Relational Health, Ethnic Identity, and Well-Being of College Students of Color: A Strengths-Based Perspective Ψ

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Abstract

Within the framework of relational-cultural theory, the current study examined how relational health and ethnic identity contribute to overall well-being in a sample of college students of color. A total of 229 students completed measures of relational health, ethnic identity, indicators of subjective well-being (SWB), and perceptions of physical health. Canonical correlation analyses revealed two patterns of relationships between the variable sets: (a) students who reported lower scores in ethnic identity and in peer, mentor, and community relationships, also demonstrated lower SWB and fewer days in good health, and (b) students who reported high relational health in peer and mentor domains, but lower scores for ethnic identity, had higher reports of both positive and negative affect, as well as both good *and* poor health. These preliminary findings reflect the complexity of how ethnic identity and relational health differentially predict the well-being of college students of color. The implications of these findings for counseling psychologists are discussed.

Keywords

prevention/well-being, multiculturalism, race/ethnicity, dimensions of diversity

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Historically, counseling psychology has been concerned with the strengths and assets of individuals, as well as with how to operate competently within a multicultural context (Gelso & Fretz, 2001). These values have been brought together over the past decade as research on identifying and cultivating the unique strengths of individuals from diverse groups has gained momentum (Lopez et al., 2006). In a special issue of *The Counseling Psychologist* devoted to the positive aspects of human functioning, Frazier, Lee, and Steger (2006) suggested that counseling psychologists could make a significant contribution to this burgeoning area of research by examining multicultural aspects of optimal human functioning. Furthermore, Constantine and Sue (2006) identified multiple strengths of individuals of color that are unique to the experience of being part of a cultural or ethnic community. However, the extent to which cultural factors can be conceptualized as strengths has received mixed reports in research, with one construct emerging as a strength in one study only to be identified as a liability in another (Frazier et al., 2006). Furthermore, much of the research on the optimal functioning of ethnic minorities has centered on psychological well-being, exempting physical factors. Within counseling psychology, health-related theories have emerged with a focus on strengths and the intersection of psychological and physical well-being (e.g., biopsychosocial model, positive health; Berman & James, 2012). Health psychology research has focused on these elements together, but the primary focus of such research has been on the negative social factors that contribute to the existence of poor health outcomes (Schmidt, Raque-Bogdan, Piontkowski, & Schaefer, 2011). Although research on the effect of discrimination, racism, and oppression on health is essential, the objective of the current study was to provide a strengths-based perspective of factors that contribute to the psychological and physical well-being of college students of color.

The experience of being a member of a marginalized group leads to particular strengths and coping mechanisms that may influence health in a positive direction (Constantine & Sue, 2006). Although virtually all members of oppressed groups experience discrimination and racism on multiple levels, certainly not all of these individuals are in poor psychological and physical health, and many would be considered in optimal health. Thus, more research is needed from a strengths-based perspective to honor the experience of socially marginalized individuals who are thriving, and to illuminate the variables that relate to flourishing. To further our knowledge in this area, the current study used relational-cultural theory (RCT) as a framework to explore the role of ethnic identity and relational health in the psychological and physical health of college students of color.

RCT

RCT is a strengths-based model that focuses on the influence of relational (personal, social) and cultural (contextual, societal) elements on the development and maintenance of health and dysfunction for all people, especially marginalized individuals (Jordan, Kaplan, Miller, Stiver, & Surrey, 1991). RCT was originally conceptualized based exclusively upon the experiences of women, but recent developments of this theory have extended beyond only women's experiences to focus on exploring the influence of socialization, power, dominance, and subordination on all individuals' development and ways of relating to others (Frey, 2013). In addition, RCT emphasizes culturally based strengths and the maintenance of healthy relationships not only at the dyad level, but also within broad social networks and communities. Specifically, RCT suggests that growth-fostering relationships are at the core of human development and are a central human necessity. In turn, it argues that disconnection—whether in dyadic relationships or from society—is a fundamental source of psychological distress (Jordan et al., 1991). Alternatively, RCT suggests that connection with others, particularly when it is characterized by mutuality, authenticity, empowerment/zest, and the ability to deal with difference or conflict, is central to psychological health (Frey, Beesley, & Miller, 2006; Jordan, 1995, 1997; Miller & Stiver, 1997). Moreover, Frey (2013) stated that an approach that defines psychological health and maturity from a relational rather than individual perspective is crucial for individuals with a collectivistic worldview. Similarly, in their conceptualization of optimal theory, Myers et al. (1991) ascertained that "optimal" should be seen as "a holistic conceptual system designed to foster peace and harmony within *and subsequently among* people" (p. 56, italics added). Thus, many multicultural scholars agree that applying a relational model is central to the conceptualization of optimal functioning in psychological and physical health for all individuals, but particularly for individuals who maintain collectivistic values.

For college students, the population of focus in the current study, RCT suggests that the development of growth-fostering connections occurs as individuals renegotiate and reframe their relationships in light of newfound capacities and identities as young adults (Frey et al., 2006; Gilligan, 1988; Jordan et al., 1991). This process ideally results in increasing levels of complexity, fluidity, and articulation within relationships (Jordan et al., 1991). Consequently, RCT frames the process of gaining maturity as one that does not imply a weakening of emotional connections with others, as the separation–individuation process might traditionally suggest, but of growing within those connections (Jordan et al., 1991). Similarly, Greenberg and Johnson

(1990) have stated that interdependence, as compared with independence, may be the "true sign of optimal development" (pp. 18-19) because it allows young adults to develop a sense of themselves as simultaneously connected and differentiated. In many cultures, interdependence is a central value that is reflected in how individuals relate to their surroundings (Sue & Sue, 1999), and thus, any conceptualization of health and well-being for ethnic minority college students must take this into consideration.

As noted previously, RCT suggests that it is the *quality* of connections that matters, and there is an extensive body of empirical literature to support the idea that the quality of relationships is critical to psychological health (Bryant, 1985; Fiore, Becker, & Coppel, 1983; Liang et al., 2002). Stemming from RCT, the concept of "relational health" conceptualizes the quality of support that an individual receives from key others in their social support network, namely, peers, mentors, and community (Liang et al., 2002). This conceptualization may be particularly relevant for those from cultures that value interdependence, as the role of emotional support has been shown to exert differential effects on well-being for individuals from different cultural contexts (Uchida, Kitayama, Mesquita, Reyes, & Morling, 2008). For example, the authors of one study found that for European American individuals, the effect of emotional support on well-being existed through its influence on self-esteem, whereas for Asian individuals, the association between emotional support and well-being was more direct (Uchida et al., 2008). The authors concluded that there are important cultural differences in the relation between support from others and well-being: For those with interdependent values, well-being is at least partially defined by support from others, whereas individuals who value independence derive benefits from others' support through its influence on enhancing one's view of herself or himself as an individual.

Frazier et al. (2006) emphasized that attention to the role of positive relationships in the enhancement of human functioning is needed. This may be particularly true for people of color as the importance of racial and ethnic pride, family, and community are relationship-based strengths that individuals may possess (Constantine & Sue, 2006). Sue and Sue (1999) pointed out that for many cultural groups with collectivistic values, relationships with others are not only a contributor to well-being but also the foundation of its essential definition. Much of the literature focused on coping strategies of different ethnic groups, including Latinos, Asian Americans, African Americans, and Native American Indians, highlights how collectivistic values influence the development of strengths that assist in managing an oppressive social context (Constantine & Sue, 2006). Thus, research findings suggest that relationship-based strengths, such as relational health, may be

intertwined with racial and ethnic identity to predict optimal functioning for people of color.

Ethnic Identity

Ethnic identity is one construct that has been linked to strengths within people of color, though recent findings have been mixed (Frazier et al., 2006). A strong ethnic identity helps individuals recognize positive virtues about their own ethnic group, which may help minimize the harmful effects of racist beliefs on people of color (Phinney, 2000). A recent meta-analysis found that maintaining a strong sense of ethnic identity may be more robustly related to the positive end of well-being, rather than the mitigation of distress (Smith & Silva, 2011). Although the constructs of ethnic and racial identity have been defined in different ways (Cross & Cross, 2008; Helms, 2007), much of the research on ethnic identity and well-being has centered on Phinney's (1992) definition that can be generalized across ethnic groups. In this conceptualization, ethnic identity is comprised primarily of two main components: a sense of attachment or belonging to one's ethnic group, and the sense of identifying and engaging with ethnic practices. In a recent revision of the theory and its measurement (the Multi-Ethnic Identity Measure), Phinney and Ong (2007) proposed two factors within ethnic identity: (a) the desire to learn more about one's group and participate in it (exploration) and (b) a positive affirmation of one's group and membership within it (commitment). College students of color are likely to be in varying degrees of exploration and commitment, and as such, they likely exhibit differences in the extent to which ethnic identity can be considered a strength.

Subjective Well-Being (SWB) and Health Among People of Color

SWB, which includes both cognitive (i.e., life satisfaction) and affective components (i.e., positive affect [PA] and negative affect [NA]) of one's overall evaluation of happiness, has been referred to as "the gold standard" of psychological well-being (McGregor & Little, 1998, p. 505), yet comparatively little is known about the variables that contribute to its development for people of color in the United States (Constantine & Sue, 2006). There has been evidence that predictors of well-being are connected to cultural values and context (Uchida et al., 2008). For example, Molix and Bettencourt (2010) found that ethnic identity was a more important predictor of well-being and psychological empowerment for ethnic minority undergraduate students than

for their White counterparts. Ethnic minorities have been found to have more fully developed ethnic identities compared with Whites, and more advanced identity statuses are associated with higher reports of SWB for ethnic minorities but not for Whites (Yoon, 2011). One recent study suggested that the relation between ethnic identity and well-being is complex. In a large sample of ethnic minority college students, Syed et al. (2013) found that engaged participation in activities that contribute to one's ethnic identity development was positively related to well-being, whereas more ambivalent attempts to learn about one's ethnic identity were negatively related.

Although research on ethnic identity and psychological well-being has become more prominent, our understanding of how ethnic identity relates to physical well-being is less developed. Much of the research on race and physical health points to the significant negative effects of the experience of racism on adverse health conditions such as cardiovascular disease, lower immune functioning, and chronic pain (Williams & Mohammed, 2009). Although research of this nature is of vital importance to advocating for better and more inclusive health care, counseling health psychologists have advocated for greater attention to health disparities from a prevention and positive health promotion standpoint (Berman & James, 2012; Tucker et al., 2007). In a review of the literature on racial disparities and health, Williams and Mohammed (2009) called for more research on vulnerability and resilience factors in the health of people of color, and others have specifically cited the need for greater attention to the role of ethnic identity in physical health (Brondolo, verHalen, Pencille, Beatty, & Contrada, 2009). Therefore, the investigation into the relationship between strengths-based variables and both physical and psychological well-being for people of color is an important endeavor.

Summary

The purpose of this study was to explore the relations between growth-enhancing relationships, ethnic identity, and psychological and physical well-being for college students of color. Drawing from RCT and a strengths-based approach, we hypothesized that healthy relationships in peer, mentor, and community realms, and a well-developed sense of ethnic identity would be predictive of better SWB and improved indicators of physical health. As little research has been conducted in this area, the aim of this study was to provide initial evidence regarding the factors that contribute to optimal health and well-being of college students of color.

Method

Participants

This study was part of a larger project examining positive psychological contributors to physical health. Although the data were collected for these projects simultaneously, there were only two variables that were examined in both studies (relational health and PA), and the larger project did not examine cultural influences on well-being within its conceptualization. Undergraduate college students were recruited from two large mid-Atlantic universities to complete a survey online. A total of 712 individuals participated, with 602 completing the survey in its entirety. Of those participants who completed the survey, 229 self-identified as an ethnic minority, and this subset of students served as the sample population for the current study. Among this group, 42.4% self-identified as African American/Black, 20.1% as Asian American, 13.5% as White Hispanic/Latina(o), 7.9% as non-White Hispanic/Latina(o), 6.6% as Biracial, 6.1% as Asian Indian/Pakistani, 2.6% as Middle Eastern, .4% as American Indian/Alaskan Native, and 0.4% as Native Hawaiian/Other Pacific Islander. A large majority of the students completing the survey identified as female (80%). Ninety-one percent of participants were between 18 and 25 years of age, and were evenly distributed across years in school. Many participants reported living on campus (41.9%), while 33.6% lived off-campus (without parents), and 23.6% lived off-campus with their parents or guardians. Participants' parents represented a relatively well-educated group with 61% of mothers and 69% of fathers having completed at least some college or more.

In terms of the overall health of the sample, all mean scores on psychological indicators were average or slightly above average, indicating that participants were within the normal range for psychological health. All mean scores on the physical indicators were in line with recent statistics of college students, including ethnic minorities (American College Health Association, 2012). For instance, participants in this sample endorsed having more days in good health than in poor health. The average number of visits to the doctor in the past year (for something other than a routine physical) was 3.2. The average body mass index (BMI) across participants was on the high side of healthy weight (18.5-24.9) at 24.31 (American College Health Association, 2012). In terms of health behaviors, the mean number of days that participants spent exercising in the last 30 days was between 10 and 12. The rate of cigarette smoking was low with a mean score of less than 1 day spent smoking per week. Recreational drug use was also low with a mean score just

above "never." In terms of alcohol consumption, participants reported a mean of 0 to 5 days in the last 30 engaged in "heavy drinking."

Procedure

All data were gathered from participants through the use of an online survey tool for universities (StudentVoice). In addition to designated research recruitment tools in the academic departments (e.g., research participant pool), online advertisements and snowball sampling were used to recruit participants. All participants had the opportunity to enter a random drawing for a chance at one of 50 gift certificates valued at $20 at the end of the study. The survey was either completed at designated times in a computer lab or at the discretion of the participant.

Measures

Relational health. Relational health was assessed using the 37-item self-report Relational Health Indices (RHIs; Liang et al., 2002). Consistent with RCT, the RHI measures the quality and nature of individuals' relationships in terms of how much mutuality, authenticity, and empowerment/zest is present within them (Liang et al., 2002; Miller & Stiver, 1997). Furthermore, consistent with RCT, the RHI addresses both the "relational" (dyadic) and "cultural" (societal) components of RCT by measuring relationship quality in three relational contexts or domains: community, mentor, and peer. Items assess a sense of engagement, authenticity, and empowerment in these three domains. Three composite scores assessing the relationship domains of peer (12 items), mentor (11 items), and community (14 items) can be obtained to assess relational quality within each relationship domain (e.g., engagement of peer relationships). Participants rate each item using a 5-point Likert-type scale (0 = *never* to 4 = *always*). An example item includes "I feel understood by my friends." Cronbach's alphas for the RHI have been reported as ranging from .85 to .92 (Frey, Beesley, & Newman, 2005; Liang et al., 2002) and were .86 for the Peer scale, .96 for the Mentor scale, and .85 for the Community scale in the current study. Liang et al. (2002) also provided support for the RHI's convergent and concurrent validity.

Ethnic identity. Ethnic identity was measured using the Multigroup Ethnic Identity Measure (MEIM; Phinney, 1992). The MEIM is a 12-item measure designed to assess ethnic identity across a wide range of ethnic and cultural groups. The Ethnic Identity scale has two subscales. The seven-item Affirmation, Belonging, and Commitment subscale (an affective component) measures individuals' positive feelings about their ethnic group and sense of

commitment to their ethnic identity. An example item is "I feel a strong attachment toward my own ethnic group." The 5-item Ethnic Identity Search subscale (a developmental and cognitive component) addresses individuals' desire to learn more about their ethnic group and participate in it. An example item is "In order to learn more about my ethnic background, I have often talked to other people about my ethnic group." Participants were asked to endorse statements using a 5-point Likert-type scale where 1 = *strongly disagree* and 5 = *strongly agree*. Mean total scores can be calculated for the overall scale and for individual subscales. Higher scores indicate a more fully developed ethnic identity. Cronbach's alpha reliability estimates of scores have ranged from .81 to .90 (Phinney, 1992; Ponterotto, Gretchen, Utsey, Stracuzzi, & Saya, 2003). In the current study, the reliability coefficient for the total scale was .91, and for the subscales .79 for Identity Search, and .92 for Identity Affirmation, Belonging, and Commitment.

Satisfaction with life. Satisfaction with life was measured using the Satisfaction With Life Scale (SWLS; Diener, Emmons, Larsen, & Griffin, 1985), a five-item measure that assesses the positive cognitive components of SWB. Participants were asked to rate their agreement with items on a 7-point scale where 1 represents *strongly disagree* and 7 represents *strongly agree*. Participants' scores are computed as sum totals, and can range from 5 to 35. An example of an item on the scale is "In most ways, my life is close to my ideal." The reliability and validity of the SWLS have been substantiated in numerous studies, as this measure is widely used (Steger, Frazier, Oishi, & Kaler, 2006). The measure's scores have a high Cronbach's alpha of .87 and a test–retest correlation of $r = .82$ over 2 months (Pavot & Diener, 2008). Cronbach's alpha reliability for the current study was .89.

PA and NA. The present study utilized the 10-item scale for PA and the 10-item scale for NA from the Positive and Negative Affect Schedule (PANAS; Watson, Clark, & Tellegen, 1988). The PA scale of the PANAS contains 10 positive emotions, and the NA scale contains 10 negative emotions. Users rate the intensity of each emotion for the past week on a scale of 1 to 5, with 1 representing *very slightly or not at all* and 5 representing *extremely*. The PANAS has been shown to have high reliability and validity (Crawford & Henry, 2004), and to be stable over a 2-month period (Watson et al., 1988). In the current study, the PA scale scores were found to have a Cronbach's alpha reliability of .90, and the NA scale scores an alpha of .86.

Healthy days. Select items from the Health-Related Quality of Life Questionnaire (HRQOL-14; Centers for Disease Control and Prevention, 2000) were used to assess participants' ratings of good and poor health in the past 30

days. The HRQOL-14 is a measure included in the Behavioral Risk Factor Surveillance System (BRFSS), which measures participants' health behaviors across various domains for the purpose of tracking nation- and statewide trends in health and health management (National Center for Chronic Disease Prevention and Health Promotion, 2009). The BRFSS is widely used in research examining health issues (e.g., Brownson et al., 1992) and is designed to be flexible and adaptive to specific research questions (National Center for Chronic Disease Prevention and Health Promotion, 2009). In the current study, two items were taken from the Healthy Days Core Module to assess ratings of poor health (i.e., "Thinking about your physical health, which includes physical illness and injury, for how many days during the past 30 days was your physical health not good?" and "Thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?"). Responses to these items were added together to represent an overall estimate of unhealthy days in the past month, with an upper limit of 30 (Centers for Disease Control and Prevention, 2000). In addition, one item from the Healthy Days Symptom Module was used to determine positive physical functioning (i.e., "During the past 30 days, for about how many days have you felt very healthy and full of energy?"). These items were selected for the purpose of separating participants' reports of poor health from those of positive functioning in line with the study's research questions. The Healthy Days modules of the HRQOL-14 have been found to have construct and criterion-related validity when compared with the Short Form 36, another well-used measure of perceived health (Newschaffer, 1998). This measure has been found to relate strongly to self-rated health and activity limitation across many studies, including those examining diverse populations (Jia, Lubetkin, Moriarty, & Zack, 2007).

Results

Means, standard deviations, and bivariate correlations are listed in Table 1. All but two variables (number of days in poor health, relational health-mentor) met normality assumptions upon examining statistics for skewness and kurtosis of the distributions, as well as the stem and leaf and normal Q-Q plots. The number of days spent in poor health demonstrated a skewed distribution, such that the population reflected a physically healthy group. This issue represents a common problem with measuring physical indicators of health in a healthy population. Given the higher number of female participants and the nature of the relational health subscales, means of all variables were compared between females and males. The only variable that demonstrated a statistically significant difference was PA, with males scoring higher than

Table 1. Means, Standard Deviations, and Correlations for Study Variables.

Variable	M	SD	RHI-peer	RHI-community	RHI-mentor	SWL	PA	NA	MEIM-search	MEIM-affirmation	PH	GH
Relational health-peer (RHI-peer)	3.95	0.64	—									
Relational health-community (RHI-community)	3.13	0.62	.36**	—								
Relational health-mentor (RHI-mentor)	3.65	0.94	.35**	.21**	—							
SWL	4.85	1.31	.37**	.38**	.19**	—						
PA	33.85	8.46	.34**	.39**	.30**	.45**	—					
NA	24.19	7.86	−.29**	−.24**	−.08	−.42**	−.13	—				
MEIM-search	2.70	0.70	−.01	.19**	−.01	.21**	.08	−.22**	—			
MEIM-affirmation	3.17	0.66	.13*	.29**	.01	.28**	.17*	−.33**	.68**	—		
PH	1.53	0.91	−.10	−.28**	−.01	−.30**	−.36**	.31**	−.24**	−.28**	—	
GH	2.82	1.48	.31**	.28**	.24**	.35**	.44**	−.26**	.03	.12	−.21**	—

Note. RHI = Relational Health Inventory; SWL = satisfaction with life; PA = positive affect; NA = negative affect; MEIM = Multigroup Ethnic Identity Measure; PH = poor health; GH = good health.
*p < .05. **p < .01.

females. When the variables were compared across racial/ethnic groups, the only statistically significant difference between groups was on the scales of the MEIM, with African American participants reporting the highest mean scores on the Affirmation subscale, and Asian American reporting the highest mean on the Search subscale. Given the different subsample sizes of racial/ethnic group classification, these differences should be interpreted with caution. Many of the variables demonstrated moderate bivariate correlations in expected directions. The two scales of the MEIM demonstrated the strongest relations ($r = .68$) of all the variables. As these scales represent two factors on the same instrument, a moderate to high bivariate correlation was expected (Phinney & Ong, 2007). Furthermore, in the canonical analysis, these variables were both included in the predictor set, which indicated that they were joined by a unifying construct.

To investigate the pattern of relations between relational health and ethnic identity with indicators of psychological and physical health, a canonical correlation analysis was employed (Tabachnick & Fidell, 1989). As little research has been conducted in the area of optimal functioning of people of color, this exploratory analysis allowed for prediction of multiple independent variables to multiple dependent variables. The variables included within each set are related by a common thread. For instance, the predictor variable set in this study focused on strengths unique to persons of color, and included the Community, Peer, and Mentor subscales of the RHI, as well as the Affirmation and Search subscales from the MEIM. The criterion variable set was comprised of variables related to overall well-being, and consisted of scores on the SWLS, the PA and NA scales on the PANAS, and the number of days in the past 30 spent in good and poor health. From Wilks's , it was clear that at least one statistically significant function was present, Wilks's = .56, $F(25, 1072) = 5.51$, $p < .01$, in the five roots that were possible in the analysis (due to the fact that there were five variables in the independent variable set). Therefore, the percentage of variance explained by the variable sets was 44% $(1 -)$.

The dimension reduction analysis was examined for the statistical significance of the hierarchical arrangement of functions. Two statistically significant functions, or roots, were uncovered, Roots 1 to 5, $F(25, 804) = 5.51$, $p < .01$; Roots 2 to 5, $F(16, 663) = 2.09$, $p < .01$. This demonstrated that of the five possible combinations of variables (due to there being five variables in the independent variable set), two combinations were statistically significant at the .01 level. The squared canonical correlations (R^2) indicated that the first function accounted for 35% of the variance in the canonical composite, representing a medium effect (Cohen, 1988), and the second function accounted for 11%, representing a small effect (Cohen, 1988). The remaining

Table 2. Canonical Solution for Strengths Predicting Overall Well-Being for Functions 1 and 2.

Variable	Function 1			Function 2			
	B	r_s	$\%r_s{}^2$	B	r_s	$\%r_s{}^2$	$\%h^2$
Strengths							
RHI-peer	−.48	−.76	57.28	.19	.31	9.89	67.17
RHI-mentor	−.22	−.48	22.69	.57	.62	38.44	61.13
RHI-community	−.43	−.76	57.45	−.06	−.07	0.56	58.01
MEIM-search	−.03	−.34	11.73	−.44	−.72	52.52	64.25
MEIM-affirmation	−.34	−.56	30.90	−.39	−.68	41.02	71.92
Overall well-being							
Positive affect	−.50	−.77	59.58	.55	.34	11.48	71.06
Negative affect	.42	.65	42.64	.29	.43	18.56	61.20
SWL	−.29	−.76	57.69	−.19	−.14	2.02	59.71
Good health	−.18	−.62	38.21	.44	.36	12.88	51.09
Poor health	.02	.46	20.87	.79	.64	41.13	62.00

Note. B = standardized canonical function coefficient; r_s = structure coefficient; $r_s{}^2$ = squared structure coefficient; h^2 = communality coefficient. RHI = Relational Health Inventory; MEIM = Multigroup Ethnic Identity Measure; SWL = satisfaction with life.

three functions did not reach statistical significance, and were therefore not interpreted.

Interpreting the canonical correlation included a two-step procedure. First, structure coefficients (r_s; that is, correlations between the variables and the canonical variate) greater than .30 (recommended by Tabachnick & Fidell, 1989; see Table 2) were examined. The second step included examining the standardized canonical coefficients (B) for these variables to determine if there was redundancy in the composite. For the first function, all variables within the predictor set (RHI-peer, RHI-mentor, RHI-community, MEIM-search, MEIM-affirmation) were associated with one another in the same direction, and the squared structure coefficients ($r_s{}^2$) demonstrated that the highest percentage of variance in the canonical variate was accounted for by RHI-peer and RHI-community. Although the structure coefficient was above .32 for the Search subscale of the MEIM, it had a relatively low function coefficient which could indicate that it was redundant with other variables in the composite. Within the dependent set, SWL, PA, and good health over the last 30 days demonstrated associations in the same direction, whereas NA and poor health in the last 30 days demonstrated an opposite association (positive) with the other variables in this set. PA accounted for the highest

percentage of variance in the canonical variate, followed closely by SWL. The function coefficient for poor health over the last 30 days was relatively low, which may indicate redundancy with others in the set. Thus, consistent with the hypotheses, the function demonstrated that participants who reported lower scores for relational health in peer, mentor, and community relationships, and a less well-developed sense of ethnic identity, also demonstrated lower SWB including lower satisfaction with life, lower PA, and higher NA, and lower reports of good health over a 30-day period. This pattern of responses, or function, accounted for 35% of the variance in the canonical composite, representing a medium effect (Cohen, 1988).

The second function that reached statistical significance demonstrated a slightly different pattern of relationships among the variables. On the predictor side, peer and community relational health were positively related to the predictor set, whereas both subscales of the MEIM were negatively associated, and the most variance in the canonical variate was accounted for by the Search subscale of the MEIM ($r_s^2 = .52$). On the dependent side, PA, NA, and reports of good and poor health in the last 30 days were all positively related to the canonical variate, and the most variance was accounted for by poor health in the last 30 days ($r_s^2 = .41$). None of the variables on either side of the equation demonstrated indicators of redundancy with other variables. Therefore, this function described a pattern of relationships that showed individuals who reported high relational health in peer and mentor domains, but lower reports of ethnic identity (both Search and Affirmation subscales), had higher reports of both PA and NA, as well as good and poor health in the last 30 days.

The communality coefficient (h^2), or the proportion of variance in the observed variable that is explained by the canonical functions that are interpretable, demonstrated that across the two statistically significant functions, the Affirmation scale of the MEIM on the predictor side, and PA on the dependent side, accounted for the most variance in these equations.

Discussion

The findings of this study contribute to an emerging picture of how relational health and ethnic identity intersect with one another in predicting psychological and physical health indicators, and demonstrate that these variables can relate in multiple ways for different individuals. As was predicted, the pattern of associations that accounted for the highest amount of variance indicated that students of color who have fewer growth-enhancing relationships with peers, mentors, and their community, and a less-developed sense of ethnic identity, appear to have lower levels of physical and psychological

well-being. Specifically, having lower ratings of relational health and ethnic identity in all domains was associated with lower PA and satisfaction with life, higher NA, and fewer days spent in good health over the previous month. In addition, a second pattern of relations revealed that for some individuals, higher ratings of relational health in peer and mentor domains, but lower levels of ethnic identity, were associated with higher PA *and* NA, as well as higher reports of both good *and* poor health in the last month.

Overall, the results of the current study are in line with previous research findings. For instance, previous studies have found that higher levels of ethnic identity and social support go hand-in-hand in predicting greater well-being (Noh & Kaspar, 2003; Phinney, Horenczyk, Liebkind, & Vedder, 2001), as people of color who have a strong sense of ethnic identity typically have close connections with others from their ethnic group. Furthermore, previous research has shown that ethnic identity and social support can work together as buffers between stressful experiences (e.g., the experience of discrimination) and distress (Ponterotto & Park-Taylor, 2007; Yoo & Lee, 2005). Higher levels of social support and ethnic identity have also been associated with positive indicators of well-being, such as self-esteem and sense of mastery (Smith & Silva, 2011; Thoits, 2011). Thus, the finding that students who scored low on relational health and ethnic identity had lower SWB, as well as lower indicators of good health, is consistent with expectations. For many students of color in this study, higher levels of ethnic identity and healthy connections to peers, mentors, and community related to indicators of positive psychological and physical well-being.

The current study contributes to the understanding of what type of social support—peer, mentor, and community—is important for students of color. Healthy relationships with peers and community appeared to make the strongest contribution to the relation between strengths and well-being for the largest part of the sample. This finding is consistent with the notion that peer relationships are especially important to adolescents and college students (La Greca & Prinstein, 1999). However, much of the research on social support with this age group has focused on the quantity of peer support (Bryant, 1985) or the quality of attachment to parents or romantic partners, rather than peers (e.g., Fraley & Shaver, 2000; Hazan & Shaver, 1987). We have comparatively little information about the nature and quality of peer and community relationships during this developmental period, and the current findings suggest the importance of exploring these specific types of relationships further. RCT emphasizes balancing independence and connection with the goal of becoming "interdependent" (Jordan et al., 1991), as opposed to the traditional emphasis of separation–individuation (e.g., Erikson, 1968; Mahler, 1989). Within RCT, healthy relationships that are authentic,

empowering, and engaging are particularly important to marginalized groups as they navigate an oppressive society (Liang et al., 2002). When considering the strengths of college students of color, peer relationships play a central role. Furthermore, healthy relationships with a community contributed substantial variance to the association between strengths and well-being, supporting the inclusion of community-based relationships as a particular strength for people of color (Constantine & Sue, 2006).

The second pattern of associations that was uncovered may be preliminary evidence for how the variables of interest relate differently for students with a diffused ethnic identity, as evidenced by less active engagement with the exploration and commitment developmental processes that are associated with the development of a strong sense of ethnic identity (Phinney & Ong, 2007). Notably, as compared with the first function in which relational health accounted for the most variance, in this second function, the indicators of diffused ethnic identity accounted for the highest percentage of variance. Furthermore, a less-developed ethnic identity did not demonstrate a consistent relation with indicators of well-being for this function. Specifically, students who exhibited these characteristics demonstrated higher PA and NA, and provided mixed reports of physical health, showing evidence of higher reports of both good and poor health over the previous month. Similarly, another recent study found that active engagement with ethnic identity was related to positive reports of well-being, whereas ambivalent attempts to learn about one's ethnic identity were negatively related (Syed et al., 2013).

However, in the current study, students who scored low on both dimensions of ethnic identity also had high ratings of relational health with peers and mentors. One possibility is that these students may feel supported by peers and mentors, but not necessarily connected to others within their ethnic or racial group. A recent study demonstrated that engagement with ethnic identity exploration and commitment is often similar across friends, but only in those friendships where both members identify with an ethnic minority group (Syed & Juan, 2012). Ethnic minority friends are believed to engage in exploratory behaviors (e.g., joining ethnic student groups) and communication (e.g., talking about ethnicity-related issues) with one another, but this typically does not occur across mixed-race friendships (Syed & Juan, 2012). Thus, in the current study, the second function may be explained by the differences in ethnic identity, and how this interacts with relational health for these individuals. The correlational nature of these findings presents preliminary evidence of these relations, and the connection between diffused ethnic identity and well-being requires further investigation.

Researchers using a strengths-based approach have examined how a well-developed ethnic identity may be related to greater psychological health and

flourishing. For example, Smith and Silva (2011) synthesized research on the relation between ethnic identity and personal well-being, and found a modest positive relation between the two. They called for further investigation, however, to clarify the independent contributions of variables that coincide with advanced ethnic identity, including quality of social relationships. By measuring elements of these two constructs together, the current study has provided support for the independent contributions of ethnic identity and relational health to SWB. Both constructs appear to have validity as strengths for people of color related to optimal health and well-being.

The strengths variable set was found to relate to elements of both psychological well-being and physical health in this study. Although these data were limited to the self-reported perception of health rather than actual physiological indicators of health, it is notable that higher reports of strengths were associated with both psychological and physical well-being. This finding mirrors a recent meta-analysis regarding ethnic identity and psychological well-being, which demonstrated that ethnic identity was more strongly related to the positive end of the spectrum than it was to distress (Smith & Silva, 2011), and indicates that the same trend may be true for physical health. Ethnic identity and relational health appear to be significant contributors to people of color's physical well-being, and not just their mental well-being. With counseling health psychology's focus on positive health and the biopsychosocial model (Berman & James, 2012), these findings could be expanded in future studies, thereby contributing to a better understanding of optimal functioning in all areas of health, including physical health. For instance, longitudinal studies on whether a causal relationship exists between ethnic identity, relational health, and physical health are needed to determine whether these variables hold promise for interventions directed at reducing health disparities.

Limitations

This study presents a unique look into some strength-related constructs of college students of color, although limitations should be considered in the interpretation of the findings. First, the population studied was limited to healthy college students and cannot therefore be generalized to others outside of this developmental period and health status. Ethnic identity is a developmental process (Phinney, 1989, 1992), and traditional-aged college students are likely to be considering their identity in this area and other realms in a qualitatively different way than individuals in other age groups across the life span. Similarly, the role of peers, mentors, and community within relational health likely has different meaning for those at this stage of development than

for individuals who are further into adulthood (Liang, Tracy, Kenny, Brogan, & Gatha, 2010). In addition, as the current study focused on a healthy college student population, and instruments measuring physical health and well-being focus almost exclusively on disease and disability, the measurement of these constructs was limited. Thus, the role that the strengths-based constructs of ethnic identity and relational health play in the psychological and physical health of people of color across the life span deserves further investigation and instrumentation.

A second limitation in this study was the characteristics of the sample. First, females made up a large majority of the participants, and thus, the findings of this study may be more applicable to women than to men and women combined. Past research has shown that social support tends to play a different role for women than it does for men (Shumaker & Hill, 1991), and there is preliminary evidence of differences in relational health among women and men (Frey et al., 2006). Future research could investigate potential differences by including a balanced sample and studying the potential role of gender and gender identity in these relationships. Second, although socioeconomic status was not explicitly studied, the sample reported a fairly high parental education level, which is a strong indicator of participants from a higher socioeconomic background. Socioeconomic status has been found to be a strong predictor of health and well-being, and is often confounded with race and ethnicity (Williams, Lavizzo-Mourey, & Warren, 1994). In future studies of this nature, socioeconomic status is likely an important variable to consider. Finally, people from different ethnic and racial groups may be developing and utilizing different strength sets that are consistent with their heritage and identity, thus studying ethnic minorities together as a population limits the ability to investigate these differences. The door is open for future studies to investigate the strengths of individuals from various cultural groups to help identify and enhance those traits that relate to overall well-being.

Implications

RCT points to growth-enhancing relationships to influence healthy development and optimal functioning, particularly for individuals from marginalized groups. The findings of this study support the idea that ethnic identity and relational health relate to greater well-being. Still, relatively little is known about optimal health and functioning for people of color, and the unique and essential strengths that allow individuals to thrive. Counseling psychologists are positioned to contribute to this growing body of knowledge with a focus on multicultural aspects of optimal human functioning (Frazier et al., 2006), and through a holistic conceptualization of health from a positive health or biopsychosocial perspective (Berman & James, 2012). RCT provides the theoretical

groundwork to examine the quality of relationships in multiple domains that appear particularly important for the well-being of people of color.

Future studies of optimal functioning for people of color should examine additional strengths unique to multicultural populations including bicultural flexibility, mechanisms for coping with discrimination, and culture-specific values. Furthermore, as pointed out by Frazier et al. (2006), the complexity of the relation between strengths and optimal functioning across different cultural groups and contexts needs consideration. Thus, within- and between-group cultural differences in the patterns of these relationships are areas that need development. Finally, as we examine the prediction of optimal functioning along both psychological and physical parameters, the idea of optimal health is still in need of definition, particularly for marginalized groups.

The findings of this study also have implications for interventions with marginalized individuals on campus, and this possibility deserves further exploration. For instance, given the importance of healthy relationships with peers and community to well-being for students of color, counseling professionals on campus could direct outreach efforts toward campus groups for students of color as well as support for community-based volunteer or service learning opportunities. Students of color may benefit from additional ways to connect with others in their ethnic group on campus as a means of fostering identity exploration and commitment (Syed & Juan, 2012), as well as psychological and physical well-being. In addition, the findings of this study support a biopsychosocial approach to assessing clients' concerns and strengths throughout counseling. Efforts could be made to evaluate clients' engagement with physical health and healthy behaviors, social groups and relationships with mentors, peers, and community, and psychological functioning including aspects of identity. Such information could be collected through client interviews as well as the inclusion of reliable and valid measures such as the MEIM, PANAS, and the RHI at intake or thereafter. In closing, counseling psychologists are well positioned as researchers and practitioners to contribute a strengths-based, holistic, and multicultural focus to the optimal functioning of people of color so that we can promote greater health and well-being for all individuals.

Declaration of Conflicting Interests

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