Investigating the Relational Well-Being of a Group of Adolescents in a South African High-Risk Community

Izanette van Schalkwyk* and Odette Geldenhuys

Centre for Child, Youth and Family Studies, North-West University, South Africa

Submission: June 06, 2019; Published: July 01, 2019

*Corresponding author: Izanette van Schalkwyk, Centre for Child, Youth and Family Studies, COMPRES: Faculty of Health Sciences, North-West University, Potchefstroom, South Africa

Abstract

Relational well-being is regarded as an important facet of adolescents’ functioning well and of psycho-social health. A quantitative approach was used to establish the levels of a group of South African adolescents’ well-being living in a high-risk environment. Adolescent learners from three secondary schools (N=808 quantitative study) in a selected community took part in this study. Participants were Grade 8 learners (middle school) between 12 and 15 years old. Findings indicate that most adolescent learners, i.e., 56%, do not experience high levels of well-being. It was also found that adolescents have higher scores with regard to social well-being than psychological well-being. This finding indicates adolescents’ strengths as to connectedness and communal living, while lower scores pertaining to psychological well-being could undermine their relational competence. It is recommended that a programme is developed to protect and promote the personal and relational well-being of adolescents living in this South African high-risk context.

Keywords: Relational Well-Being; Positive Psychology; Flourishing; Languishing; Adolescents; Quantitative Approach; High-Risk Community

Introduction

Human beings cannot exist in isolation and relational functioning is central to human experience [1], Lombard (2011), McGoldrick & Carter (2003). Healthy relationships are indicative of psycho-social well-being [2] and positive relationships have been identified as a psychological factor that influences well-being [3-5]. Gergen [6] posited that humans are relational beings as such, and that each person is first and always a nexus of relations. Kitching, Ferreira, & Roos [7] argued when we consider positive human development, relationships – as the interpersonal connections between people - are an integral part of healthy human development. Prilleltensky & Peirson [8] stated adolescents’ constant yearning to be part of a peer group, to be one of the strongest psychological drives of this life phase. And, Jordan (2006) found that “growth-fostering” connections are the source of well-being and resilience for adolescents. Evidently, adolescents’ relational well-being is of key importance as to their healthy development, overall well-being and resilient managing of difficulties. This article focuses on relational well-being of a group of adolescents in a South African high-risk community.

Felner [9] describes a high-risk community in terms of poor housing, high levels of crime and violence (including gangster violence), domestic violence, school drop-outs, scarce provision of care facilities for children, teenage pregnancies, poverty, high levels of unemployment as well as economic inactivity [10]. The contextualisation of the specific demographic area is important [11]. Children growing up in the selected South African high-risk community are continuously exposed to gangsterism and related activities such as theft, violence, shootings and murder [12,13]. The occurrence of dysfunctional families [14]; parents’ substance abuse and domestic violence is also common in this community. South African research about the negative outcomes of fractured or broken families conducted in this high-need environment contains serious risks for adolescents’ relational well-being [15]. Also, since adolescents who are exposed to enduring poverty are more at risk to develop mental health problems [16,17], it is crucial that socio-economic factors should also be considered when we look at adolescents’ relational well-being as these factors can also be a strong predictor of the presence of well-being [18]. Hence, if we consider the extremely negative influence of poverty for South African youth, then the investigation of adolescents’ relational well-being as a mediator of personal and collective well-being is imperative [19].

Positive Psychology: Relational Well-Being

Relational well-being is becoming a very important topic in positive psychology research [5,20-23] Frederickson (2011), Frederickson in Jarden (2012). As the field has grown, scholars
have expanded their investigation into the influence of the quality of social relationships on individual well-being, described as “relational well-being” [11]. Relational networks of people include intimate personal relationships, social and group relations, intergenerational relations, even facets such as secure attachments, minding relationships, and, relational appreciation. Studies about quality ties are fundamental to positive psychology, such as Fredrickson (2009) showing that relationships, for example, the ordinary positive relational interacting among family and friends, are important resources for well-being.

Seeing that relational connecting does not arise within a vacuum, Van Schalkwyk & Wissing [24] suggested that well-being should be examined while considering the role of the external environment [19,25-28]. South African research [11] emphasizes context-specific challenges when we investigate relational interacting, since we cannot assume that these contexts equate enabling conditions. While relational well-being has been explored to some extent in Western and Eastern contexts, very few studies have been conducted in an African context where the spirit of “Ubuntu” is so particularly important [29]. “Ubuntu” indicates an inter-relatedness that captures the essence of human connectedness for societies with a collectivist worldview [30]. Wissing [29] mentioned that research is needed on relational well-being in order to understand how these psychological processes that are common to the human species develop and are expressed and shaped within the South African context. Also, information about relational well-being during adolescence is vital, since social functioning is paramount during this life phase [24], Van Schalkwyk & Wissing (2013). Then again, when we consider complete mental health, or the holistic perspective of sustainable wellness, it implies the presence of those key components that indicate the fullness of well-being, including relational health [230-33], Fredrickson (2004).

According to Evans & Prilleltensky [34], adolescents’ relational well-being is key to personal and collective well-being. Seeing that positive relations are a determining facet of well-being; we argue that levels of adolescent well-being would be an indicator of relational well-being. For this reason, it was imperative to establish the well-being levels of South African adolescents living in a high-risk community.

Method

Participants and Setting

Non-probability sampling with elements of purposive sampling took place to deliberately select specific features from the sampled population [35]. This specific type of non-probability sampling method relies on data collection from population members who are conveniently available (convenience sampling) to participate in a study. The sample (n = 808) was drawn from a population of learners at three different secondary schools in a Western Cape high-risk community. In this quantitative research questionnaires were completed in a one-shot cross-sectional survey design to determine the mean levels and prevalence of the various degrees of mental health; and, to determine participants’ satisfaction with domains of life. The biographical questionnaire was used to gather general information about the participants of the study, such as gender [371 male and 437 female participants]; and age (participants were between 12 and 15 years of age); and Afrikaans, English and isiXhosa-speaking. The participants who took part in the quantitative data collection were Grade 8 learners.

An important study done in the Western Cape with regards to underperforming schools indicates that Grade 8 learners in high-risk environments are faced with unique challenges and many difficulties [36]. In light of this information, Grade 8 learners have been chosen as participants for the study.

In terms of social problems, the school’s surrounding area is known as a high-risk community due to the prevalence of poverty, unemployment, substance abuse, high levels of crime such as robberies and violent crime, domestic violence, and other negative factors, City of Cape Town (2011); South African Police Services, cited in Grimova & Van Schalkwyk [15].

Data Gathering

Quantitative Approach

The quantitative method was used in the first phase of research to determine the prevalence of adolescents’ well-being – which includes social functioning - within a high-risk environment, Kao & Sun, (2007). Quantitative data was gained with three measures:

a. The Mental Health Continuum-Short Form (MHC-SF [37,38]);

b. The Fortitude Questionnaire (FORQ [39]); and

c. The Coping Self-Efficacy Scale (CSE [40]) which were completed by the adolescents of the three participating schools.

This quantitative data offered numerical understanding of the extent of the participants’ well-being and their relationships [41].

Quantitative Data Collection

The selected questionnaires were completed in English, as all the participants were fluent in the English language, and English was mainly their language of tuition. The following measures were used and the Cronbach’s alpha for these measures for the current study is added. The MHC-SF. The 14-items of the MHC-SF comprise three subscales:

a. Emotional well-being (EWB),

b. Social well-being (SWB), and

c. Psychological well-being (PWB).

The focus of the study was on the social well-being measure, although all these items were necessary for relational well-being. Wissing & Temane [42] reported Cronbach’s alpha of 0.75 to 0.90 for the MHC-SF in four different South African samples. The Cronbach’s alpha in this study was 0.82.
The FORQ. This 20-item FORQ measures to what degree a person experiences that he/she manages stress and experience well-being ("fortitude") as supported by the self, the family and the support of others. This measure has three subscales:

a. Personal understanding of problem solving (S);

b. Observed/experienced support from family (FA) and,

c. Perceived support from friends (FR).

The focus on the support of family and friends of this South African-designed measure of great interest to this study. The FORQ measure is a reliable and valid measure as indicated by Pretorius (1998) in the South African context. The Cronbach’s alpha for the current study was 0.82.

The CSE. This 26-measure scale measures individuals’ perceived management of stress and their coping mechanisms when they are dealing with threats and difficult challenges. The CSE has three subscales:

a. Problem-focused management (PFC);

b. Stop unpleasant emotions and thoughts (SUE); and

c. The support of friends and family (SFF).

This measure sheds light on the participants’ relationships with friends and family in the management of difficult challenges, which are often experienced in high-risk environments. The Cronbach alpha for this study was 0.70.

Procedure and Ethical Considerations

Approval for the research was obtained from the ethical committee of North-West University (NWU-00060-12-A1), as well as the necessary permission from the following parties: Permission from the Western Cape Education Department; the school principals of the three selected secondary schools; and, written assent of all participants’ as well as the informed consent (permission) for participation from the parents/legal guardians, in order for their minors to participate in the study. The participants were informed that the data would be treated confidentially, and only relevant people would have access to the data.

The risk-potential benefit relationship was appropriate to the vulnerable population, and potential vulnerabilities were considered. Although the fact that participants were poor since (many of the parents are economically not active (jobless) people), the researcher(s) did not assume that the participants cannot choose responsibly whether to participate in the research, as this could have been disrespectful, and could have implied the denial of their autonomy. Additional steps were taken to minimise coercion, and undue influence of the vulnerable population, such as special attention given to the recruitment process; the participants knew that they took part in research and that the research was carried out only with their assent (and parents or guardians’ consent).

Data Analysis

Descriptive statistics and reliability indicators (Cronbach’s alphas) were determined for all the measures [41,43,44]. And frequencies for the various categories of mental health according to the criteria stipulated for the MHC-SF. The data obtained in this study was analysed by the statistical consultation service of the North-West University in Potchefstroom, South Africa, utilising SPSS for Windows version 22 [45]. Descriptive statistics and Cronbach alpha reliability coefficients were determined for all scales and sub-scales used.

Questionnaire: Domains of Life

All participants (N= 808) were asked to complete a questionnaire. This was done to get general information about the participants of the study such as their age, language (culture), gender, as well as information about the participants’ satisfaction with domains of life in the selected community, namely school, family, standard of living, interpersonal relations, health, personal development, leisure – free time, spirituality – religion, community, life in general. This information was used to gain a general insight of these participants’ quality of life rated as their satisfaction with the abovementioned domains of life [46].

Results

Descriptive Statistics

Table 1: Descriptive statistics and alpha coefficients of the measuring instruments.

<table>
<thead>
<tr>
<th>Measures</th>
<th>Mean</th>
<th>SD</th>
<th>Minimum</th>
<th>Maximum</th>
<th>α</th>
</tr>
</thead>
<tbody>
<tr>
<td>MHCSF_EWB</td>
<td>10.24</td>
<td>3.06</td>
<td>0</td>
<td>15</td>
<td></td>
</tr>
<tr>
<td>MHCSF_SWB</td>
<td>12.68</td>
<td>5.29</td>
<td>0</td>
<td>25</td>
<td></td>
</tr>
<tr>
<td>MHCSF_PWB</td>
<td>21.15</td>
<td>5.19</td>
<td>4</td>
<td>30</td>
<td></td>
</tr>
<tr>
<td>Total MHCSF</td>
<td>44.03</td>
<td>10.48</td>
<td>5</td>
<td>70</td>
<td>0.82</td>
</tr>
<tr>
<td>FORQ-S</td>
<td>20.64</td>
<td>3.49</td>
<td>7</td>
<td>28</td>
<td></td>
</tr>
<tr>
<td>FORQ-SP</td>
<td>17.85</td>
<td>3.34</td>
<td>6</td>
<td>24</td>
<td></td>
</tr>
<tr>
<td>FORQ-F</td>
<td>21.08</td>
<td>3.99</td>
<td>7</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>Total FORQ</td>
<td>59.58</td>
<td>8.73</td>
<td>20</td>
<td>80</td>
<td>0.82</td>
</tr>
<tr>
<td>PFC</td>
<td>58.73</td>
<td>17.78</td>
<td>15</td>
<td>116</td>
<td></td>
</tr>
<tr>
<td>SUE</td>
<td>43.34</td>
<td>13.96</td>
<td>0</td>
<td>87</td>
<td></td>
</tr>
<tr>
<td>SFF</td>
<td>26.13</td>
<td>8.90</td>
<td>0</td>
<td>50</td>
<td></td>
</tr>
<tr>
<td>Total CSE</td>
<td>128.34</td>
<td>37.15</td>
<td>30</td>
<td>243</td>
<td>0.70</td>
</tr>
</tbody>
</table>

MHCSF_EWB: Mental Health Continuum Short Form Emotional Well-being; MHCSF_SWB: Mental Health Continuum Short Form Social Well-being; MHCSF_PWB: Mental Health Continuum Short Form Psychological Well-being; MHCSF: Mental Health Continuum Short Form; FORQ-S: Fortitude Questionnaire-Personal understanding of problem solving; FORQ-SP: Fortitude Questionnaire-Observed/experienced support from family; FORQ-F: Fortitude Questionnaire-perceived support from friends; FORQ: Fortitude Questionnaire; PFC: Problem focused management; SUE: stop unpleasant emotions and thoughts; SFF: the support of friends and family; CSE: Coping Self-Efficacy Scale.
The descriptive statistics and Cronbach’s alpha reliability indices for all of the various measuring instruments scales are presented in Table 1. Mean scores and standard deviations are shown for all measures and are more or less in line with those reported in the literature. The alpha coefficients of all the scales were acceptable compared to the guideline of 0.70 [47].

**Table 1:** The prevalence of levels of mental health of adolescents exposed to high-risk environments in three South African (SA) schools in comparison with findings for South African-Youth (15-18 years old) and USA – Youth middle school.

<table>
<thead>
<tr>
<th>Studies</th>
<th>Number of participants</th>
<th>Languish-ing</th>
<th>Moderately Mentally Healthy</th>
<th>Flourishing</th>
</tr>
</thead>
<tbody>
<tr>
<td>SA (12-15 years) current study</td>
<td>808</td>
<td>4%</td>
<td>52%</td>
<td>44%</td>
</tr>
<tr>
<td>US (12-14 years)</td>
<td>1260</td>
<td>6%</td>
<td>45%</td>
<td>49%</td>
</tr>
<tr>
<td>US (12-18 years)</td>
<td>1234</td>
<td>6%</td>
<td>56%</td>
<td>38%</td>
</tr>
<tr>
<td>SA (15-18 years)</td>
<td>665</td>
<td>5%</td>
<td>53%</td>
<td>42%</td>
</tr>
</tbody>
</table>

The prevalence of the various levels of mental health. The prevalence of the degrees of psychosocial well-being of a group of South African psychologists is shown in Table 2 in addition to two other studies conducted with adolescents, namely [32] who measured the well-being of United States adolescents (between the ages of 12 and 18 years); and a South African study looking at the well-being of Grade 10 learners (between the ages of 15 and 17 years) [24]. The percentages of participants on the various levels of mental health, as conceptualised in Keyes’s model of positive mental health, indicate either flourishing, moderate mental health or languishing. In this South African sample, 44% are flourishing, 4% are languishing, while moderate mental health is 52%; thus approximately 44% are functioning optimally (i.e., flourishing). In comparison to the Keyes’s middle school ages study (2009), his finding suggests that most youths are flourishing (49%), less than half (45%) of youth fits the criteria for moderate mental health, while 6% were mentally unhealthy, as they fit the criteria for languishing. Within his findings it was supported that the descriptive hypothesis was that flourishing youth function better than moderately mentally healthy youth, who in turn functioned better than languishing youth.

**Table 2:** The prevalence of levels of mental health of adolescents exposed to high-risk environments in three South African (SA) schools in comparison with findings for South African-Youth (15-18 years old) and USA – Youth middle school.

<table>
<thead>
<tr>
<th>Measures</th>
<th>Range of scores</th>
<th>Cronbach’s alpha (α)</th>
</tr>
</thead>
<tbody>
<tr>
<td>12-15 years</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MHC SF EWB</td>
<td>10.24</td>
<td>3.06</td>
</tr>
<tr>
<td>MHC SF SWB</td>
<td>12.68</td>
<td>5.29</td>
</tr>
<tr>
<td>MHC SF PWB</td>
<td>21.15</td>
<td>5.19</td>
</tr>
<tr>
<td>Total MHC SF</td>
<td>44.03</td>
<td>10.48</td>
</tr>
<tr>
<td>Total FORQ</td>
<td>59.58</td>
<td>8.73</td>
</tr>
<tr>
<td>CSE</td>
<td>128.34</td>
<td>37.1</td>
</tr>
<tr>
<td>15-17 years</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MHC SF EWB</td>
<td>10.42</td>
<td>2.70</td>
</tr>
<tr>
<td>MHC SF SWB</td>
<td>10.81</td>
<td>5.06</td>
</tr>
<tr>
<td>MHC SF PWB</td>
<td>21.66</td>
<td>5.52</td>
</tr>
<tr>
<td>Total MHC SF</td>
<td>42.91</td>
<td>11.04</td>
</tr>
<tr>
<td>Total FORQ</td>
<td>61.88</td>
<td>11.82</td>
</tr>
<tr>
<td>CSE</td>
<td>185.39</td>
<td>39.92</td>
</tr>
</tbody>
</table>

**Domains of life.** Also, all participants (N = 808) (study one) were asked to complete a questionnaire pertaining to domains of life. Information about life domains (i.e., school, family, standard of living, interpersonal relations, health, personal development, leisure – free time, spirituality – religion, community, and life in general) is important to establish participants’ rating of quality of life [46]. Adolescents’ perception of their social environment (including their school, neighbourhood, and home life) has also been seen to have an impact on well-being [48].

Next, the ratings of participants’ satisfaction with domains of life (in the selected community) of the three schools are presented (Table 4). Ratings of participants’ satisfaction with domains of life (in the selected community) are given. Percentages are an indication of most satisfying to less satisfying: i) family (78.23%); ii) health (75.90%); iii) school (73.54%); iv) Spirituality/religion (70.64%); v) life in general (70.29%); vi) standard of living.
Table 4: Indications of participants’ satisfaction – rating of various domains.

<table>
<thead>
<tr>
<th>Satisfaction rating</th>
<th>School 1 (n = 221)</th>
<th>School 2 (n = 263)</th>
<th>School 3 (n = 324)</th>
<th>Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family</td>
<td>76.90%</td>
<td>79.20%</td>
<td>78.52%</td>
<td>78.23%</td>
</tr>
<tr>
<td>Health</td>
<td>75.54%</td>
<td>75.55%</td>
<td>76.60%</td>
<td>75.90%</td>
</tr>
<tr>
<td>School</td>
<td>70.50%</td>
<td>75.55%</td>
<td>74.56%</td>
<td>73.54%</td>
</tr>
<tr>
<td>Spirituality - religion</td>
<td>70.80%</td>
<td>73.60%</td>
<td>67.52%</td>
<td>70.64%</td>
</tr>
<tr>
<td>Life in general</td>
<td>69.18%</td>
<td>71.40%</td>
<td>70.28%</td>
<td>70.29%</td>
</tr>
<tr>
<td>Standard of living</td>
<td>65.46%</td>
<td>68.40%</td>
<td>66.56%</td>
<td>66.81%</td>
</tr>
<tr>
<td>Personal development</td>
<td>64.50%</td>
<td>68.25%</td>
<td>64.16%</td>
<td>65.64%</td>
</tr>
<tr>
<td>Interpersonal development</td>
<td>64.14%</td>
<td>67.25%</td>
<td>62.76%</td>
<td>64.72%</td>
</tr>
<tr>
<td>Leisure</td>
<td>64.86%</td>
<td>65.90%</td>
<td>61.84%</td>
<td>64.20%</td>
</tr>
<tr>
<td>Community</td>
<td>59.92%</td>
<td>65.30%</td>
<td>59.44%</td>
<td>61.32%</td>
</tr>
</tbody>
</table>

Ratings of participants’ satisfaction with domains of life (in the selected community) of school 1 are given. Percentages are an indication of most satisfying to less satisfying: i) family (76.90%); ii) school (75.54%); iii) health (70.50%); iv) spirituality - religion (70.80%); v) life in general (69.18%); vi) standard of living (65.46%); vii) personal development (64.50%); viii) interpersonal relationships (64.14%); ix) leisure – free time (64.86%); and, x) community (59.92%). The participants of this school rated family as the most important domain of life, and they were least satisfied with their community. Interpersonal relations were not rated as satisfying, while family was rated as most important.

In summary: It was found that all participants value their families and they are least satisfied with their community. Interpersonal relations were not rated as satisfying by participants from all three schools (64.72%), while family was rated as important (78.23%).

Levels of Psychosocial Well-Being

First, it was found that most adolescents (between 12 and 15 years of age), i.e. 56%, in this study do not experience high levels of well-being, since the bigger percentage can be categorised as moderately mentally healthy or not functioning optimally, as measured with the MHC-SF Well-being models and previous research indicated that high levels of wellness and flourishing are of key importance for relational well-being [2,3,5,49]. Given that positive relational functioning is a required diagnostic criterion for flourishing (Keyes, cited in [50]), it was argued that adolescents showing high levels of well-being, experience positive relational functioning. Therefore, if since most adolescents in this study cannot be categorised as flourishing youth, it is highly probable that they do not experience high levels of relational well-being. Furthermore, if when we compare the findings of the current study with Keyes’s study (middle school – between 12 and 14 years of age), the group of South African adolescents (between 12 and 15 years of age; Grade 8) measures lower than the same age group of the USA youth, and even lower when we take into consideration Keyes’s supposed level of 60% for this age group [51].

If we situate these results in terms of related literature, the importance to protect and promote adolescents’ well-being is evident, since there are typically many risks linked to the adolescent life phase, such as emotional maladjustment and risky behaviours, for example, early sexual activity with associated health risks, depression, suicide, drug use, delinquency and dropping out of school [14,16,24,52]. Therefore, if adolescents are not flourishing, it leaves the door wide open for conditions of vulnerability regarding relational health. Moreover, if adolescents’ interpersonal protective resources are at risk more than relational well-being and personal well-being is threatened, namely firstly, risks as to relational functioning in families, for example, supportive grandparenting, positive attachments, interested parents, security and sense of belonging experiences; secondly, risks as to relational functioning in the community, for example, supportive educator practices, effective schools, effective school services, positive school practices, pro-social organisation (youth clubs), safe neighbourhoods, and cohesive neighbour systems; and finally, risks as to culture, for
example, cultural belonging, religious and spiritual practices, and positive values and believe systems [53,54].

What’s more, this finding indicates vulnerabilities or possible risks for adolescents’ relational functioning and healthy connecting during adolescence as well as in future. Apart from risks for relational functioning, since this group of adolescents’ well-being are lower than Keyes’s supposed level of 60% for this age group, Keyes [51] also indicated that flourishing may decline over time. He found a loss of approximately 10% of flourishing between the ages of 12 and 14 years (middle school) and between the ages of 15 and 18 years (high school). Also, it means that most South African learners do not experience high levels of well-being during “middle school”, and this indicates lower levels of relational functioning which refers to psychological, emotional and social well-being. This is ominous when we consider that Keyes found a drop of 10% between the ages of 12 and 14 years; and between the ages of 15 and 18 years. In other words, mere maturation does not imply improved levels of well-being. Since lower levels of well-being are associated with deficits as to relational well-being, then decreasing as to overall well-being over time could imply the decline of relational well-being. However, we need future research to investigate this.

Furthermore, Dobois, et al. [55] stated the enduring negative difficulties related poverty, hazardous environmental conditions as well as those who experience difficulty in their transactions with others, are at increased risk for disorder. They particularly underlined the more serious implications of such settings and social interactions may hinder early adolescents’ later development. Ultimately, it is important to protect and promote adolescents’ relational well-being toward sustainable positive human health.

Another important finding is the quantitative measuring of participants’ social well-being. Scores of the three sub-scales of Keyes’s [37] well-being measure (MHC-SF), namely psychological, emotional and social well-being indicate that the South African group of adolescents show the highest scores for social well-being. These scores revealed interesting information. Although Keyes (2007) has shown that complete well-being comprises social well-being, it is also important to emphasize dimensions of emotional and psychological well-being regarding relational well-being. Next to social well-being, the highest scores were found for emotional well-being indicating adolescents’ experience of happiness and life satisfaction is (linked to the hedonic approach). The lowest scores were found for psychological well-being, and this is noteworthy for relational functioning, since essential aspects of interacting, namely the role of self-esteem, self-regulation, effective coping, achievement of long-term goals, and personal growth are linked to facets of positive functioning.

Also, the noteworthy difference between the participants of the current study and a previous South African study [24] about the role of coping (as indicated by Coping Self-efficacy Scale) (Table 3) and well-being, could probably be linked to a lack of psychological competence and interpersonal functioning. Yes, adolescents’ well-being is a positive state where among the various dimensions, the psychological, emotional, social and relational needs of individuals are being met [37]. Nevertheless, although these needs are interdependent, they have their own unique set of qualities, Benade (2014). Therefore, adolescents’ psychological well-being is of paramount importance for healthy relating. This finding can be illuminated by the fulfillment of relational needs viewed as basic to human well-being in the self-determination theory of Deci & Ryan [56-58], as well as Erikson’s work as to the adolescence life phase and the development of a sense of self and identity.

Although adolescents’ identity is shaped and maintained to a large extent by their interactions with others, Erikson [59] stated that if a sense of identity does not emerge during adolescence, the individual will be confused when making decisions that will affect his/her adult life. Therefore, although social and interpersonal skills are important to foster, adolescents’ psychological strengths or personal well-being cannot be considered less important. Personal well-being is central for i) healthy interactions, such as anger and stress management and coping skills; ii) positive relating, such as showing empathy, active listening, recognizing and appreciating individual and group; iii) pro-social activities such as negotiation, conflict management, resisting peer pressure, networking, motivation); and, iv) responsible decision-making, such as information gathering, critical thinking, evaluating consequences of actions [60]. In this way psychological well-being of adolescents are important, not to exist merely as part of a group or society, but to be equipped as healthy individuals nested in a network of positive and supporting relationships [61].

When we consider this finding within the African context, it is worthwhile to take note that a typical characteristic of social relationships in an African context is an undeniable sense of responsibility for the well-being of the other [29]. Therefore, higher scores for social well-being can be regarded as beneficial for relational well-being. Then again, it is interesting that information gained from the questionnaire (Life Domains) showed that participants rate their families (or belonging to a family) as important, but satisfaction about relations indicating the quality of relating was rated much lower: This finding is supported by Wissing, et al. [62] who showed that a group of adolescents ( Setswana group of African students) - in line with previous Western studies - viewed relationships as the most important source for meaningful existence. Facets of family referred to the intrinsic value of the family and this was indicated as "to have a family" and to get support, voiced as ‘cared for when days are dark". However, although belonging to a family is viewed as of utmost importance, this perspective does not necessarily imply close ties (for example, living together/co-residence) or healthy relational functioning. This finding should be viewed in the light of research about absent fathers [63]; early adolescents living in a high-risk community and their perspectives of their parents’ lack of support as to education [12]; information that 40% of all households in South Africa are headed by a single parent [64]; only 35% of children in South Afri-
ca living with both their parents; 23% of children live with neither their parents and 3% are living with their father and almost 30% with only the mother; also, statistics indicate that the majority of children not living with their parents are not orphans, but they were removed from their parents due to being neglected by their parents [45].

Briefly put, findings indicated that most adolescents in this study do not experience high levels of well-being, and this finding implies several risks for adolescents' relational well-being. Insight gained from this finding is that if adolescents' relational well-being and interpersonal protective resources are at risk, these risks hold threats for adolescents' interrelatedness in families, in the community, and culture. Furthermore, these vulnerabilities or possible risks for adolescents' relational functioning have implications for their healthy connecting during adolescence as well as in future as adults. The second finding revealed that this group's high scores for social well-being do not equate relational functionality, since complete well-being comprises psychological and emotional dimensions too. In this sense, we recognise that adolescence is the life phase for the formation of a healthy identity. Yet, a healthy self will acknowledge the importance of the greater good.

Finally, the findings that the bigger percentage of a group of South African adolescents living in a high-risk community do not flourish should be considered while considering the destructive influences of a high-risk community and the violence of long-term poverty. Evidently, contextual vulnerability entails much more than being economically disadvantaged, it also holds lacking in social and psychological well-being [29,65]. This finding supports Alatartseva & Barysheva's [66] argument that well-being must be considered in the framework of a conceptually comprehensive logic (including objective as well as subjective aspects of well-being), that embraces one's existence in accordance with one's natural essence, i.e., being in harmony with others and the environment [67-77].

Limitations of This Study

Seeing that the data was collected in three selected secondary schools in a particular South African high-risk community, it must be noted that these findings are not representative of all adolescents in South Africa [78-88]. Also, the conclusions made cannot be used to generalise experiences, perceptions and interpretations on behalf of all adolescents living in high-risk environments [89-99].

Recommendations

We need future research about the processes of relational well-being toward good growth when youngsters are growing up in conditions of adversity, such as broken homes and impoverished relational ties. Also, we need more research about adolescents living in high-risk communities and their relationships with God/higher being. Existing literature/research highlighted the connections between human relationships and meaning in life. O'Donnell, Bentele, Grossman, Le, and Steger (2014) indicated that better relationships, such as family, romantic and friendship relationships go hand in hand with experiencing more meaning in life. This was not found in the current study, and future research is recommended to look at this issue within the South African context [100-109]. It is recommended that a programme is designed to enhance the relational well-being of adolescents living in this South African high-need and high-risk community [109-117].

Conclusion

South African adolescents residing in a high-risk community do struggle, since poverty does not merely influence monetary/economic issues related to daily needs, it also has the risk potential to damage those relational connections and relational participation central to well-being. In a country such as South Africa, diverse cultures are represented and need to be considered for relational functioning. Also, since the South African society recognises that our real wealth is our people; all efforts toward the creation of material wealth should aim at the ultimate objective of enriching human lives. And, adolescents’ relational well-being offers the key to this prosperity.

References

Psychology and Behavioral Science International Journal

30. Pretoria: Department of Social Development/Department of Women, Children and People with Disabilities/UNICEF.


