	Categorical Diagnosis			Continuous Assessment						Total n=1,234
	Mentally Unhealthy, <i>Languishing</i>	Moderately Mentally Healthy	Mentally Healthy, <i>Flourishing</i>	1 Never	2 Once or Twice	3 About Once a Week	4 Two or Three Times a Week	5 Almost Every Day	6 Every Day	
	n=79	n=718	n=487	n=16	n=62	n=244	n=440	n=417	n=56	
Global Self Concept	18.8 (4.2)	22.9 (3.5)	26.3 (2.7)	17.1 (4.8)	18.7 (3.8)	21.4 (3.3)	23.9 (3.1)	26.1 (2.6)	28.3 (2.0)	24.0 (3.8)
Self Determination	15.6 (3.7)	18.1 (3.1)	20.4 (2.7)	15.1 (3.8)	15.8 (3.6)	17.1 (3.2)	18.7 (2.8)	20.2 (2.7)	21.9 (2.1)	18.8 (3.3)
Closeness to Others	2.6 (1.4)	3.3 (1.4)	4.2 (1.4)	1.5 (1.5)	2.6 (1.1)	3.0 (1.4)	3.6 (1.3)	4.2 (1.4)	4.3 (1.3)	3.6 (1.5)
School Integration and Quality	12.1 (5.7)	16.2 (5.3)	19.9 (4.6)	9.2 (5.1)	12.4 (5.0)	14.4 (6.0)	17.4 (4.8)	20.0 (4.4)	20.5 (5.0)	17.5 (5.6)

Note: All F-tests p < .001 (two-tailed). All possible contrasts using the Tukey *Honestly Significant Difference* test between the categorical diagnoses were statistically significant at p < .01.

Figure 1a. Mean Depressive Symptoms by Categorical Mental Health Diagnosis

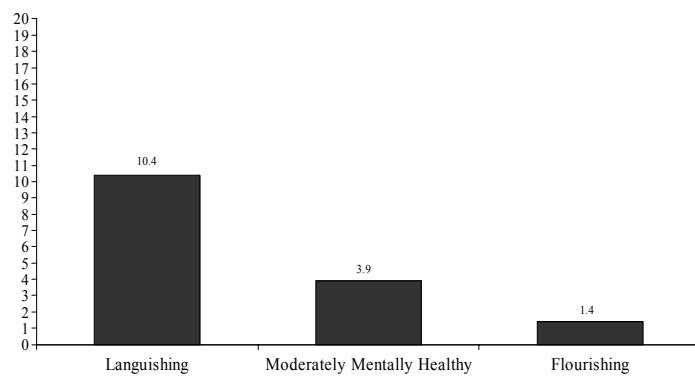


Figure 1b. Mean Depressive Symptoms by Continuous Assessment of Mental Health

