

**The perception of clergy of their role in counselling parishioners for  
emotional and psychological difficulties.**

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## DECLARATION

I, Rumbidzai Chidzonga declare that

- (i) The research reported in this dissertation, except where otherwise indicated, and is my original work.
- (ii) This dissertation/thesis has not been submitted for any degree or examination at any other university
- (iii) This dissertation/thesis does not contain other persons' data, pictures, graphs or other information, unless specifically acknowledged as being sourced from other persons.
- (iv) This dissertation/thesis does not contain other persons' writing, unless specifically acknowledged as being sourced from other researchers. Where other written sources have been quoted, then:
  - (a) their words have been re-written but the general information attributed to them has been referenced;
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Signed: .....

Rumbidzai Chidzonga

As the candidate's Supervisor I have approved this dissertation/thesis for submission

Supervisor

Signed.....

Professor Lance G. Lachenicht

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## **ABSTRACT**

Professional counselling is scarcely available and hardly affordable for the vast majority of the South African society. However, clergy could be a source of help available for those who may not afford treatment expenses for consulting psychologists and psychiatrists. This study looked at the role that clergy working in pastoral situations in a mainline church in the province of KwaZulu-Natal play in the provision of mental health. A questionnaire survey was distributed to 52 licensed clergy investigating the types of problems presented to clergy, how clergy respond to their parishioners' emotional and psychological problems, and how confident and how competent they feel in dealing with the problems presented to them. It investigated factors that enhance and hinder the helping process. To analyze and interpret the data, a series of statistical procedures were run using Statistical Package for Social Sciences and qualitative content analysis. Findings indicated that a wide variety of emotional and psychological problems were presented to clergy, including bereavement, alcohol or substance abuse, marital conflict, divorce and relationship problems. Clergy had a very positive attitude towards their role in counselling, and its importance in their ministry; however, the training of clergy has been considered insufficient to meet the needs of parishioners with emotional and psychological problems. Clergy reported a high level of perceived self-efficacy that seemed inconsistent with the training clergy have in emotional and psychological difficulties. Clergy tended to refer more severe psychological difficulties to either government, Non-Governmental Organisations or Faith-Based Organisations for specialised intervention. No formal support was reported to be available to clergy who engage in counselling although a large proportion of clergy mentioned getting support from fellow priests. The discussion of findings is focussed on empowering clergy to continue providing counselling for common emotional and psychological difficulties for their parishioners. Clergy may be a valuable resource in promoting mental health of their community members.

# Chapter 1 Introduction

## 1.1 Introduction to the study

The role of clergy as counsellors for parishioners experiencing emotional and psychological difficulties in their communities has been overlooked in the South African context compared to the contribution of clergy to mental health that has been extensively studied in the United States of America and United Kingdom (Leavey, Loewenthal & King, 2007, Weaver 1995). Clergy are usually the first source of help for people experiencing difficulties. Offering help to people in distress has always been the domain of clergy. Clergy have always been involved in the provision of welfare before it was taken over by the state, although today they are not considered partners in providing mental health services by other mental health professionals (Leavey, 2008). At the turn of the 20th century, the priest would have been the obvious person to turn to for much of the practical help now provided by the state. Clergy involvement in counselling is based on pastoral counselling which is some kind of effort to adapt psychological procedure to the solution of common problems met in the pastoral work of clergy (Lee, 1968). Clergy “function as frontline mental health workers. They are accessible helpers with established patterns of reacting to people’s personal problems long term relationships with individuals and families and have been labelled as warm, caring and stable, a circumstance that better places them in a position to discern early signs of emotional and psychological difficulties” (Weaver, Flannelly, Flannelly & Oppenheim, 2003, p. 162).

This research has been concerned with the perception by clergy of their role in counselling for emotional and psychological difficulties. Information about clergy in mental health delivery is particularly scarce. A small amount of literature recognises the role that clergy play in mental health delivery in South Africa. However, there is a need to establish how competent and confident clergy feel in fulfilling this role. To contribute to this literature, this research seeks to establish the levels of clergy’s confidence based on self-reports of perceived counselling self-efficacy, which will be used as a measure of confidence. According to Bandura (1986), behaviour is best predicted by people’s beliefs in their capabilities to do whatever is required of them. Self-efficacy as a counsellor can be determined by the degree of confidence one has in their counselling abilities (Smaby & Maddux, 2011). In order to fully account for factors that could be influencing clergy’s role in counselling as well as clergy’s counselling self-efficacy, Bronfenbrenner’s bio-ecological model of human development will form the theoretical perspective, to allow person/environment interactions to be explored.

In gathering the data for this research, a survey method was used. The clergy questionnaire comprising closed-ended questions measuring counselling frequency for various emotional and psychological difficulties and perceived levels of efficacy was completed by a diverse sample of 52 clergy from a mainline church in the province of KwaZulu-Natal. This questionnaire package also included the Perceived Counsellor Self-Efficacy Scale (PCSES), an adapted version of Counsellor Self-Efficacy Scale. Melchert, Hays, Wiljanen, and Kolocek, (1996) designed the Counsellor Self-Efficacy Scale (CSES) to assess counsellor development. This data was then captured and measured statistically, reflective of a survey design and a quantitative methodology. Follow-up interviews were done to augment the questionnaire data.

## **1.2 Research problem**

The health system in South Africa is undergoing transformation and striving to match the recommendations of the World Health Organisation (WHO), which encouraged that mental health care and development of community-based mental health services be integrated (Lund and Flisher, 2006). South Africa has an unmet need in the area of mental health (Stein et al. 2007). Despite government efforts to make mental health resources available to all, psychological services in many public hospitals are offered mostly by White graduates who are not fluent in any of the African languages (Pillay & Kramers, 2003). Furthermore, psychological services from psychologists and psychiatrists in private practice are beyond the means of many in South Africa. Consequently, many seeking help may end up in the office of the church minister, or other complementary and alternative sources of help like the traditional healers (Stein, et.al. 2007).

It is possible that religious leaders may play a critical role in promoting congregants' mental health. Clergy could be the first and only source of help that individuals may contact for help. People may feel less stigma in seeking help from clergy than other mental health professionals. Weaver, et al. (2003) suggest that clergy are always available in times of crisis, have long-term relationships with people and have earned high levels of trust from parishioners. This scenario places clergy in an advantageous position to help compared to other mental health professionals. Furthermore, priests have the right to approach congregants in need, unlike mental health professionals who have to wait for clients to make appointments. Thus clergy can intervene more quickly and directly than other helping professions (Pargament, 1997).

Despite clergy involvement in counselling for emotional and psychological problems, they are not considered partners by mental health practitioners. Concerns have been raised about the ability of theologically trained rather than psychologically trained clergy to counsel for significant psychological problems (Pargament, 1997). Neethling (2003) highlighted the lack of a professional council for pastoral workers who exist in South Africa to support pastoral counsellors. Leavey (2008) argued that clergy find themselves bewildered when dealing with parishioners with psychological difficulties. He also maintained that priests do not receive support from either their organisations or other mental health service providers. In a context like South Africa, with limited resources for mental healthcare, clergy may be integrated into a specialized ministry of mental health care delivery. However, this should be done without compromising on the quality of help offered.

### **1.3 Rationale for this study**

The investigation into the role played by clergy in counselling for emotional and psychological difficulties may be potentially beneficial to the communities that do not have access to psychologists. Studying the role played by clergy in mental health is important within the South African context where the disparity in mental health accessibility for the previously disadvantaged needs to be redressed (Havennar, Geerlings, Vivian, Collinson & Robertson, 2008). Neethling (2003) highlighted the shortcomings of the current mental health system in South Africa, thus proposing that pastoral counsellors may be a possible mental health resource especially with reference to community mental health care, spirituality, social change, reconciliation and multicultural application of interventions for mental health difficulties. The contribution of faith-based organisations and religious leaders in mental health has been well documented in the developed world. There is a paucity of knowledge on clergy's contribution to mental health in the South African context. This study proposes the investigation into their experiences as counsellors for psychological and emotional difficulties may shed some light into the role they play in helping their communities. Consequently, the knowledge gained may influence policy makers to design models of mental health provision that empower and utilise clergy as they could potentially be a valuable resource.

### **1.4 Research aims**

The primary aim of this study has been to investigate the extent of involvement of clergy in counselling for emotional and emotional difficulties thus deriving some insight into the role played by clergy in the area of mental health. The current research seeks, firstly, to gather

representative data on the kind of emotional and psychological difficulties that are presented to clergy by parishioners. Secondly, the study enquires about the counselling frequency of clergy for particular emotional and psychological difficulties presented by parishioners. Thirdly, this study also seeks to derive some insight into perceived levels of counselling self-efficacy as reported by clergy themselves in counselling and explore the factors that enhance and impede on their perceived counselling self-efficacy. Very little is known about the steps that are taken by clergy when helping parishioners presenting with emotional and psychological issues. It is anticipated that by determining the extent to which clergy help and how they help, may be useful in complementing the government efforts to make mental health accessible to all, especially at a primary health care level. This has resulted in a series of research questions and hypotheses. Specifically, the study seeks to answer the key question: Do clergy contribute to mental health service delivery in their communities by offering counselling for emotional and psychological difficulties in view of their training? If clergy are helping people in communities, then,

- ❖ How often do clergy counsel people experiencing emotional and psychological problems?
- ❖ How do clergy offer help to people in their parish experiencing emotional and psychological difficulties of their parishioners?
- ❖ How confident do clergy perceive themselves in addressing these issues?
- ❖ How equipped do clergy feel when dealing with emotional and psychological issues?

The hypothesis and findings will be further expounded in later chapters.

### **1.5 The structure of this dissertation**

Following this introduction, readers should expect a review of relevant literature in the role of clergy in mental health and the prevalence of psychological difficulties in South Africa. This review will provide an introduction into the self-efficacy theory as well as relevant research findings on counsellor self-efficacy. The Bronfenbrenner ecological theory will be expounded to give insight into the broader context in which clergy are functioning. The third chapter will include an outline of the research design and methods of data collection. An important part of this section will also be to consider some of the ethical challenges associated with conducting this research. Finally, an outline of the results of this research and a discussion of these findings and recommendations will be given.

## **1.6 Definition of terms**

In this study the following terms were defined as follows.

**Clergy:** An ordained minister of religion regardless of denomination. The terms clergy and priest were used interchangeably.

**Counselling:** “An activity or intervention of giving guidance and advice on a personal basis with the aim of relieving anxiety or other emotional pain often caused by life events and difficulties such as relationship problems, loss and bereavement” (Leavey, 2008, p.81)

**Counsellor self-efficacy:** “One’s beliefs about his or her capabilities to effectively counsel a client in the near future” (Larson & Daniels, 1998, p. 180).

**Counselling self-efficacy:** Counsellor’s perceptions that they are able to handle situations that may emerge in counselling for emotional and psychological difficulties (Larson & Daniels, 1998).

**Mental health:** “A state of well-being in which the individual realizes his or her own abilities to cope with normal stresses of life, can work productively, fruitfully and is able to make a contribution to his or her own community” (World Health Organisation, 2005, p. 2).

**Mental health professionals:** A professional with a qualification in a mental health discipline, such as psychologists and psychiatrists.

## **Chapter 2 Literature Review**

### **2.1 Introduction**

This literature review will be presented in three parts, which are reflective of three major areas of concern in this research. An introduction to the role that clergy play in mental health and the historical perspective of the relationship between clergy and professional health care will be outlined first. Also of importance will be the health-seeking behaviours of parishioners and the epidemiology of psychological problems in South Africa, a review of the ecological framework and self-efficacy theory and how it is applicable in explaining the role and the extent to which clergy engage in counselling. It will also look at the factors that impede and enhance counsellor self-efficacy.

### **2.2 Religion, spirituality, counselling and psychology**

Historically, the church has always provided counsel to her members. The work of Freud, Jung and many others professionalized counselling while on the other hand fundamentalist religious groups were sceptical “about scientific approaches [thus creating] a split between religious counselling and psychology which has existed for many years” (Millar & O’Kane, 200, p. 324). Currently, the church is being drawn back to counselling and assisting society members deal with personal problems beyond the spiritual needs of her congregants. Other forms of personal development like spiritual direction fall within the domain of the church. In the church there are no clear boundaries as clergy take up this role. In recent times, there has been a burgeoning of faith-based organisations that are helping with the provision of mental health in different communities. Help is offered through offering faith-based counselling drawing from the individual’s religious aspects (Mental Health Foundation, 2007).

The effect of a parishioner’s “reliance on religious and spiritual beliefs is positively correlated with their health and adaptation. The effects of faith and religious belief has been documented in areas of fertility, contraception, [depression, substance abuse], other contemporary issues which challenge coping skills” (Kane, 2003 p.262).

According to the Mental Health Foundation, (2007) report, beneficial aspects of religion include ceremony, social support, prayer and relationships with God. However, other aspects of religion have been attributed to pertain to both negative and positive effects on mental health. Religion is used moderately for coping. There is a possibility that clergy may take a moralistic view thus be inclined to judge parishioners presenting with emotional and

psychological issues as spiritually impoverished. This has implications for people consulting clergy for emotional and psychological problems. The use of clergy for guidance with mental health problems has been empirically demonstrated, but research that explores how they help and their own perceptions of their confidence and ability to help is limited.

### **2.2.1 Religion and help seeking behaviour**

Durkheim (2001) observed that religion has as a central function in the healing of individuals and of society. Research evidence from the United Kingdom and United States of America suggests that community priests have significant contact with people who suffer from emotional and psychological difficulties (Leavey, et al., 2007). In South Africa, there is evidence that religious institutions and religious leaders assist in providing mental health care services to society (Hugo & Trump, 2006).

The mental health service delivery system in South Africa is bio-orientated, excluding cultural and spiritual dimensions of life, whereas the mental health incorporates cultural, physical and spiritual dimensions of life (Mkhize & Kometsi, 2008) thus creating a void in mental health service delivery. Moreover, the insertion of psychiatric care for mental disorders at primary health care level left common mental disorders like anxiety, depression, behavioural problems and life adjustment difficulties unattended (Mkhize & Kometsi, 2008). It is in this light that clergy may be consulted as an alternate source of help, to assist people cope with life transitions.

Socio-economic status may influence choices of where people seek help; for instance, the less affluent tend to rely more on traditional healers (Havennar et al. 2008). Treatment expense is a recognized significant deterrent for people experiencing emotional and psychological difficulties from seeking aid from psychologists and psychiatrists (Taylor, Ellison, Chatters, Levin & Lincoln, 2000). In South Africa some sections of society do not know or understand what psychologists and psychiatrists do and these professionals are not recognised and are at times highly mistrusted. Some may avoid psychotherapy because they do not define psychological distress in the same ways as mental health professionals do. Therefore people would not seek help from government provided services; rather they seek help from other alternate sources. Furthermore, in South Africa there are limited culturally appropriate psychological services especially in nonurban areas (Pillay & Kramers, 2003). Nevertheless, others are more inclined to seek help from the church because admitting an emotional and psychological problem is tantamount to admitting spiritual failure (Weaver et al. 2003).

### **2.2.2 The role of clergy as mental health counsellors**

Literature regarding clergy's role in offering help for psychological and emotional difficulties is scarce (Weaver, 1995). Literature available demonstrates a general agreement that priests formally or informally counsel their parishioners (Leavey, 2008). Clergy are usually seen as honest, familiar, and understanding (Weaver et al., 2003). Community members tend to consult clergy first for counsel and guidance on family matters and personal crises. It is worth noting that "not all people who request help from the clergy require counselling" (Millar & O'Kane, 2001, p. 325) and clergy do not always respond to parishioners' emotional and psychological difficulties by offering counselling. In the South African context, unlike abroad, clergy involvement in mental health issues has not been extensively documented. This research seeks to contribute towards literature in the role of clergy in counselling because clergy hold a very privileged and influential position in society with high levels of attributed trust (Weaver et al. 1997). They could be a useful resource in the mental health delivery system.

Clergy with more counselling training and education tend to be more proactive and engage in counselling although they also tend to be more aware of their limitations (Leavey et al. 2007; Millar & O'Kane, 2001). The deinstitutionalization of psychiatric care presented communities, faith based organisations and non-governmental organisations with an additional burden of caring for those living with mental illness (Leavey et al. 2007). Counselling is an important aspect of pastoral care. Grimm & Bassett (2000) noted that clergy see essentially the same client issues as seen by mental health professionals. However, evidence that clergy draw favourable comparisons with other mental health professionals is limited. Leavey et al. (2007) found that clergy play a role in supporting and counselling people experiencing distressing life events; however they could not ascertain how clergy responded to cases of anxiety and depression. This finding suggests that clergy are not on a par with other mental health professionals. Priests, however, counsel couples, individuals, partners and families and may lead groups covering issues such as grief and bereavement (Leavey et al. 2007) which falls within the scope of their work.

Jewish and Muslim clergy commented that the synagogue or the mosque was approached first by members seeking help for emotional and psychiatric problems (Leavey et al. 2007). Priests from different faiths and denominations provide substantial support and comfort for people in times of crises, bereavement, separation and divorce through pastoral counselling

(Leavey et al. 2007). All these relate to major developmental events which cause considerable amount of distress where individuals require emotional support. Religious functions and sacraments afford the priest contact with people at these critical points of their lives. In affluent areas the church may also provide outreach programmes for people with psychological difficulties for example, for individuals living with substance abuse, the homeless and for people living with mental illness (Leavey, 2008).

Kane (2003) investigated Catholic clergy's perceptions of their ability to counsel parishioners and he established that moral problems were areas that priests felt more competent. Kane, (2003, p. 264) noted that priests "believed that most emotional, personal and family issues were within the competence of professionals such as clinical social workers, psychiatrists and psychologists". Kane (2003, p.264) also highlighted that "even though priests may initially assess an individual with problems they preferred that most problems be referred to professionals". Although priests felt less competent to deal with such issues, their parishioners were satisfied to have their priests counselling them for emotional and psychological issues. Leavey, (2007) also reached the same conclusion that British clergy in various denominations wished to refer to professionals and felt less competent with dealing with more emotional and psychological problems. Generally, the population prefers to seek help from their priests while priests prefer to refer them.

Virkler (1979, as cited in Koenig, 1998) noted that depression was a presenting problem that was frequently seen by clergy, but depression was also a psychological difficulty that clergy felt inadequately trained to counsel for. Leavey (2007) also reached the same conclusion highlighting that how clergy responded to parishioners presenting with depression and anxiety is unknown. Leavey (2007) commented a significant level of psychological literacy is evident among the clergy in the mainstream churches. However, it remains undetermined if the same can be generalized about the situation in South Africa.

### **2.2.3 Involvement of church in mental health**

In the South African context there appears to be a dearth of information regarding the role of the church in promoting mental health. Unlike the dialogue between traditional healers and primary mental health care (Havennar et al. 2008), the public status of religious leaders as mental health counsellors was regulated by Act 89 of 1997 that stipulated that counselling should be a purview of psychologists. Churches as faith based organisations generally play a welfare role; however, "the nature or status of this position is unclear as it is further

complicated by a range of pastoral and leadership styles between and within religions” (Leavey et al. 2007 p. 549). This poses a challenge in trying to incorporate religious leaders as counsellors.

Affiliation with a particular spiritual or religious ideology provides a social network of support from friends and other members for emotional and physical well-being (Mental Health Foundation, 2007). Religiosity and spirituality are viewed as important components of the psychological health of many (Pargament, 1997). Research has indicated the benefits of religious involvement to well-being and health (Taylor et al., 2000). The church and its members provide a therapeutic haven that buffers the impact of psychological distress (Mental Health Foundation, 2007). For centuries, prior to the professionalization of psychology, mental health had been the domain of the church (Millar & O’Kane, 2001). Christians sought counsel from their pastors for help with life’s varying problems.

On the other hand, the differences in theological frameworks of pastoral support pose difficulties in conceptualising the role played by clergy from other denominations other than the traditional mainstream churches. Mental ill health, poverty and other forms of affliction could be interpreted as evidence of sinfulness (Leavey, 2004). Among the traditional African churches, for example, the Shembe Church faith healers, mental ill health is seen as a result of witchcraft or is described according to traditional African beliefs (Crawford & Lipsedge, 2004). This vast difference in interpretations of faith across churches has an impact on how clergy will respond to the problem presented to them by their parishioners and also has an influence on help-seeking decisions made by parishioners. It is a possibility that not all clergy can engage in counselling depending on the interpretation of their faith and beliefs as well as their theological framework and training.

#### **2.2.4 Clergy training**

Clergy in their training receive a variety of courses in pastoral care and pastoral counselling. Pastoral counselling is an approach to counselling in which insights of theology and spirituality are integrated with principles of modern behavioural science to help individuals achieve wholeness and health in a community of faith (Ross, 1999). Pastoral counselling is similar to other forms of counselling (in technique) but it differs in spiritual character. In South Africa it is uncommon to become a pastoral counsellor with an Honours qualification in Social Work or Psychology and a Master’s Degree or Doctorate in Theology. At different

universities there are modules for counselling that equip clergy with basic counselling skills and a supervised internship for the Bachelor's degree in Theology (Neethling, 2003).

Among the many courses clergy study, some courses do not prepare them for specialized clinical helping (Kane 2003). Most of them are aware of these professional limitations. It is notable that in cases of more debilitating psychological difficulties, clergy feel inadequate and overwhelmed by inability to help (Leavey, 2007). The priest relies "on theological training and human compassion compels [them] to act to relieve emotional suffering... [not on] knowledge of theory and clinical procedure fundamental to mental health disciplines" (Clemens, Corradi & Wasman, 1978, p. 230). There is considerable consensus that the level of training for pastoral counselling does not adequately address mental health issues by those in ministry and in mental health profession alike (Leavey et al., 2007). It is also worth noting that it is unfair to judge clergy competence based on the criteria for clinical practice while their training is limited to spiritual helping.

The training of psychoanalysts take 15 years of rigorous work, psychologists and psychiatrists take about seven years of rigorous work with a lot of supervision and psychotherapists having to undergo psychotherapy themselves. Part of the training of the psychotherapist is aimed at helping him/her find his/her own motives, solve his/her own conflicts, not only to acquire skill and method of handling cases. The therapist has to solve his/her emotional problems and the training is therefore geared to enable him/her to discover himself in personal relations in order to be able to deal with transference and counter-transference issues which are inevitable in counselling and psychotherapy relationships (Weiner, 1975).

There are different levels of qualifications of clergy especially in the United States of America and some of them possess a depth of training above mental health professions. There are also courses that prepare clergy for clinical counselling in pastoral settings, namely, Clinical Pastoral Education. The same cannot be said about the South African context, where some churches do not even have formal training for their ministers.

Lee, (1968), one of the pioneers in investigating the inter-relationships of religion and psychology, suggested that there are great counsellors in the church who are endowed with wisdom and skill, not as a result of special training aimed at improving the competence they have as pastoral counsellors. Lee (1968) attributed the clergy's competence to the quality of

character that most clergy possess, like humility, selflessness and sympathy for others. These qualities seem to give them the ability to listen with understanding and an unshakable faith in the healing and renewing action of God. From a psychological counselling point of view these are the same qualities that a counsellor should have. So by the very nature of their disposition, clergy may be relying on innate counselling abilities.

### **2.3 Socio-emotional and psychological difficulties experienced in South Africa**

Clergy are often sought at most transitional stages of their parishioners like, the birth of a child, blessing of a marriage, advent of an illness or tragedy and coping with death and bereavement. These events cause internal conflict and considerable levels of distress. The problems presented to clergy are in many cases the same that would be presented to any other type of counselor (Graber, 2004; Grimm & Bassett, 2000). This section will focus on some of the socio-emotional and psychological problems that may be presented to clergy and their prevalence in the general South African population.

In South Africa, like in most developing countries, reliable and valid epidemiological information of various mental disorders is insufficient (Mkhize & Kometsi, 2008). Corrigan (2007) noted that apart from South African Stress and Health (SASH) study, there is no other reliable data on the prevalence of mental health issues in SA. The SASH estimated the national prevalence of mental illness at 30.3 % for any psychiatric disorder (Stein et al., 2008). Kleintjes et al., (2006) reported that the prevalence rate of mental disorders was 25% for adults and 17% for children and adolescents.

#### **2.3.1 Depression**

Depression is a commonly occurring difficulty among South Africans. Olivier (1989) reported a 30.6 % prevalence rate of clinical depression among urban black South Africans and 15% white, Asian and Coloured adult South Africans. SASH found lifetime prevalence for major depression to be 9.8%. Depression was significantly associated with being female and being a divorcee, separated or widowed (Stein et al., 2008). Havennar et al., (2007), in a study that looked at the prevalence of mental disorders in previously disadvantaged rural and peri-urban areas, found that depression was very prevalent in both areas alike. Bhagwanjee et al., (2004), as cited by Mkhize & Kometsi (2008) discovered that anxiety and depressive disorders were prevalent among rural African adults in KwaZulu-Natal.

### **2.3.2 Socio- economic problems**

Socio-structural factors influence the individual's ability to respond to stressors. The degree of exposure to socio economic problems has a negative influence on mental health. The negative effects of transformation have affected South Africans across the racial divide. High levels of unemployment and poverty are experienced in both rural and urban areas (Van Niekerk & Prins, 2001). Socio-economic factors, including unemployment, poverty, low social capital and community violence, increase vulnerability to mental illness and the reverse is also true. Mental health can also be a determinant of socio-economic outcomes. There is a high possibility that the mentally ill are unemployed and live below the poverty datum line (Corrigal, 2007). Havennar et al. (2007) found that poverty is prevalent in rural areas and peri-urban areas with 17.6 % participants unemployed and 15.3% participants showing visible poverty.

### **2.3.3 Alcohol and substance abuse**

Swartz (1981) found a high prevalence of alcoholism in black communities. SASH found that alcohol abuse (11.4% lifetime prevalence) and substance use disorders (13.3% lifetime prevalence) were significantly associated with male gender. According to SASH, substance use disorders have an early onset at age 21 or younger compared to other psychiatric conditions (Stein et al., 2008). Mental health and substance abuse problems were found to have a high prevalence in previously disadvantaged communities in South Africa (Havennar et al., 2007).

### **2.3.4 Marital distress/Domestic violence**

South Africa has seen an escalation of divorce cases. In 2002 divorce rate was 526 per 100 000 married couples and increased to 6.4% at the end of 2009 (Statistics South Africa, 2005). Marital distress and divorce are associated with numerous psychological disorders and negative life events (Amato, 2000). Domestic violence and abuse is common in South Africa, although no reliable statistics are available on the prevalence of domestic violence. One of the contributing factors to marital distress and domestic violence is the use of alcohol and substances. The prevalence of alcohol and substance abuse has been extensively documented.

### **2.3.5 Suicide**

Transformation is exerting pressure on South Africans independent of race and culture, leading to high stress levels. Consequently, South Africa is experiencing an increase in suicide rates and estimated to be higher compared to WHO globally related ratios (Schlebusch & Bosch, 2000; Van Niekerk & Prins, 2001). All races are experiencing

comparable rates of fatal and non-fatal suicidal behaviour. The rates for blacks in urban areas are similar to other population groups in contrast to previous assumptions that suicide is rare among black South Africans (Schlebusch & Bosch, 2000). Family problems and interpersonal conflict are the common reasons given for suicidal behaviour.

### **2.3.6 Teenage problems/pregnancy**

South Africa has been plagued with an astronomical increase of teenage pregnancies with Eastern Cape, KwaZulu-Natal and Limpopo recording the highest incidences. The increase could be accounted for by the socio-economic conditions which young people are exposed to. Poverty, unemployment in African and Coloured communities and the disruption of the family structure predispose young people to early sexual onset for monetary gain ( Panday, Makiwane, Ranchod & Letsoala, 2009). The high rate of teenage pregnancies and teenage fathers highlights the need for sexual counselling for adolescence. Clergy may be a valuable resource in supporting the high-risk families through home visits.

### **2.3.7 Family relationship problems**

The urbanisation process has disrupted the family unit. Investigating the adolescent population, Pillay & Wassenaar (1997) showed that a problematic relationship with parents was the most significant factor precipitating self-destructive behaviours in adolescents. Family conflict has also been implicated in the high rate of teenage problems. Psychological difficulties are intricately intertwined although one does not necessarily cause the other. A cohesive family unit has been cited as one of the protective factors against mental health problems (Pillay & Wassenaar 1997). There are few professionally trained people to counsel the public and to deal with basic problems that people experience especially in family contexts.

### **2.3.8 HIV/ AIDS**

The findings from the South African Department of Health study, (2006, cited in South Africa HIV & AIDS Statistics, 2007) estimated that KwaZulu-Natal (KZN) had a prevalence of 39.1% of antenatal attendees living with HIV; the figure rose to 39.5 for 2009.

Approximately 11% of South Africans between 2 and 14 years old were living with HIV in 2008 (South Africa HIV & AIDS Statistics, 2007). The national HIV prevalence for ages between ages 15 and 49 was estimated to be 16.8%. KZN had highest prevalence at 15.8 % in 2008. Until 1998 South Africa had the fastest growing HIV infection rate. The infection rate had relatively stabilised by 2006. The impact of HIV/ AIDS has a ripple effect on families accompanied by loss of income through death, child-headed families and emotional

strain of witnessing a family member ill. All these affect the mental health of those infected and affected (South Africa HIV & AIDS Statistics, 2007). Clergy may contribute in reducing stigma and treatment gap by encouraging people to seek early treatment. However, there is a possibility of getting the opposite effect especially when religious leaders take a moralistic view that may lead to prejudice and discrimination against those affected by HIV/AIDS.

### **2.3.9 Bereavement**

In South Africa annual deaths from HIV/AIDS rose between 1997 and 2006 by 93% although part of the increase is due to population growth (South Africa HIV & AIDS Statistics, 2007). On the other hand, the prevalence of homicide in KZN was estimated at 4.7% and road traffic 2.8% respectively (Corrigal et al. 2007). The incidence of murders and road traffic accidents also increases the number of deaths in society. The death of a loved one is considered one of the most stressful life events. Clergy are directly involved in matters linked to death and dying. The visits of priests to families following death is of social and psychological value. Priests offer support to the widowed and orphaned.

### **2.3.10 Sexual abuse/sexual orientations**

The prevalence of abuse in the population is difficult to determine. Issues like sexual orientation are not psychological difficulties although there may be high levels of distress associated with it in communities where homophobia is rife. It may also cause distress and conflict in marriages where sexual preferences were kept secret (Olivier, 1989).

### **2.3.11 Summary**

South Africans are experiencing a variety of psychological and emotional problems. There are few mental health professionals in South Africa and many are concentrated in urban areas, leaving South Africa with a huge unmet need in mental health care (Stein et al., 2008). Clergy are a group of people who are within the community structures and can provide a protective buffer for people experiencing emotional and psychological difficulties. It is of utmost importance that the role clergy play in counselling be discussed.

## **2.4 Bronfenbrenner's bio-ecological framework**

In order to fully account for all factors that influence the role of clergy in counselling, Bronfenbrenner's bio-ecological model of human development will form the framework of this study. This theoretical perspective will allow person/ environment interactions to be explored. While the Bronfenbrenner's model was originally formulated to account for child development (Bronfenbrenner, 1978; Bronfenbrenner & Morris, 1998) and applied to successfully understand the development of children, it can be also applied to adult

development. The model can account for different settings in which the individual acts and the dynamic relationship between the settings. The bio-ecological model has similarities with Bandura's (1986) Social Cognitive Theory but it has a broader application and is not specific to learning outcomes. Hence, it was chosen to give context to the study.

#### **2.4.1 Introduction to the bio-ecological systems theory**

The bio-ecological systems framework explains how interlocking factors like family, culture and the social environment can influence the individual's development over time.

Bronfenbrenner's bio-ecological systems theory states that development is the outcome of the bi-directional interactions between active individuals and the dynamic environment. The bio-ecological model accounts for each setting within which the individual acts and the dynamic relationship between the settings (Bronfenbrenner & Morris 1998, 2006)

Bronfenbrenner (1979) described an ecological environment as consisting of five systems nested within each other. Each level, and processes occurring at each level, reciprocally influences the other levels and processes that occur in that level and other related contexts (Bronfenbrenner, 1979). By specifying the nature of each level, a richer understanding of the dynamic processes between the individual and the environment can be gained. Individuals operate in different domains containing specific interactions, roles, activities and relationships. These interactions between the systems impact on how an individual develops and in turn how the individual influences the systems. The interconnected systems are: the microsystem, the mesosystem, exosystem, macrosystem and finally the chronosystem.

*Microsystem:* This comprises of the individual's immediate context. It is concerned with the day-to-day functioning of the person and his/her interaction with the immediate context of family members, friends, school and the workplace.

*Mesosystem:* This microsystemic context is entrenched within the larger mesosystem. The mesosystem can be described as the connections between two or more settings in which the developing person actively participates (Bronfenbrenner, 1998). It includes connections and relations between the immediate environments. The individual may have numerous mesosystemic linkages. In the context of this study a link is established when clergy enter a community, when they interact with the broader society and when they interact with their own workplace. When clergy get involved in counselling a link is formed with the mental

health-care system. When a referral occurs with other service providers such as the hospital and mental health professionals in the community another link is formed.

*Exosystem:* The exosystem incorporates the events occurring in a setting external to the individual. The individual is excluded in that setting but is indirectly affected by the interactions in that system. For example, a change in the health care system does not have a direct impact on the priest and his ministry and his work-place. However, the unavailability of adequate resources in terms of mental health care workers can encourage people to seek help from clergy because of clergy's accessibility. The exosystem consists of the external environmental settings that only affect the individual indirectly (Bronfenbrenner, 1979). The linkages and processes occurring between settings, religious beliefs, socio-economic status and health-seeking behaviours might make it inevitable for clergy to engage in counselling for emotional and psychological difficulties.

*Macrosystem:* The macrosystem encompasses the overarching patterns of all the other systems, the cultures, subcultures or other extended social structures. The macrosystem is the broadest ecosystem and it comprises the larger socio-cultural context, the society at large. All the interactions of the macrosystem influences the role clergy play in offering mental health care service to their parishioners: the regulations in the Health Department, the limitations of the health care system, and the epidemiological prevalence of emotional and psychological difficulties, the community's religious and cultural beliefs, among other things.

*Chronosystem:* The chronosystem is concerned with historical time as manifest in changes in the larger context of the macrosystem and in personal changes for example puberty. The chronosystem could possibly involve the transition of clergy counselling, from being a predominantly clergy domain, to the professionalization of counselling and currently the resurgence of spirituality in mental health matters.

Bronfenbrenner updated his ecological model giving rise to the Person-process-context-time model of human development. The expanded formulation (Bronfenbrenner, 1998) noted that the emphasis on the context obscured a necessary and essential component of the process that the individual contributes (Bronfenbrenner & Morris 1998). The extension of the original model led to the new name the bio-ecological model and the individual becomes an active participant engaged in a bi-directional relationship with a dynamic environment. According

to the bio-ecological model, development is a function of interactions or proximal processes between the person's characteristics, their context or their environment that, occur with time.

#### **2.4.2 Understanding the proximal processes**

Proximal processes that occur between the person and their environment are considered to be the drivers of development and involve activities which occur regularly and with increasing complexities. These activities are reciprocal exchanges and interactions with people and symbols and can be moderated by the individuals' developmental capacity and influenced by significant others (Bronfenbrenner, 1998). The clergy's demand characteristics, such as age, training, disposition, or gender, influence activities and interactions that an individual can pursue. Engagement in counselling by clergy is one of these proximal processes that occur on the everyday basis of clergy carrying out their pastoral duties. Person characteristics, context and time also influence these proximal processes.

#### **2.4.3. Understanding the person**

The person in the bio-ecological model is defined by characteristics that assist and lead to proximal processes occurring. These characteristics are generative disposition, physical and intellectual resources and the individual demand characteristics (Bronfenbrenner & Morris 1998, 2006). The generative disposition is defined by the individual's selective responsiveness to the social and physical environment and how the individual engages and persists with complex tasks and their belief systems such as self-efficacy and locus of control that direct their actions over time. The individual physical and intellectual resources develop across the lifespan and can foster development or place limits on how well an individual is equipped to deal with the changing world. The demand characteristics show how the individual relates to other people and whether interpersonal relationships are positive or negative (Bronfenbrenner & Morris 1998, 2006). The independent variables used in this study: age, pastoral counselling education, experience, and perceived self-efficacy, all refer to the demand characteristics of the priest as an individual. These factors would influence how clergy would approach counselling as part of their work.

#### **2.4.4 Understanding the context**

Context refers to the ecosystemic climate in which individuals carry out proximal processes. In the discussion of ecological theory, the elements of the context are described by the roles and activities and relationships that the individual engaged in within each setting (Bronfenbrenner, 1979). However, person characteristics are situated and interact within other ecological systems; the microsystem, mesosystem, exosystem and macrosystems. For

instance, the self-efficacy beliefs of an individual are influenced by factors in the mesosystem (the person's religious community, the peers), in the macrosystems (e.g. the culture and socio-economic factors), as well as the microsystem. The congregational system idealises clergy and she/he is perceived as a knower and the solver of problems. Clergy are therefore sought after for counsel, advice and are utilized in times of joy and crisis and are therefore persuaded to engage into counselling. Even if the priest is aware of his/her shortcomings, in a bid to be useful and to measure up to the idealised state they engage in this counselling and a vicious feedback loop is created, which often leads to clergy burnout (Haug, 1999).

#### **2.4.5 Time**

All aspects of the bio-ecological model can be thought of as existing and manifest in historical time. When thinking of developing individuals, the types of activities and interactions in which they engage form part of the transitions which are constantly evolving.

#### **2.4.6 Summary**

The bio-ecological theory is a comprehensive theory that described how the congregational system, the health system, demographics, cultural values and beliefs and self-efficacy beliefs viewed as part of cognition can influence clergy engagement in offering counselling to their parishioners thus contributing to mental health care delivery. The variable self-efficacy is a personal characteristic of the priest as a person and it belongs in the microsystem. The interactions being examined include the process of clergy's involvement in counselling and the process of the members of the congregation seeking counselling from clergy. Regarding the context, the environment in which the clergy engage in counselling is influenced by the broader ecological settings such as inadequate resources, limitations in mental health systems and historical transitions of clergy's involvement in counselling.

#### **2.5 Self-efficacy theory**

One major approach to investigating competence and ability is Bandura's self-efficacy theory. Self-efficacy beliefs are a resource in personal development and change (Bandura 1997). Bandura noted that a developing person is always interacting with his/her environment. The environment includes the immediate setting in which the person is involved, the interconnections among settings and the larger environmental surroundings as explained by the bio-ecological framework

Self-efficacy theory is based on Bandura's social cognitive theory. According to the social cognitive theory, when people believe that they have the ability to act and their actions will

produce the desired outcome, they are motivated to act in ways that are more likely to produce the desired outcome than when they do not believe that their efforts will be successful. Within this theoretical context, Bandura, (1986, p. 381) defined self-efficacy as “people’s judgements of their capabilities to organize and to execute courses of action required to attain designated types of performance.” Self-efficacy is considered a determinant of people’s interests, choices, actions, behaviour and performance (Bandura, 1997).

Based primarily on the social cognitive theory, studies have found out that individuals with high self-efficacy levels set higher goals and reach higher performance than individuals with low efficacy (Bandura, 1986). High efficacy levels have been associated with complex skill acquisition. Self-beliefs provide ability to control individual thoughts, feelings and how much one would exert oneself in the face of challenges. Self-efficacy is a dynamic construct that is also believed to be multidimensional and hierarchical, differing in magnitude, strength and generality. The magnitude of self-efficacy refers to the difficulty level of tasks one thinks one can accomplish. Individuals with low magnitude self-efficacy perceive that they may accomplish simple tasks but not complex tasks. Strength of self-efficacy is the conviction that an individual has so that they can master a task. Individuals with low strength efficacy are likely to give up following experiences of failure. Generality is the extent to which self-efficacy in one domain may be broadly applied to other situations. Individuals may perceive themselves as efficacious in one domain but the confidence may not be extended to other similar domains (Bandura, 1977).

Bandura (1986) proposed four sources of information that enhance self-efficacy beliefs namely, mastery experiences, vicarious experiences, verbal persuasion and emotional arousal. Performance accomplishment offers evidence of personal capability. Experiences of success increases self-efficacy by buffering the negative impact of failure. Vicarious experience involves witnessing someone perform a task successfully. This is considered a weaker source of self efficacy compared to mastery. Self-beliefs of capability increase as individual expects that they also can perform the task. Bandura (1986) observed that self-efficacy increased if the observer and the observed have similarities. Verbal/social persuasion is a process that involves receiving verbal/non-verbal judgments by others. Bandura (1986) found that positive encouragement from others increases self-efficacy. Self-efficacy diminishes if the performance outcome does not match expectations. People attain information about their confidence based in part on their judgement in emotional arousal. The individual’s

interpretation of emotional arousal could be motivating or debilitating for self-efficacy (Bandura, 1977). Emotional arousal can be detrimental to the development of self-efficacy leading to self-defeating thoughts. Taken further negative interpretation of emotional arousal can lead to learned helplessness.

### **2.5.1 Perceived self-efficacy**

Perceived self efficacy can be also been conceptualised as an explanatory construct that links anticipation of success with the necessary advanced self-regulatory and self-reflective skills that are essential to making one's beliefs a reality (Bandura, 1997). In this study, perceived self-efficacy is the clergy's beliefs about their capabilities of engaging in counselling for emotional and psychological difficulties. Perceived self-efficacy is conceptualised as perceived operative capability. It is concerned with the strength of the belief that they are capable of executing a task. High perceived self-efficacy enables individuals to withstand chronically unfulfilled challenges without giving up (Bandura & Wood, 1989). However, it is important to note that self-efficacy is not the only, or even the most important factor that influences an achievement outcome. No amount of self-efficacy will produce competent performance which requires skills and learning (Schunk, 1991). Perceived self-efficacy alone can affect the level of motivation, but will not produce new tangible performance if the necessary sub-skills necessary for the exercise are lacking (Bandura, 1986)

### **2.5.2 Perceived counsellor self-efficacy**

Research in various disciplines provide insights into the role played by perceived efficacy in the fields of education health promotion, clinical dysfunctions, sport organisational functions and the efficacy of social and political systems (Bandura, 1997; Pajares & Urda, 2006; Maddux, 1995). Perceived self-efficacy can be equally be extended to the counselling field. Consistent with Self efficacy theory, self-efficacy for counselling would lead to motivation to engage in counselling and to persist in the face of challenges and impediments. The complex nature of counselling requires a degree of competence, motivation and confidence. Bandura's self-efficacy theory will be used as an approach to investigating competence and confidence of clergy in counselling because self-efficacy theory renders itself useful in assessing complex endeavours like counselling that require confidence in one's ability to attain desired goals (Bandura, 1977; Bandura, 1986).

Counsellor self-efficacy has been defined by Larson and Daniels (1998) as “one’s beliefs about his or her capabilities to effectively counsel a client in the near future” p.180. In counselling, perceived counsellor efficacy would involve the degree of confidence a counsellor has to perform basic helping skills, manage sessions and to negotiate challenging situations and presenting issues (Lent, Hill & Hoffman, 2003). When adapting Bandura’s self-efficacy theory, it follows that the higher the CSE, the more likely the counsellor would appraise challenges and impediments and then set realistic and obtainable goals. Larson & Daniels’ (1998) showed a positive relationship between counsellor self-efficacy and counsellor performance.

Counsellor self-efficacy could be regarded as a primary mechanism between the knowledge of skill to perform and the counselling task execution through engaging in effective counselling action (Bandura, 1977, Larson & Daniels 1998). Greason and Cashwell (2009) noted that counsellor efficacy plays an important mediating role between one’s knowledge of the appropriate actions in a counselling situation and one’s propensity to execute these actions. Higher counsellor self-efficacy is related to perseverance in the face of challenging counsellor tasks and the ability to receive and incorporate evaluative feedback (Bandura 1977, 1986; Larson & Daniels, 1998).

Ronnestad & Skovholt (2003) described becoming a counsellor as an intellectually and emotionally challenging task. A counsellor is expected to learn a new way of relating to others in a way that is contrary to the social norms. The counsellor is expected contain the clients’ emotions and ambiguity, to be genuine and at the same time non-judgemental. Research has shown that this often results in diminished assurance about the ability to execute the required task under the designated situational demands (Larson & Daniels, 1998). Consequently, counsellors are often preoccupied with feelings of incompetence. Accordingly, it follows that cultivating counsellor self-efficacy is an important aspect in developing competent and efficacious counsellors.

### **2.5.3 Factors influencing perceived counsellor self-efficacy**

The four ways of enhancing self-efficacy will be visited in order to illuminate factors that influence counsellor self-efficacy. In a general context, self-efficacy theory postulates that successful human performance requires not only the knowledge and skill, but also a cultivation of confidence in those skills and a deep-rooted belief system that one has the

ability to perform such behaviour (Skovholt & Ronnestad, 1995). Individual's belief systems are built through the person's sense of mastery. Mastery is attained through the acquisition of skill and experience in performing the task. Larson et al., (1992); Lent et al., (2003); Melchert et al., (1996) found the main effect on counselling self-efficacy by level of training and amount of counselling experience. Larson & Daniels (1998) found a linear relationship between counsellor self-efficacy and advanced students in counselling. Daniels & Larson, (2001) found counsellor training to positively influence counsellor self-efficacy over time. Studies by Larson & Daniels, (1998) and Urbani et al., (2002) showed a linear relationship between counsellor self-efficacy and counsellor development and counsellor characteristics. No significant differences were found between counsellor self-efficacy and counsellor characteristics, for example age and gender.

In counselling, verbal persuasion is experienced in a supervision relationship. Cashwell and Dooley (2001) investigated the impact of supervision and found a statistically significant difference in counsellor self-efficacy between counsellors who receive clinical supervision and those who do not receive clinical supervision. Getting performance feedback was found to have an influence on counsellor self-efficacy depending on the type of feedback. In counsellor development, verbal feedback is received in a supervision relationship. Positive feedback was found to positively influence counsellor self-efficacy (Daniels and Larson, 2001 and Larson & Daniels, 1998). Negative feedback was found to be related to lower levels of counselling self-efficacy (Lane, Daugherty, & Nyman, (1998). Positive feedback is interpreted as a mastery experience and according to self-efficacy theory mastery experiences tend to increase self-efficacy.

Greason and Cashwell (2009) found that internal cognitive skills also play a part in the enhancement and the cultivation of self-efficacy in counsellors. Mindfulness, attention and empathy have significant positive relationships with counsellor self-efficacy. Counsellor self-efficacy is also found to be influenced by emotional intelligence. Emotional arousal has been found to have a debilitating effect on counsellor self-efficacy particularly arousal of anxious emotions. Larson and Daniels (1998) found that anxiety was negatively correlated with counsellor self-efficacy. Greason and Cashwell (2009) also found that anxiety was negatively correlated with counsellor self-efficacy. Spirituality has also been found to increase counsellor self-efficacy. Pollock (2007) also found a correlation between counsellor self-efficacy and spirituality. Individuals who are tuned to their spiritual beliefs may have greater confidence, focus and compassion and this may translate into greater efficacy.

## **2.6 Hypotheses**

The following predictions will be tested in the study:

### ***Hypothesis 1***

It was hypothesized that there is a relationship between the perceived incidence of emotional and psychological difficulties in the parishes and how often clergy engage in counselling for the specific emotional and psychological difficulties.

### ***Hypothesis 2***

There is no statistically significant relationship between perceived incidence of emotional and psychological difficulties (as measured by Clergy questionnaire part 1) and their perceived counselling self-efficacy (as measured by the Perceived Counsellor Self-efficacy Scale).

### ***Hypothesis 3***

There is no statistically significant relationship between how often clergy counselled (as measured by Clergy questionnaire part 2) and their perceived counselling self-efficacy (as measured by the Perceived Counsellor Self-efficacy Scale).

### ***Hypothesis 4***

There are no statistically significant differences in perceived counselling self-efficacy for the following variables age, gender, type of training, mental health training, type of mental health training, level of education, size of congregation and type of parish.

## **2.7 Summary**

This chapter explored the role that clergy could possibly play in counselling for emotional and psychological difficulties and the prevalence of psychological difficulties in South Africa. It has been highlighted that there is an unmet need for mental health services. This led to the consideration of clergy as an alternate source of help. There is a lack of empirical literature investigating the role played by clergy in mental health and their perceived self-efficacy in counselling. It is anticipated that this study will contribute towards the knowledge in this area as well as help map out ways in which clergy can be incorporated as a mental health resource.

## **Chapter 3 Methodology**

### **3.1 Introduction**

This chapter provides an overview of the aims and rationale for this study. Starting with an outline of the research design and methods of data collection and analysis, this chapter will also review the ethical challenges arising in conducting this research, and strategies adopted to address these. Methodology entails a perspective or framework which guides the research (Bernard, 2002). The common methodological approaches in social sciences, namely, quantitative and qualitative research are based on different philosophical foundations.

### **3.2 Research design**

Durrheim (2004, p. 29) describes a research design as “a strategic framework for action that serves as a bridge between research questions and the execution or implementation of the research.” Essentially, this step becomes an important starting point in designing data collection and analysis that will best answer the research questions at hand.

This research investigates the role of clergy in counselling for emotional and psychological difficulties. It was anticipated this research would give insight into the extent to which clergy are involved in promoting mental health through counselling for emotional and psychological difficulties of their parishioners. It also seeks to find if there is a correlation between level of counselling frequency and the occurrence of emotional and psychological difficulties in the parishes. It was also expected that the research would advance our knowledge on how clergy perceive their self-efficacy for counselling for emotional and psychological problems.

Therefore this study might be classified as “descriptive”, where the findings are intended to “advance our fundamental knowledge of the social world,” and “applied” where there is the potential for a “practical application” (Durrheim, 2004, pp. 40-41). This descriptive design includes both quantitative and qualitative descriptions of the phenomena under investigation.

This study is a combination of two studies done sequentially employing a quantitative research methodology which relies on a positivist approach to social sciences and a qualitative research methodology which relies on interpretive or critical approach to social sciences (Neuman, 2000). The quantitative research was used in order to provide a means of quantification of the role played by clergy in mental health in KwaZulu-Natal and to determine their levels of perceived self-efficacy in counselling for psychological and emotional difficulties. The qualitative research had two main focal points: to explore the

phenomenon in its natural settings and to study its complexities (Bryman, 2008). The qualitative study was used as a follow-up study to get an in-depth understanding of the role played by clergy in mental health and the challenges, impediments and steps taken by clergy to overcome the challenges and impediments.

### **3.3 Instrument**

A questionnaire was developed for this study specifically for the purposes of measurement. The Clergy Questionnaire makes use of Likert scale-type format, in which participants must rate a) the occurrence of emotional and psychological difficulties b) how frequently they engage in counselling and c) perceived self-efficacy levels. The range of this scale is along a 5-point continuum. For the occurrence of emotional and psychological difficulties, 1 represents “very rare”, 2 “rare”, 3 “moderate”, 4 “frequent” and 5 “very frequently”. For the frequency of engagement in counselling; the scale ranged from 1 “never”, 2 “seldom”, 3 “sometimes”, 4 “frequently” and 5 “always”. The perceived efficacy scale ranged from 1 “strongly disagree”, 2 “disagree”, 3 “neutral” 4, “agree” to 5 “strongly agree”.

The instrument, Clergy Questionnaire was composed of three sub-sections that are summarised below.

#### *Section A: Personal information*

This section assessed socio-demographic factors. Participants were requested to provide their personal information for example, age, gender, level of education, the location and size of their congregations and seminary attendance.

#### *Section B: The prevalence of psychological and emotional problems*

This section required respondents to indicate the perceived occurrence of emotional and psychological difficulties in their parishes. The psychological and emotional problems were based on the cases that clergy would normally deal with in pastoral settings (Graber, 2004). The situations included interpersonal problems, alcohol dependency, HIV/ AIDS, marital difficulties, premarital conflict, bereavement, depression, mental illness, life adjustment issues and sexual orientation.

### Section C: Perceived self-efficacy scales

This section consisted of items derived from the Counsellor Self-Efficacy Scale (CSES) that was developed by Melchert et al., (1996). This scale is a 20-item scale where participants rate their feelings of competence in counselling knowledge and skill related to the practice of individual and group counselling. The CSES is a validated instrument with a reported Cronbach alpha internal consistency of .93 and a test-retest reliability of .85 (Melchert et al., 1996). The convergent construct validity was done through a correlation of scores with Friedlander and Snyder's (1983), Self-Efficacy Inventory. The correlation between the two instruments was moderately high ( $r = .83$ ) (Melchert et al., 1996).

The CSES focused on items that comprehensively assessed the skills normally used in the practice of counselling while excluding skills primarily associated with particular theoretical approaches. This was ideal for this particular study as this study is about clergy who probably may not have a particular theoretical approach to counselling. Nevertheless, the instrument is construct validated and theoretically grounded; thus, the CSES was chosen for adaptation for use in this study. The Counsellor Self-Efficacy Scale was modified to create the Perceived Self Efficacy Scales (PCSES) (see Appendix C) to measure clergy's perceived counselling self-efficacy for emotional and psychological difficulties. The items were rephrased to suit the purpose of the study. Items referring to group counselling were eliminated, thus only fifteen items were included in the PCSES. The split-half reliability was measured using SPSS and the scale has coefficient of ( $r = 0.7337$ ). Negatively worded items were reverse coded. A higher score represented higher levels of perceived counselling self-efficacy for emotional and psychological difficulties, the same way the CSES would have been scored. The minimum score of the PCSES is 15 and the maximum score is 75. It was hypothesized that the PCSES would show variations in clergy's levels of perceived counselling self-efficacy between all socio-demographic variables.

Investigations for perceived self-efficacy include quantifiable self-reports measures to include person to person variations. Actual levels of competence are difficult to measure therefore perceived counselling self-efficacy was used as a measure of confidence. Perceived counselling self-efficacy is a construct that relies on individual self-reports of perceived self-efficacy. This tends to increase self-report bias and poses measurement validity issues. Negative wording was used for some items to mitigate acquiescence.

### **3.4 The qualitative study**

The last item on the questionnaire was an open-ended question that asked the priest to describe how they had actually offered help to a parishioner who presented with a psychological or emotional difficulty. This was included to afford the respondents an opportunity to provide more information. Content analysis was used to analyse these answers. After going through the responses, a coding schedule was designed with seven distinct categories based on subject and themes. The data was recoded by an independent person and the Kappa coefficient was found to be .74 which is considered to be significant (Bryman, 2008).

An interview schedule was also designed with open-ended questions (see appendix D). Respondents who had indicated an interest in further discussion on their questionnaires were contacted by telephone and telephone interviews were conducted. After going through the responses a coding schedule was designed for each question based on subject and themes.

### **3.5 Participants**

A total of fifty-two licensed clergy from the Diocese of Natal completed the questionnaire (mean age 53.86) who attended seminary (n = 38) and who had not attended seminary (n=14), as well as those that had further training in mental health (n= 11) and those who had not (n = 41), females (n=25) and males (n=39). Participants from suburban parishes (n=22) served rural parishes (n=21), township parishes (n= 9). Participation in the study was on a voluntary basis. Ten follow-up interviews were carried out with clergy from the original fifty-two who completed the questionnaire. The second sub-sample consisted of two females and eight males. This formed the second part of the study.

### **3.6 Procedure**

Permission to carry out the study was sought from and granted by the Bishop. The questionnaire was administered using a group of clergy who had gathered for synod or other regional meetings. The questionnaire was distributed amongst participants by the researcher. The format of the questionnaire and what was expected of each participant was explained to the entire group. The aims of the research and the value of their participation were explained. Participants were referred to the cover letter and the consent form ( see Appendix A: Informed consent form). Prospective participants became part of this sample after being invited and choosing to participate on a voluntary and informed basis. This was generally achieved by approaching clergy just before the beginning of their Church Conference and also at the beginning of regional meetings. Most of the completed survey questionnaires were

collected immediately. Some of the participants took the questionnaire away and mailed them to the researcher at a later date. Some clergy declined to participate.

The response rate was low 54 of 150 questionnaires distributed were returned (approximately 35% response rate). This could be probably because participants were reluctant to give up their time without some form of incentive. Another possibility could be clergy may not be engaging in counselling for emotional and psychological difficulties. Given the low response rate there is a possibility of sample bias.

### **3.7 Sampling**

The process of sampling “involves decisions about which people, settings, events, behaviours and/or social processes to observe” (Durrheim 2004, p. 44). The primary population of analysis was the clergy of a mainline church in KwaZulu-Natal. This exercise used a convenience sampling method, in which research participants were invited to take part in this research on the basis of their availability and willingness to be studied. Clergy were approached during their conferences and regional meetings.

### **3.8 Data analysis**

To analyze and interpret the data collected for the first part of this study, a series of statistical procedures were run using Statistical Package for Social Sciences. These will be listed below according to specific research questions and the hypothesis they attempted to explore. For the second part, a qualitative content analysis was done using the deductive approach.

#### **3.8.1 The relationship between emotional and psychological difficulties, clergy’s frequency of counselling**

To measure the participants’ responses on the clergy questionnaire on their judgement of the incidence of psychological and emotional problems their parishes and frequency at which they engage in counselling, participants’ responses on the clergy questionnaire were tallied and listed as frequencies. In order to investigate this relationship, the association between the incidence of psychological difficulties in the parishes was weighed with how often clergy engaged in counselling for these particular difficulties. Chi-square tests for association could not be done from the raw data as some cells had very few counts. In order to circumvent this problem the cells were collapsed to get more counts in most cells.

Cross tabulations of raw data were run per particular difficulty for frequency of counselling and perceived incidence of emotional and psychological problems. Frequency counts from “very rare” and “rare” were collapsed into a “low incidence category” and frequency counts

from “moderate” constituted “moderate incidence category” and lastly “frequent” and “very frequent” were collapsed into “high incidence category” of a particular difficulty. For the question of how often clergy counselled, frequency counts for “never” and “seldom” were collapsed into one cell; “low frequency of counselling”, and frequency counts from “sometimes” constituted “moderate frequency of counselling”, whilst “frequently” and “always” were collapsed into one cell, called “high frequency of counselling”.

Chi-squares determine the significance of association, whether the relationship observed in the sample provides enough evidence to conclude that there is a corresponding relationship in the population (Gravetter & Wallnau, 2011). Thus chi-square measure of association were used to determine the relationship between the perceived incidence of psychological and emotional difficulties among parishioners and clergy’s counselling frequency for the psychological difficulties.

A correlation of each particular difficulty was done for the incidence of the difficulty and how often clergy engaged in counselling for that difficulty. A correlation was done to show the degree of variance between the perceived incidence of a psychological or emotional difficulty and how often the clergy counselled for specific difficulties. The correlation also measured the strength of the relationship between the perceived incidences and actual engagement in counselling. It is important to note that correlation does not imply causation; there might be a possibility of another variable at play that may be contributing to the correlation (Gravetter & Wallnau, 2011).

### **3.8.2 Perceived counselling self-efficacy**

Using ANOVAs, the level of efficacy held by the clergy in this research were measured. At the same time, differences in the levels of perceived counselling self-efficacy between all socio-demographic details was also compared using a series ANOVAs and t-tests.

### **3.9 Qualitative data**

For follow-up interviews the participants were contacted via telephone and explained the purpose of the study which was to explore the role played by clergy in mental health and obtained their consent to participate. Telephone interviews and face -to-face interviews were done depending on the availability of the priest. This was done at the convenience of the participants. Interviews were recorded and transcribed by the researcher.

In order to get some new insights into clergy’s role in mental health in South Africa, content analysis was done for the ten follow-up interviews. Transcriptions were thoroughly read

through before categorisation and coding. An analysis matrix was developed. Words, phrases and sentences were allocated smaller content categories on the basis of manifest content of the text (Weber, 1990). To improve reliability, coding and categorisation rules were based on psychological counselling and therapy techniques. The reliability of the coding was checked when a fellow Masters student recoded the data. We discussed similarities and differences in our coding.

### **3.10 Ethical issues**

It is important to ensure the safety and respectful treatment of participants. According to Durrheim and Wassenaar (2004), researchers should take into consideration the principles of autonomy and non-maleficence. All participants gave their informed consent before voluntarily taking part in this study. Research participants were informed that the research was for educational purposes with the aim of empowering clergy. This was done verbally as well as in a written format using language that was comprehensible to the research participants. It was emphasized by the researcher that participation in the study was entirely voluntary. No participant was coerced into taking part in the study.

Individuals have the right not to have their personal and identifying details disclosed. Therefore anonymity and confidentiality was kept. The participants' identities remained anonymous. This was assured by removal of all identifying information and the use of letters and numbers in reporting data (Nagy, 2000; Sieber, 2008). Therefore, personal information was linked to the participants. The audio recordings have been kept safe and will be incinerated after 5 years which is in line with the research ethics guidelines of the University of KwaZulu-Natal.

The research codes of ethics require that no harm should be done to participants (Health Professional Council of South Africa, 2002). This study posed no immediate physical or psychological harm to the participants. However, referral for counselling had been arranged at Child and Family Centre, for participants who may have needed counselling as a result of participating in the study. No participants required any counselling after participation in the study.

## **Chapter 4: Results**

The findings will be presented in relation to each of the research aims and hypotheses stated earlier in this research. This chapter will therefore be organized by the three major areas of consideration in the first part of the research, namely: parishioners' emotional and psychological difficulties, the frequency with which clergy counsel their parishioners and thirdly the levels of self-efficacy as reported by clergy.

### **4.1 The relationship between emotional and psychological difficulties and clergy's counselling frequency**

This section will present findings related to parishioners' emotional and psychological problems and the counselling frequency of clergy for particular difficulties. To meet the demands of the research questions at hand, a report on reported frequencies of occurrences of psychological difficulties and the extent to which clergy engage in counselling for these difficulties is presented. In an attempt to show the association between the parishioners' emotional and psychological difficulties and the frequency of counselling by clergy, the findings are summarized in the tables and figures below, and a narrative description for each difficulty is given. It has been established through the literature review that clergy are consulted by parishioners with a variety of difficulties, including emotional and psychological. It was therefore hypothesized that there is a relationship between parishioners' psychological difficulties and how frequent clergy counsel for emotional and psychological difficulties.

#### 4.1.1 Alcohol/ substance abuse

Table 4.1.1 Association of perceived incidence of alcohol/substance abuse and the frequency of counselling for alcohol and substance abuse.

(Perceived Incidence)	Frequency of Counselling			Chi Square Value	Sig. (df = 4)	Spearman's rho
	Low	Med	High			
Low	9	7	1	15.019	.005	0.510
Med	5	4	0			
High	4	10	12			

Fifty percent of the participants rated the incidence alcohol abuse as a frequently encountered problem in their parishes whilst 25 percent said they regularly counsel parishioners presenting with alcohol and substance abuse difficulties. Nonetheless, approximately 33 percent of clergy reported alcohol and substances abuse as rare, with about 35 percent reporting that they seldom counsel for alcohol and substance abuse. Approximately 40 percent of clergy said they sometimes counsel parishioners who come for help with alcohol and substance abuse while the estimate of incidence was 17 percent by clergy who reported moderate incidence of the difficulty.

The bimodal distribution of parishioners' alcohol and substance abuse suggest that alcohol and substance abuse is considered to be a problem in some parishes while it is considered not to be a problem in others. The Chi-square test of association  $\{\chi^2 (df = 4, n = 52) = 15.019, p = 0.005\}$  indicated a significant relationship between the perception of occurrence of alcohol and substance abuse and clergy's frequency of counselling for alcohol and substance abuse. The Spearman correlation between the two variables ( $r = 0.510$ ) suggests a weak positive correlation, there is only 25 percent chance that clergy will counsel parishioners presenting with alcohol and substance abuse. Figure 4.1.1 shows the frequencies for perceived incidences and how often clergy counsel for alcohol, drugs and substance abuse.

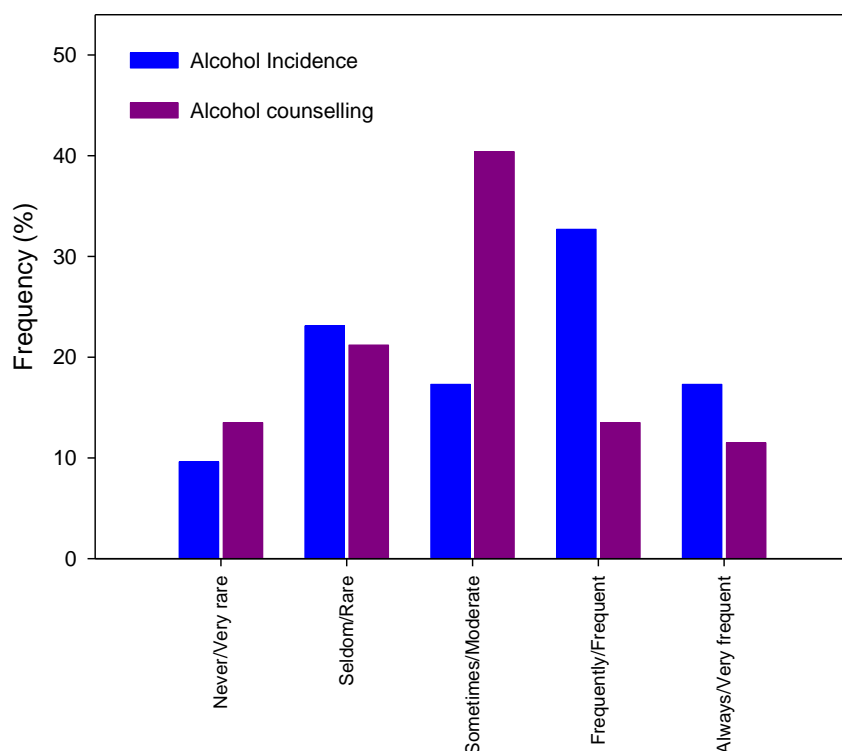


Figure 4.1.1 *Frequencies of perceived incidence and frequency of counselling for alcohol drugs and substance abuse.*

#### 4.1.2. HIV/AIDS

Table 4.1.2 *Association of perceived incidence of HIV/AIDS and the frequency of counselling for HIV/AIDS.*

(Perceived Incidence)	Frequency of Counselling			Chi Square Value	Sig. (df = 4)	Spearman's rho
	Low	Med	High			
Low	9	3	0	13.270	0.010	0.431
Med	4	4	3			
High	6	9	14			

For the incidence of HIV/AIDS in the parishes, 55 percent of the participants indicated that incidences of HIV/AIDS are frequent in their parishes whilst approximately 33 percent reported frequently engaging in counselling with parishioners presenting with HIV/AIDS

related issues. Nonetheless, 23.1 percent of clergy rated the incidence of HIV/AIDS as rarely occurring while 36 percent rated their engagement in counselling for HIV/AIDS as seldom. Approximately 31% of the clergy rated themselves as moderately engaging in counselling for HIV/AIDS and estimated the incidence of HIV/AIDS as sometimes occurring. Chi- square test  $\{\chi^2 (df =4, n= 52) = 13.270, p=0.010.\}$  revealed a significant relationship between the occurrence of HIV/AIDS and clergy's counselling frequency. The Spearman correlation ( $r = 0.431$ ) suggests that there is approximately 18 percent chance that the perceived incidence of HIV/AIDS can predict counselling frequency for HIV/AIDS. Figure 4.1.2 shows the frequencies for perceived incidence of HIV/AIDS and how often clergy counsel for HIV/AIDS and related issues.

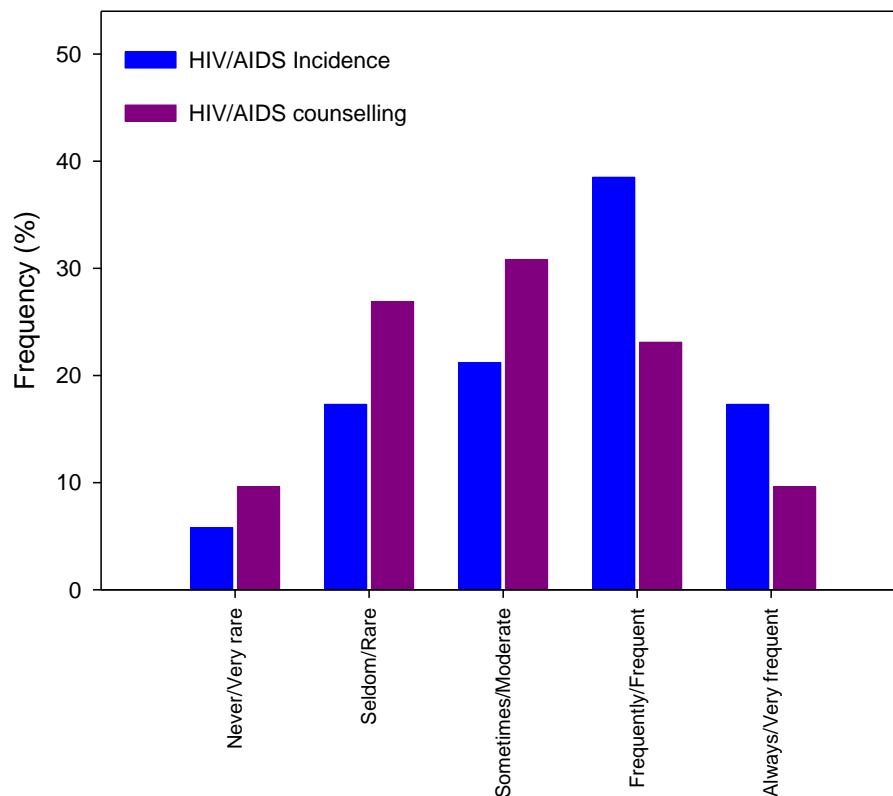


Figure 4.1.2 *Frequencies of perceived incidence and how often clergy counsel for HIV/AIDS and related issues.*

### 4.1.3 Marital conflict and divorce

Table 4.1.3 Association of perceived incidence of marital conflict and divorce issues and the frequency of counselling for marital conflict and divorce issues.

(Perceived Incidence)	Frequency of Counselling			Chi Square Value	Sig. (df = 4)	Spearman's rho
	Low	Med	High			
Low	8	2	1	35.125	0.000	0.686
Med	3	10	4			
High	0	5	19			

Marital conflict and divorce issues are amongst the frequently presented problems for counselling. Approximately 56 percent of the participants reported the incidence of marital difficulties and divorce as “frequent” and “very frequent”, while approximately 21 percent rated the occurrence as “rare” and “very rare”. Thirty-three percent of the participants felt that marital difficulties and divorce incidence is “moderate”. Nevertheless, approximately 46 percent of participants reported to be “frequently” and “always” counselling for marital difficulties and divorce, whilst 21 percent “rarely” and “very rarely” counsel for marital difficulties and divorce. The Chi-square test of association between the perceived incidence and how often clergy counsel for marital difficulties and divorce revealed a significant association  $\{\chi^2 (df = 4, n = 52) = 35.125, p = 0.000\}$ . The Spearman correlation ( $r = 0.686$ ) suggests that there is approximately 46 percent chance that the incidence of marital and divorce matters can predict clergy’s frequency of counselling for marital difficulties. Figure 4.1.3 shows the frequencies for perceived incidences of marital conflict and how frequently clergy counsel for marital difficulties and divorce matters.

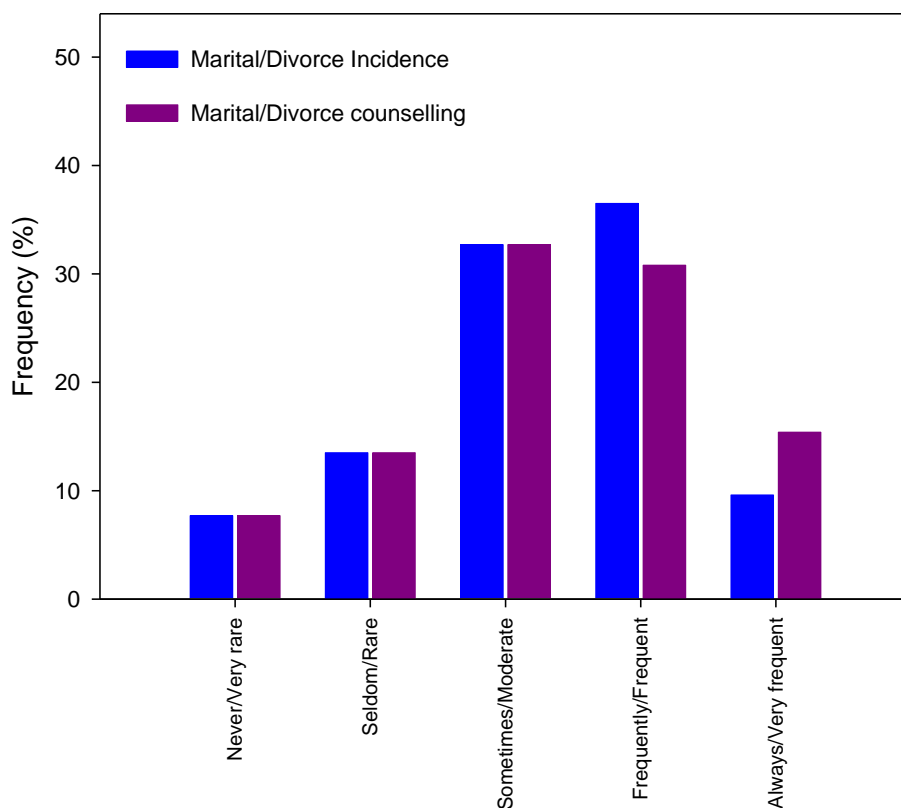


Figure 4.1.3 *Frequencies of perceived incidence and how often clergy counsel for marital difficulties and divorce.*

#### 4.1.4 Premarital conflicts

Table 4.1.4 *Association of perceived incidence of premarital conflicts and the frequency of counselling for premarital conflicts*

(Perceived Incidence)	Frequency of Counselling			Chi Square Value	Sig. (df = 4)	Spearman's rho
	Low	Med	High			
Low	20	4	2	42.812	0.000	0.619
Med	3	9	3			
High	2	3	17			

Premarital conflicts were perceived to occur very frequently in parishes by approximately 21 percent of the participants, with approximately 29 percent believing that they “moderately” occur. About 15 percent and 35 percent of the participants considered premarital conflicts to

be “very rarely” and “rarely” occurring in their parishes, respectively. Nonetheless, approximately 21 percent of the participants agreed that they “frequently” and “very frequently” counselled for premarital conflict, whilst 19 percent and 29 percent agreed that they “never” and “seldom” counsel for premarital conflict respectively. A Chi-square test of association between the perception of incidence and actual counselling for premarital conflict reveals a significant association  $\{\chi^2 (df = 4, n = 52) = 42.812, p = 0.000\}$ . The Spearman correlation ( $r = 0.619$ ) suggests an approximate 37 percent chance that the two variables can predict each other. The distribution suggests that premarital conflict is one of the difficulties that parishioners rarely present to clergy as much as clergy rarely counsel parishioners for premarital difficulties. Figure 4.1.4 shows the frequencies for perceived incidences and the frequency with which clergy counsel for premarital difficulties.

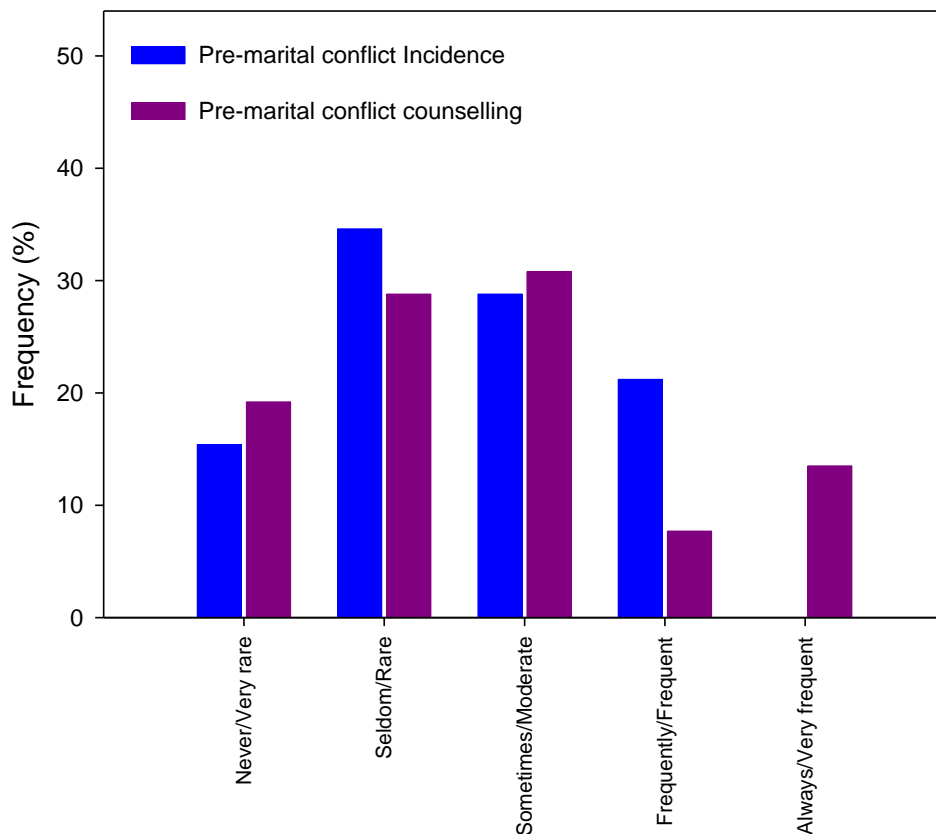


Figure 4.1.4 *Frequencies of perceived incidence and how often clergy counsel for premarital difficulties.*

#### 4.1.5 Suicidal tendencies

Table 4.1.5 Association of perceived incidence of suicidal tendencies and the frequency of counselling for suicidal tendencies

(Perceived Incidence)	Frequency of Counselling			Chi Square Value	Sig. (df = 4)	Spearman's rho
	Low	Med	High			
Low	27	7	0	27.531	0.000	0.405
Med	7	7	11			
High	0	1	2			

Only 6 percent of the sample perceived suicide to be frequently occurring, and 29 percent and 37 percent perceived suicide to be rare and very rare in their parishes respectively. This was mirrored by approximately 6 percent of the sample that reported to counsel for suicide frequently, whilst approximately 65 percent seldom or never counsel for suicide.

Approximately 29 percent perceived suicide as moderately occurring and this was mirrored by approximately 29 percent of participants who reported that they sometimes counselled for suicide. There was a significant association between the perceived incidence of suicide and how often the participants counselled for suicide  $\{\chi^2 (df = 4, n = 52) = 27.531, p = 0.000\}$ . The Spearman correlation ( $r = 0.405$ ) between the two variables suggests a weak relationship with only 16.4 percent chance of variables predicting each other. Figure 4.1.5 shows the frequencies for perceived incidences and how often clergy counsel for suicide.

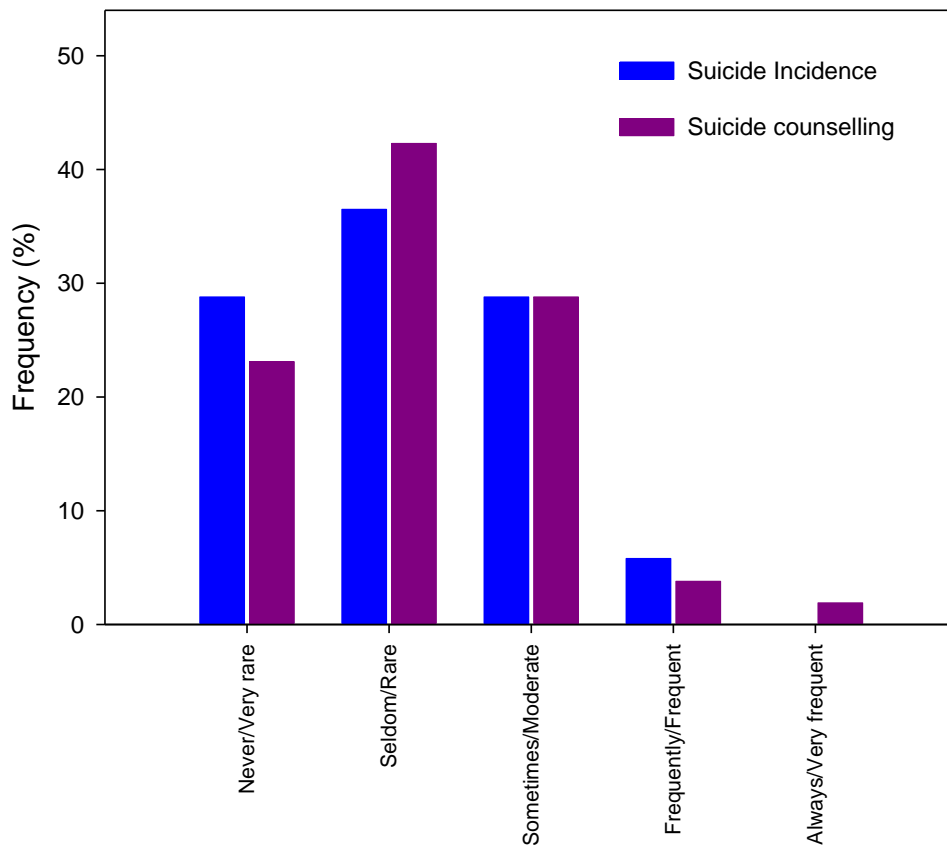


Figure 4.1.5 *Frequencies of perceived incidence and how often clergy counsel for suicide.*

#### 4.1.6 Family relations difficulties

Table 4.1.6 *Association of perceived incidence of family relations difficulties and the frequency of counselling for family relations difficulties*

(Perceived Incidence)	Frequency of Counselling			Chi Square Value	Sig. (df = 4)	Spearman's rho
	Low	Med	High			
Low	4	1	1	13.426	0.009	0.553
Med	7	13	6			
High	0	3	7			

Family relations difficulties were ranked as “very frequently” and “frequently” occurring by 38.4 percent of the participants, whilst 50 percent ranked it as “moderately” occurring and approximately 12 percent ranking them as “rare” and “very rare”. Approximately 46 percent

of the participants agreed that they “frequently” and “always” counsel people with family relations problems, 33 percent agreed that they “sometimes” counsel for family relations difficulties, whilst 21 percent “seldom” or “never” counsel for family relations matters. There was a significant association between how often participants counsel for and perceived incidence of family relations matters  $\{\chi^2 (df =4, n= 52) = 13.426, p=0.009\}$ . The Spearman correlation ( $r = 0.553$ ) suggests a 30.5 percent chance that the occurrence of family relational problems predict counselling frequency. The distribution suggests that where there is greater frequency of occurrence of family relational problems, the frequency of counselling does not match the possible need for counselling. Figure 4.1.6 shows the frequencies for perceived incidence of family relations difficulties and how often clergy counsel for family relations difficulties.

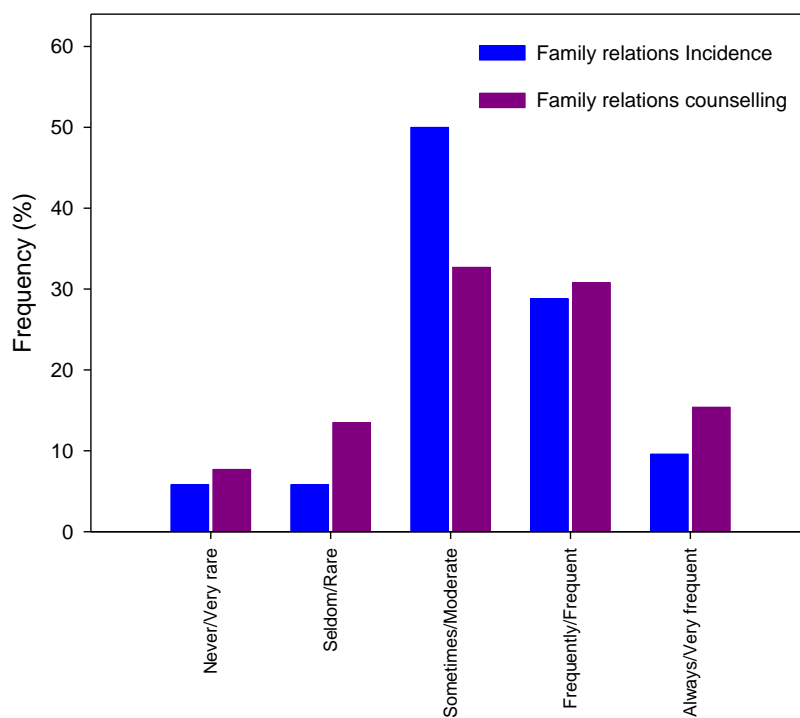


Figure 4.1.6 *Frequencies of perceived incidence of family relations issues and how often clergy counsel for family relations.*

#### 4.1.7 Bereavement

Table 4.1.7 Association of perceived incidence of bereavement and the frequency of counselling for bereavement

(Perceived Incidence)	Frequency of Counselling			Chi Square Value	Sig. (df = 4)	Spearman's rho
	Low	Med	High			
Low	3	0	0	38.801	0.000	0.485
Med	2	9	6			
High	0	6	25			

Bereavement was considered the most frequently occurring difficulty in parishes by approximately 65 percent of the participants and moderately occurring by approximately 33 percent, whilst only 1.9 percent considered bereavement as very rarely occurring. Approximately 60 percent of the participants stated that they “frequently” and “always” counsel for bereavement. Twenty-eight percent stated that they sometimes counsel for bereavement and about 11 percent never or seldom counsel for bereavement. A Chi-square test of association between the perception of incidence and actual counselling for bereavement reveals a significant association  $\{\chi^2 (df=4, n= 52) = 38.801, p=0.000\}$ . The Spearman correlation ( $r = 0.485$ ) between the two variables implies that the two variables do not necessarily predict each other. Figure 4.1.7 shows the frequencies for perceived incidences and how often clergy counsel for bereavement.

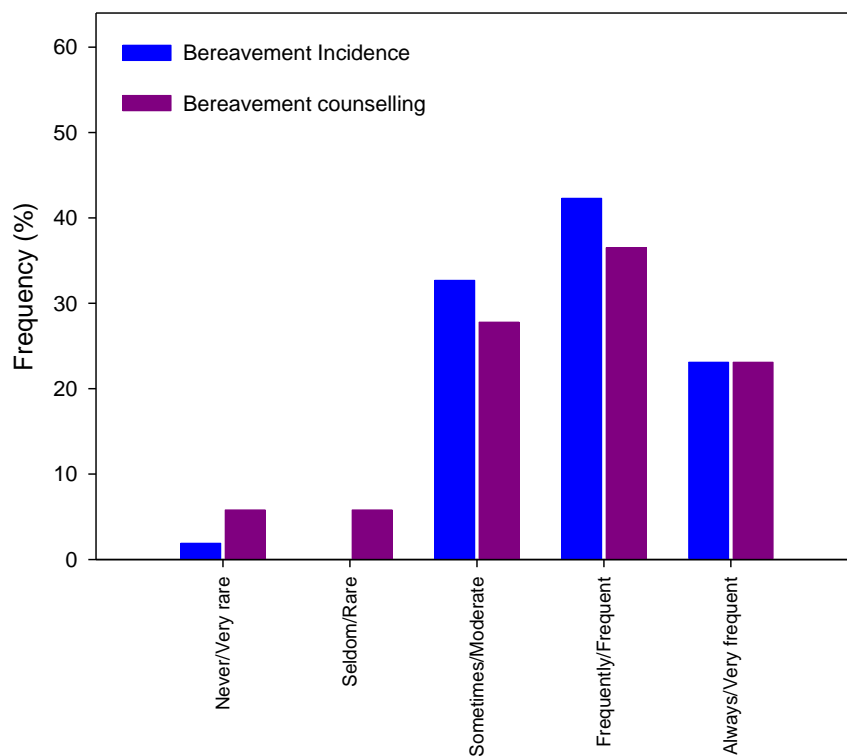


Figure 4.1.7 *Frequencies of perceived incidence and how often clergy counsel for bereavement*

#### 4.1.8 Depression

Table 4.1.8 *Chi-square results of association of perceived incidence of depression and the frequency of counselling for depression*

(Perceived Incidence)	Frequency of Counselling			Chi Square Value	Sig. (df = 4)	Spearman's rho
	Low	Med	High			
Low	9	4	1	12.844	0.012	0.426
Med	6	10	1			
High	4	9	8			

Approximately 40 percent of the participants observed the incidence of depression to be “very frequent” and “frequent” in their parishes, and about 33 percent observed the incidence of depression as “moderate”, whilst 27 percent observed the incidence to be “very rare” and

“rare”. Nonetheless, about 19 percent of the participants observed that they “frequently” and “very frequently” counsel for depression, whilst 42 percent of the participants “sometimes” counsel parishioners who are depressed and about 36 percent “never or seldom” counsel for depression. As with most of the psychological and emotional problems, there appears to be a significant association between the reported level of incidence of depression and the reported frequency of counselling for depression  $\{\chi^2 (df = 4, n = 52) = 12.844, p = 0.012\}$ . However, the Spearman correlation ( $r = 0.426$ ) between the reported incidence and reported frequency of counselling for depression suggests a weak relationship. Clergy tend to counsel less frequently for depression than they perceive its occurrence in their parishes. Figure 4.1.8 shows the frequencies for perceived incidences of depression and how often clergy counsel for depression.

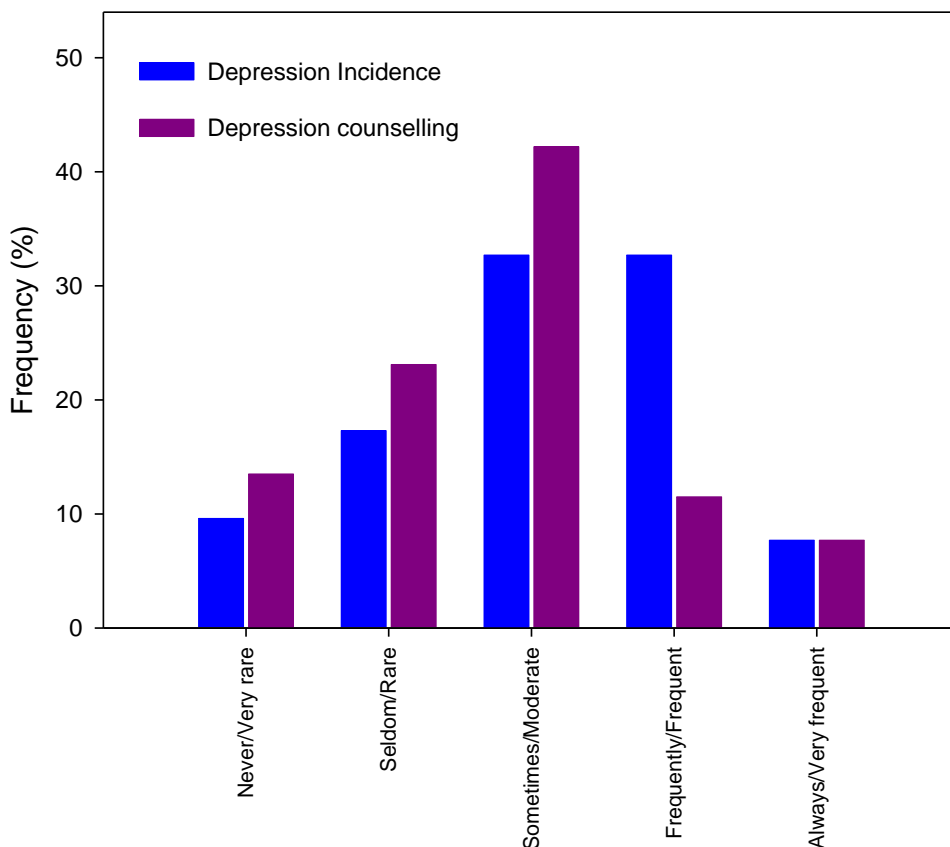


Figure 4.1.8 *Frequencies of perceived incidence of depression and how often clergy counsel for depression*

#### 4.1.9 Mental illness (psychosis)

Table 4.1.9 Association of perceived incidence of mental illness and the frequency of counselling for Mental illness

(Perceived Incidence)	Frequency of Counselling			Chi Square Value	Sig. (df = 4)	Spearman's rho
	Low	Med	High			
Low	27	4	0	10.481	0.033	0.505
Med	9	6	1			
High	2	2	1			

Twenty one percent and 38 percent of the participants considered the incidence of mental illnesses to be “very rare” and “rare” in their parishes, respectively. Only approximately 2 percent and 8 percent of the participants considered mental illness incidence was “very frequent” and “frequent” in their parishes, respectively. Congruent with the perceived incidence of mental illness in parishes only approximately 2 percent of participants and another 2 percent agreed that they “frequently” and “always” counsel for mental illness, whilst about 27 percent and about 42 percent participants reported that they “never” and “seldom” counsel for mental illness, respectively. A Chi-square test of the perceived incidence and actual engagement in counselling for mental illness reveals a significant association.  $\chi^2$  (df =4, n= 52) = 10.481, p=0.033. The Spearman (r = 0.505) correlation between the two variables suggests a weak relationship. It appears clergy reported to frequently counsel for mental illness that they perceived its occurrence in parishes. Figure 4.1.9 shows the frequencies for perceived incidence and how often clergy counsel for mental illness.

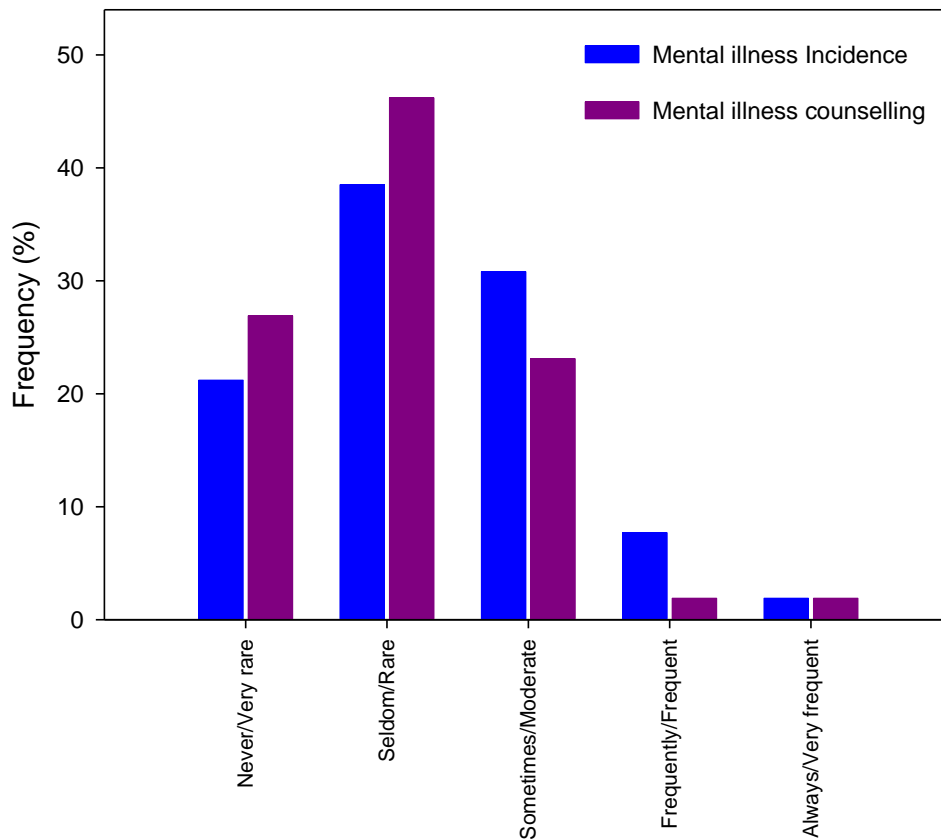


Figure 4.1.9 *Frequencies of perceived incidence and how often clergy counsel for mental illness*

#### 4.1.10 Teenage problems

Table 4.1.10 *Association of perceived incidence of teenage problems and the frequency of counselling for teenage problems*

(Perceived Incidence)	Frequency of Counselling			Chi Square Value	Sig. (df = 4)	Spearman's rho
	Low	Med	High			
Low	13	4	2	11.066	0.026	0.440
Med	7	5	5			
High	3	4	9			

There is a significant association between the reported perception of incidence and how often clergy counsel for teenage difficulties  $\{\chi^2 (df =4, n= 52) = 11.066, p=0.026\}$ . The Spearman correlation ( $r = 0.440$ ) suggests only 19 percent chance that the perceived incidence of teenage problems can predict how, frequently clergy counsel for teenage problems. Approximately 31 percent of the participants perceived teenage problems as a “frequent” and “very frequent” occurrence in their parishes whilst approximately 33 percent of the participants perceived teenage problems as “moderately” occurring and 36 percent perceived the incidence of teenage difficulties as “very rare” and “rare”. Conversely, 30 percent of the participants reported that they “frequently” and “very frequently” counsel teenagers, whilst 25 percent reported that they “sometimes” counsel teenagers and 34 percent “never” or “seldom” counsel teenagers. Figure 4.1.10 shows the frequencies for perceived incidence of teenage problems and how often clergy counsel for teenage problems.

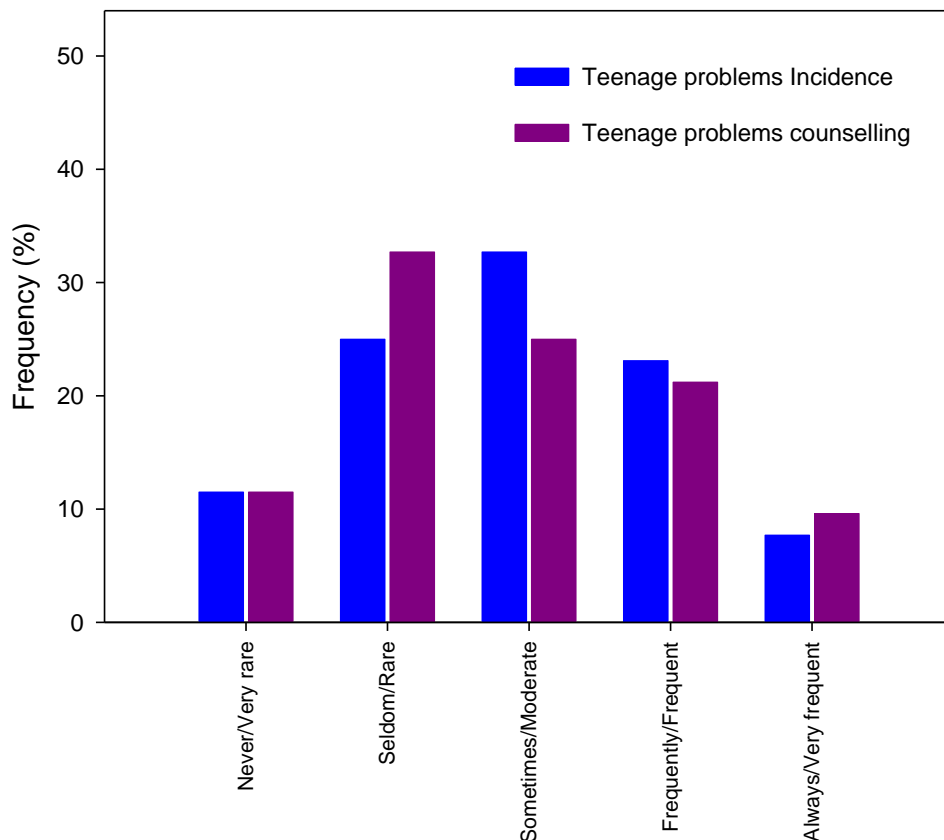


Figure 4.1.10 *Frequencies of perceived incidence and how often clergy counsel for teenage problems*

#### 4.1.11 Life adjustment issues

Table 4.1.11 Association of perceived incidence of life adjustment issues and the frequency of counselling for life adjustment issues

(Perceived Incidence)	Frequency of Counselling			Chi Square Value	Sig. (df = 4)	Spearman's rho
	Low	Med	High			
Low	8	3	1	13.780	0.008	0.464
Med	11	8	3			
High	2	7	9			

The incidence of life adjustment issues was ranked as “frequent” and “very frequent” by approximately 35 percent of the participants, and as “moderate” by 42 percent and “rare” and “very rare” by 23 percent of the participants. Nonetheless, approximately 24 percent of the participants said they “frequently” and “always” counsel parishioners who present life adjustment matters, 35 percent said they “sometimes” counsel for life adjustment, whilst approximately 40 percent “seldom” or “never” counsel for life adjustment matters. Chi-square test of association  $\chi^2$  (df =4, n= 52) = 13.780, p=0.008} reveals a significant association between the perceived incidence and how often clergy counsel for of life adjustment issues. The Spearman correlation (r = 0.464) suggest 21.5 percent chance that the incidence of life adjustment issues predict clergy’s counselling frequency for life adjustment issues. Figure 4.1.11 shows the frequencies for perceived incidence of life adjustment issues and how often clergy counsel for life adjustment issues.

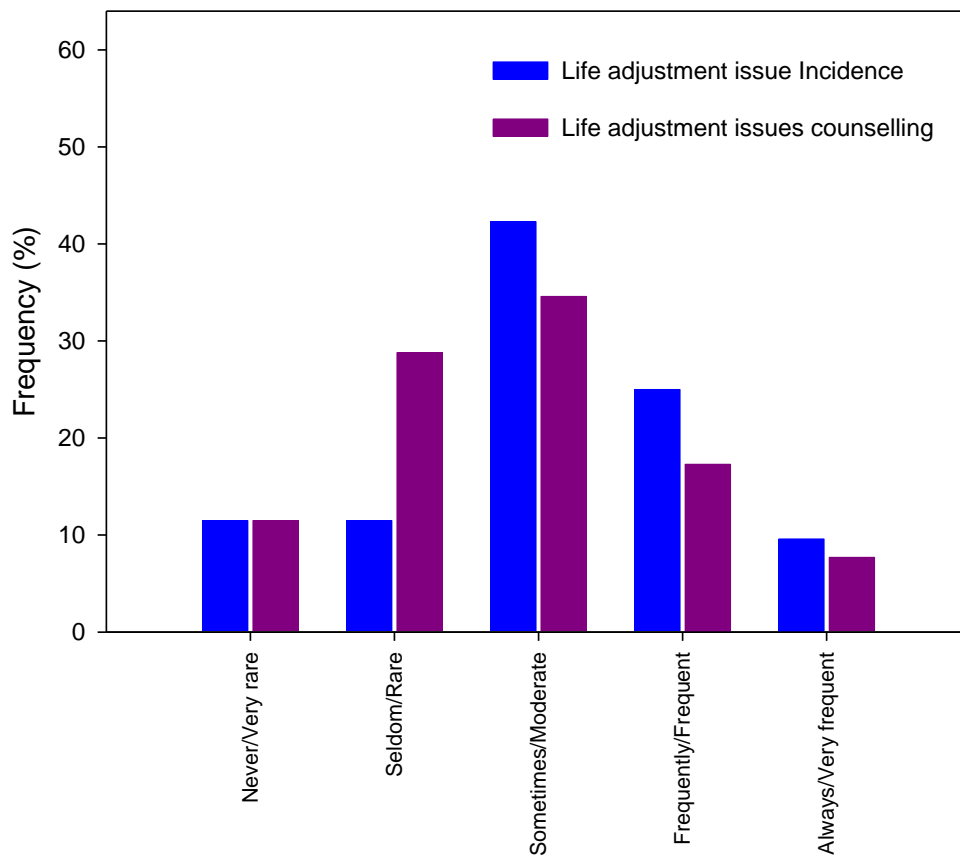


Figure 4.1.11 *Frequencies of perceived incidence and how often clergy counsel for life adjustment issues*

#### 4.1.12 Child/sexual abuse

Table 4.1.12 *Association of perceived incidence of child/sexual abuse and the frequency of counselling for child/sexual abuse*

(Perceived Incidence)	Frequency of Counselling			Chi Square Value	Sig. (df = 4)	Spearman's rho
	Low	Med	High			
Low	23	1	2	41.623	0.000	0.663
Med	5	11	1			
High	3	0	6			

For the incidences of child and/or sexual abuse, only 17 percent of the participants considered forms of abuse as “frequently” and “very frequently” occurring in their parishes. On the other hand, 50 percent of the participants considered sexual /child abuse to be “rare” and “very rare”. As for how often clergy counsel, only 17 percent reported that they “very frequently” and “frequently” counsel for child and/or sexual abuse, whilst approximately 59 percent “seldom” or “never” counsel for child and/or sexual abuse. There was also a significant association between the reported perceived incidence and how often clergy counsel for abuse  $\{\chi^2 (df =4, n= 52) = 41.623, p=0.000\}$ . The Spearman correlation ( $r = 0.663$ ) between the two variables suggests 43% chance of incidence of child and/ or sexual abuse predicting clergy’s frequency of counselling for child and/or sexual abuse, Abuse has been considered amongst the less frequently presented difficulties by the participants. Figure 4.1.12 shows the frequencies for perceived incidence of child and/or sexual abuse and how frequent clergy counsel for abuse.

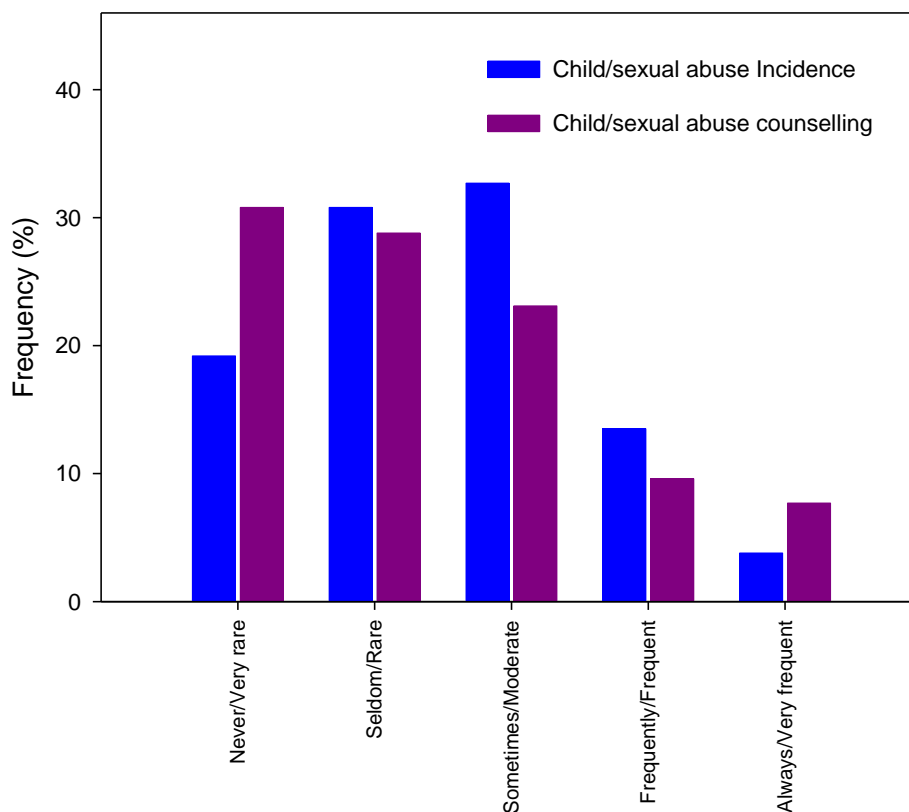


Figure 4.1.12 *Frequencies of perceived incidence and how often clergy counsel for child and/or sexual abuse*

#### 4.1.13 Sexual orientation

Table 4.1.13 *Chi-square results of association of perceived incidence of sexual orientation issues and the frequency of counselling for sexual orientation.*

(Perceived Incidence)	Frequency of Counselling			Chi Square Value	Sig. (df = 4)	Spearman's rho
	Low	Med	High			
Low	31	2	2	25.814	0.000	0.616
Med	7	5	0			
High	1	1	3			

Issues around sexual orientation were considered to have the least incidence by 67 percent of the participants, whilst only about 10 percent considered the incidence as “frequent” or “very frequent”. Supporting this, only 10 percent of the participants reported to have “frequently” or “always” counselled parishioners for sexual orientation issues and 74 percent reported that they “never” or “seldom” counsel for sexual orientation issues. Even so, there was a significant association between engaging parishioners in counselling and perceived incidence of sexual orientation issues  $\{\chi^2 (df = 4, n = 52) = 25.814, p = 0.000\}$ . The Spearman correlation ( $r = 0.616$ ) between the two variables suggest 37.2 percent chance that the variables can predict each other. Figure 4.1.13 shows the frequencies for perceived incidences and frequency of counselling for sexual orientation issues in their parishes.

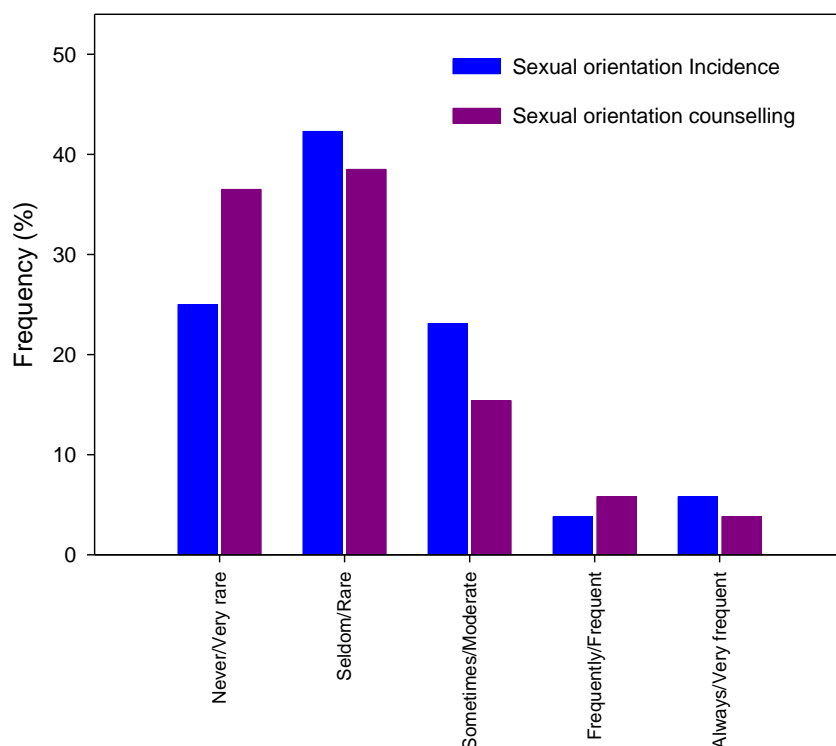


Figure 4.1.13 *Frequencies of perceived incidence of sexual orientation issues and how often clergy counsel for sexual orientation*

#### 4.1.14 Summary

It was hypothesized that there is a relationship between the parishioners' emotional and psychological difficulties in the parishes and how often clergy engage in counselling for the specific emotional and psychological difficulties. The perceived incidences of a psychological or emotional difficulty and how often the clergy counselled for specific difficulties have a Spearman's correlation ( $r = 0.592$ ) using the total sum of raw scores. This suggests that only 35 percent of the variability between perceived incidence of psychological difficulties and counselling frequency by clergy. This finding suggests a weak correlation.

One of the aims of this study was to measure clergy perceptions of counselling and to estimate the extent to which they engage in counselling and the kind of problems that are presented to them. The results of the clergy questionnaire suggest that clergy counsel for psychological and emotional problems. Bereavement issues, alcohol abuse, HIV/AIDS, marital/divorce related issues and family relations issues seem to be the most frequent difficulties that clergy counsel parishioners for. The least encountered psychological and emotional problems include sexual orientation issues, suicide and mental illness. The results

presented here have therefore confirmed that clergy engage in counselling for psychological and emotional problems.

#### 4.2. Perceived counselling self-efficacy

Using the Perceived Counselling Self-Efficacy Scales (PCSES) designed for this study, the perceived levels of counselling Self-efficacy of clergy participating in this research were measured. This was measured using an overall score on the PCSES. A series of independent t-tests and one way ANOVAS were run to make comparisons between the scores on this scales and the different independent variables. Correlations of the PCSES with other dependent variables in the study, namely, the perceived incidence of psychological and emotional difficulties in the parish and counselling frequency by clergy for the specific emotional and psychological difficulties were also done. The findings will be described according to the independent variables isolated in this study, including: seminary training, gender, mental health training, and level of education, type of parish(rural/urban) and the size of congregation.

For the purpose of this study, only 15 items of PCSES were used, thus a total number of 15 responses would give a range of 15 to 75. The PCSES scores for this sample resulted in a minimum score of 31 and a maximum score of 67 (range of 36,  $M = 47.51$ ,  $SD = 7.57$ ) There is a possible minimum score of 15 for the PCSES, the lowest score found in the present sample is 31. This suggests that clergy in this sample judged their perceived counselling self-efficacy favourably. Table 4.2.1 shows the descriptive statistics for the Perceived Counselling Self-Efficacy Scale. Table 4.2.2 shows the frequencies of perceived counselling self-efficacy per item.

Table 4.2.1 *Descriptive statistics for the Perceived Counselling Self-Efficacy Scale*

	N	Range	Minimum	Maximum	Mean	Std. Deviation	Variance	Skewness	
	Statistic	Statistic	Statistic	Statistic	Statistic	Statistic	Statistic	Statistic	Std. Error
PCSES	52	36.00	31.00	67.00	47.5192	7.5757	57.392	.201	.330
Valid N (listwise)	52								

Table 4.2.2 *Percentage frequencies of perceived counselling self-efficacy per item (original number in brackets)*

Perceived counselling Efficacy Scale items	1	2	3	4	5
	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
1. I believe I can counsel for emotional and psychological difficulties.	1.9%	11.5%	21.2%	48.1%	17.3%
	(1)	(6)	(11)	(25)	(9)
2. My knowledge of psychological difficulties is adequate for counselling effectively.	5.8%	23.1%	26.9%	34.6%	9.6%
	(3)	(12)	(14)	(18)	(5)
3. My knowledge for behaviour change is not adequate.	1.9 %	34.6%	28.8%	28.8%	5.8 %
	(1)	(18)	(15)	(15)	(3)
4. I am not able to counsel for psychological and emotional problems to professional standards.	21.2%	28.8%	13.5%	21.2%	13.5%
	(11)	(15)	(7)	(11)	(7)
5. I can communicate knowledgeable with mental health professionals.	5.8 %	23.1%	26.9%	34.6%	9.6 %
	(3)	(12)	(14)	(18)	(5)
6. I am able to recognize major psychological conditions.	7.7 %	9.6%	23.1%	53.8 %	5.8 %
	(4)	(5)	(12)	(28)	(3)
7. I am able to effectively develop a therapeutic relationship with parishioners.	3.8 %	7.7 %	17.3%	59.6%	11.5%
	(2)	(4)	(9)	(31)	(6)
8. My knowledge regarding crisis intervention is not adequate.	7.7%	26.9%	32.7%	25.0%	7.7%
	(4)	(14)	(17)	(13)	(4)
9. I am not able to accurately identify my own feelings and emotional reactions to clients.	1.9 %	17.3%	9.6%	50.0%	21.2%
	(1)	(9)	(5)	(26)	(11)
10. I can effectively facilitate appropriate goal development with parishioners.	1.9%	5.8%	26.9%	48.1%	17.3 %
	(1)	(3)	(14)	(25)	(9)
11. I am able to keep my personal issues from negatively affecting my counselling.	0 %	9.6 %	17.3%	50.0%	23.1%
	(0)	(5)	(9)	(26)	(12)
12. I am able to make appropriate referrals to other services in my community.	0%	3.8%	9.6 %	38.5%	48.1%
	(0)	(2)	(5)	(20)	(25)
13. I get a lot of support from other priests.	0%	3.8%	23.1%	32.7%	19.2%
	(0)	(2)	(12)	(17)	(10)
14. My training equipped me to deal with psychological problems.	7.7%	13.5%	42.3%	26.9%	9.6%
	(4)	(7)	(22)	(14)	(5)
15. I can effectively facilitate client exploration.	7.7%	15.4%	32.7%	38.5%	5.8%
	(4)	(8)	(17)	(20)	(3)

#### **4.2.1 Perceived ability to counsel for emotional and psychological difficulties.**

Approximately 48 percent of the participants agreed that they believe they could counsel for emotional and psychological problems, while 17 percent strongly agreed. Twenty-one percent were impartial whether they believed they could counsel or not. Nonetheless, only 2 percent of the participants strongly disagreed that they believed they could counsel for emotional and psychological problems and another 11 percent disagreed. This suggests clergy see themselves as efficacious in counselling for emotional and psychological problems.

#### **4.2.2 Perceived knowledge of psychological difficulties**

Approximately 35 percent and 10 percent of participants “agreed” and “strongly agreed” respectively that their knowledge of psychological difficulties is adequate for counselling effectively, for emotional and psychological problems respectively. About 37 percent were uncertain whether their knowledge of psychological difficulties is adequate for counselling effectively. Nonetheless, only 6 percent and another 5 percent “strongly disagree” and “disagree,” respectively. This finding suggests that approximately 44 percent of clergy felt that they had adequate knowledge to counsel effectively.

#### **4.2.3 Perceived adequacy of knowledge of behaviour change**

Thirty-four percent of clergy acknowledged that their knowledge of behaviour change was not adequate, while approximately 36 percent “disagree” and “strongly disagree” that their knowledge of behaviour change is not adequate to allow them to sufficiently counsel for emotional and psychological problems. Approximately 29 percent of the clergy could not decide whether they had or had no adequate knowledge of behaviour change. This finding suggests that clergy perceive their knowledge of behaviour change as inadequate.

#### **4.2.4 Perceived ability to counsel for psychological and emotional problems to professional standards**

A total of 35 percent of participants felt that they could not counsel for psychological and emotional problems to professional standards as expected, while 50 percent felt that they could counsel. Approximately 14 percent were impartial. This finding suggests that clergy in this sample regard themselves as confident to counsel for emotional and psychological problems to professional standards.

#### **4.2.5 Perceived ability to communicate knowledgeably with mental health professionals**

Approximately 44 percent of participants collectively “agreed/strongly agreed” that they were able to communicate knowledgeably with mental health professionals, while 34 percent collectively “disagree/strongly disagree” that they can communicate knowledgeably with

mental health professionals. About 27 percent were undecided. This finding suggests that clergy in this sample deem themselves as reasonably capable of communicating knowledgeably with mental health professionals.

#### **4.2.6 Perceived ability to recognize major psychological conditions**

About 54 percent and just about 6 percent of the participants “agreed or strongly agreed” that they were able to recognize major psychological conditions respectively. A total of 17 percent felt that they could not recognise major psychological conditions while nearly 23 percent of the participants were neutral. This suggests that clergy in this sample judged themselves as competent in recognizing major psychological problems.

#### **4.2.7 Perceived ability to effectively develop a therapeutic relationship with parishioners**

Approximately 71 percent of participants collectively “agreed/strongly agreed” that they were able to effectively develop a therapeutic relationship with parishioners, while 11 percent collectively “disagreed/strongly disagreed” that they can effectively develop a therapeutic relationship with parishioners. About 17 percent were undecided. This suggests that clergy consider themselves as highly effective in developing therapeutic relationships with their parishioners.

#### **4.2.8 Perceived adequacy of knowledge regarding crisis intervention**

Thirty-three percent of clergy acknowledged that their knowledge regarding crisis intervention is not adequate while approximately 35 percent “agreed or strongly agreed” that they had adequate knowledge of crisis intervention to adequately counsel for emotional and psychological problems. Approximately 33 percent of the clergy could not decide whether they had or had no adequate knowledge of crisis intervention.

#### **4.2.9. Perceived ability to accurately identify own feelings and emotional reactions to clients.**

Approximately 71 percent of participants collectively “agreed/strongly agreed” that they were able to accurately identify their own feelings and emotional reactions to parishioners, while 20 percent collectively “disagreed/strongly disagreed” that they can accurately identify their own feelings and emotional reactions to parishioners. About 10 percent were uncertain. This finding suggests clergy perceive themselves as competent to self-introspect and not contaminate their sessions with their own personal feelings and reactions.

#### **4.2.10 Perceived ability to effectively facilitate appropriate goal development with parishioners.**

Approximately 48 percent of the participants agreed that they can effectively facilitate appropriate goal development with parishioners, while 17 percent strongly agreed that they can effectively facilitate appropriate goal development with parishioners. Twenty-seven percent were impartial. Nonetheless, nearly 2 percent of the participants strongly disagreed that they can effectively facilitate appropriate goal development with parishioners and another 6 percent disagreed. This suggests clergy perceive themselves as effective in facilitating goal development with parishioners.

#### **4.2.11 Perceived ability to keep my personal issues from negatively affecting counselling**

Approximately, 73 percent of participants collectively “agreed/strongly agreed” that they are able to keep their personal issues from negatively affecting the counselling process, while a mere 10 percent collectively “disagreed/strongly disagreed” that they are able to keep personal issues from negatively affecting the counselling process. A mere 10 percent of the participants were uncertain whether they can or cannot keep personal issues from negatively affecting counselling. This suggests that clergy in this study perceive themselves as able to keep personal issues from negatively affecting the counselling process.

#### **4.2.12 Perceived ability to make appropriate referrals to other services in the community**

Approximately 48 percent of the participants agreed that they are able to make appropriate referrals to other services in my community, while 38 percent strongly agreed that they are able to make appropriate referrals to other services in their communities. Ten percent of the participants were impartial whether they can make appropriate referrals to other services in the community or not. Nonetheless, a mere 4 percent of the participants disagreed that they are able to make appropriate referrals to other services in my community. None of the participants strongly disagreed that they are able to make appropriate referrals to other services in my community. This suggests that clergy in this study perceive themselves as effective in making appropriate referrals to other community service providers

#### **4.2.13 Perceived level of support from other priests**

None of the participants strongly “disagreed” that they get a lot of support from other priests. Only 4 percent of the participants “disagreed” that they get a lot of support from other priests. Twenty- three percent of the participants could not say whether they get a lot of support from other priests or not. Nonetheless, approximately 33 percent of the participants “agreed”, while 19 percent “strongly agreed” that they get a lot of support from other priests

respectively. This suggests clergy in this study receive support from each other for counselling.

#### **4.2.14 Perceived adequacy of training to counsel for psychological problems**

Forty-two percent of the participants could not ascertain whether the training they received equipped them to deal with psychological problems. Approximately 27 percent of the participants “agreed” while 10 percent “strongly agreed” that the training they received equipped them to deal with psychological problems. Approximately 14 percent of the participants “strongly disagreed” that the training they received equipped them to deal with psychological problems. Nearly 8 percent of the participants “disagreed” that the training they received equipped them to deal with psychological problems. This finding suggests that clergy in this study are not very certain whether the training they get equips them to deal with psychological and emotional problems.

#### **4.2.15 Perceived ability to facilitate client exploration of issues.**

Approximately, 43 percent of participants collectively “agreed/strongly agreed” that they were able to effectively facilitate client exploration, while 23 percent collectively “disagreed/strongly disagreed” that they can effectively facilitate client exploration. About 33 percent were unsure whether they can effectively facilitate client exploration. This finding also suggests that most clergy in the sample were not confident to ascertain that they can effectively facilitate client exploration of issues.

#### **4.2.16 Summary**

It was hypothesized that clergy would judge themselves as competent in counselling despite their lack of training in mental health. The perceived counselling efficacy scale (PCSES) was used to measure clergy’s level of perceived competence and confidence in their ability to counsel. The overall score for all clergy on the PCSES indicates that clergy regard themselves as generally competent in counselling.

One of the aims of this study was to measure clergy perceptions of competence in counselling for emotional and psychological problems. The results of the PCSES suggest that clergy somewhat have confidence in their counselling. It is a possibility that clergy have low strength and low magnitude counsellor self-efficacy because generally they feel they are able counsel and they have some psychological literacy that allows them to comfortably deal with some mental health issues. This study revealed that clergy also have adequate knowledge to

make appropriate referrals. In as much as they have a degree of confidence in counselling clergy pointed out that their training is limited.

### 4.3 Relationship between parishioners' emotional and psychological difficulties, clergy's counselling frequency and clergy's perceived counselling self-efficacy

This section will present findings on the relationship between parishioners' emotional and psychological difficulties, clergy's counselling frequency and clergy's perceived self-efficacy.

#### 4.3.1 Parishioners' emotional and psychological difficulties and clergy's perceived counselling self-efficacy

There is no statistically significant relationship between perceived incidence of emotional and psychological difficulties (as measured by Clergy Questionnaire Part 1) and their perceived counselling self-efficacy (as measured by the Perceived Counsellor Self-Efficacy Scale).

A Spearman's rho correlation was run on emotional and psychological difficulties and perceived self-efficacy. The data in this study reported no statistically significant positive correlation ( $r = 0.050$ ;  $p = 0.726$ ) between the variables of perceived counselling self-efficacy and parishioners emotional and psychological difficulties. Table 4.3.1 indicates a Spearman's rho correlation of parishioners' emotional difficulties and perceived counselling self-efficacy.

*Table 4.3.1 presents the correlation parishioners emotional and psychological difficulties and perceived counselling self-efficacy as  $r = 0.050$ ;  $p = 0.726$ .*

			PESCAL	PRVLNC
Spearman's rho	PESCAL	Correlation Coef f icient	1.000	.050
		Sig. (2-tailed)	.	.726
		N	52	52
	PRVLNC	Correlation Coef f icient	.050	1.000
		Sig. (2-tailed)	.726	.
		N	52	52

#### 4.3.2 Clergy's counselling frequency and clergy's perceived counselling self-efficacy

There is a statistically significant relationship between how often clergy counselled (as measured by Clergy Questionnaire Part 2) and their perceived counselling self-efficacy (as measured by the Perceived Counsellor Self-Efficacy Scale).

A Spearman's rho correlation was run on these variables. This correlation (repeating) can range between -1.00 (completely inverse correlation) to 1.00 (absolute correlation). The data in this study reported a statistically significant positive correlation between the variables of ( $r$

= 0.336;  $p = 0.015$ ) between the variables of perceived counselling self-efficacy and how often clergy counsel for emotional and psychological difficulties. This result suggests 11.2% variance between counselling frequency and perceived counselling self-efficacy. Table 4.3.2 indicates a Spearman's rho correlation of clergy's counselling frequency and perceived counselling self-efficacy.

*Table 4.3.2 presents the correlation of clergy's counselling frequency and perceived counselling self-efficacy as  $r = 0.336$ ;  $p = 0.015$ .*

**Correlations**

			PESCAL	FRQCOU
Spearman's rho	PESCAL	Correlation Coefficient	1.000	.336*
		Sig. (2-tailed)	.	.015
		N	52	52
	FRQCOU	Correlation Coefficient	.336*	1.000
		Sig. (2-tailed)	.015	.
		N	52	52

\*. Correlation is significant at the .05 level (2-tailed).

#### **4.3.3 Perceived counselling self-efficacy and socio-demographic information**

There are no statistically significant differences in perceived counselling self-efficacy for the following variables: age, gender, type of training, mental health training, type of mental health training, level of education, size of congregation and type of parish.

To investigate if there are any differences on perceived counselling efficacy for the different independent variables, one-way ANOVAs were run for the following variables including: age, level of education, type of mental health training, type of parish, size of congregation and seminary training.

#### **4.3.3.1 Age and perceived counselling self-efficacy**

The age variable has four levels as shown in Table 4.3.3.1 below.

*Table 4.3.3.1 Descriptive statistics for Age and PCSES score.*

Age group	N	Mean PCSES	Standard deviation
20-39	6	45.17	8.60
40 -49	10	49.40	7.89
50- 59	21	47.14	7.55
60+	15	47.73	7.73

There was no statistically significant difference observed in perceived counselling efficacy for different age groups of clergy ( $F= 0.405$ ;  $df 3, 48$ ;  $p = 0.750$ ).

#### **4.3.3.2 Level of education and perceived counselling self-efficacy**

The level of education variable has 4 levels as shown in Table 4.3.3.2 below.

*Table 4.3.3.2 Descriptive statistics for level of education and PCSES score.*

Level of Education	N	Mean PCSES	Standard deviation
Less than Matric/ Matric/ Matric equivalent	5	34.54	4.94
Diploma	14	49.71	7.68
University Bachelor Degree	22	43.36	5.31
Masters/Doctoral Degree	10	50.70	9.58

There is a statistically significant difference between total perceived counselling self-efficacy scores and level of education ( $F = 3.617$ ;  $df 3, 48$ ;  $p = 0.020$ ). The significant difference was revealed to be between “less than Matric/ Matric/ Matric equivalent” and “Diploma”, as well as between clergy with “less than Matric/ Matric/ Matric equivalent” and “Master’s Degree”.

#### 4.3.3.3 Type of mental health training and perceived counselling self-efficacy

The type of mental health training variable has four levels as shown in table 4.3.3.3 below.

Table 4.3.3.3 Descriptive statistics for type of mental health training and PCSES score.

Type of Mental Health Training	No.	Mean PCSES	Standard deviation
Continuing Education classes/ One year course	6	48.25	10.26
Degree program	4	45.75	7.68
Any other	5	48.40	5.31
No mental health training	35	47.42	10.10

There are no statistically significant differences between perceived counselling self-efficacy and the different types mental health training ( $F = 0.115$ ;  $df 3, 48$ ;  $p = 0.951$ ). There is no evidence from this study that the kind of mental health training they have received has not equipped clergy to counsel effectively.

#### 4.3.3.4 Type of parish and perceived counselling self-efficacy

The type of parish variable had three levels as shown in table 4.3.3.4 below.

Table 4.3.3.4. Descriptive statistics for type of parish and PCSES score.

Type of parish	N	Mean PCSES	Standard deviation
Urban suburban	22	49.72	8.18
Urban township	9,	45.44	4.92
Rural	21,	46.09	7.50

There is no significant differences on the levels of perceived efficacy by clergy in the suburban, township or rural parishes ( $F = 1.687$ ;  $df = 2, 49$ ;  $p = 0.196$ ).

#### **4.3.3.5 Size of congregation and perceived counselling self-efficacy**

The size of congregation variable had six levels as shown in table 4.3.3.5 below.

*Table 4.3.3.5 Descriptive statistics for size of congregation and PCSES score.*

No. of congregants	N	Mean PCSES	Standard deviation
Below 200	18	45.27	8.21
201-400	17	49.70	6.97
401-800,	11	47.81	7.40
801 +	6	47.50	7.50

There is no statistically significant difference in the levels of perceived counselling self-efficacy by clergy serving in different sizes of congregations ( $F = 0.665$ ,  $df 3, 48$ ;  $p = 0.400$ ). To investigate if there are any differences on perceived counselling efficacy for the different independent variables, t-test statistics were run for the following variables, gender, seminary, mental health training.

#### **4.3.3.6 Seminary training and perceived counselling self-efficacy**

Participants who attended seminary ( $N=38$ , Mean = 47.24, s.d 6.63) and participants who did not attend seminary ( $N=14$ , Mean = 48.29, s.d 9.94) did not differ in their levels of reported Perceived Counselling Self-Efficacy { $t(50) = -0.439$ ;  $p = 0.662$ }. There was no statistically significant difference in the levels of perceived counselling self-efficacy between clergy who received seminary training and clergy and who did not receive seminary training, thus the hypothesis that clergy who had seminary training will report higher perceived counselling self- efficacy is rejected.

#### **4.3.3.7 Mental health training and perceived counselling self-efficacy**

Participants with a mental health qualification ( $N=11$ , Mean = 50.36 s.d 10.26), and those who did not have a mental health qualification ( $N= 41$ , Mean = 46.76 s.d 6.63) did not differ in their levels of reported perceived counselling efficacy { $t(50) = 1.416$ ;  $p = 0.163$ }. Mental health training involved any specialised training in social work, psychology or psychiatry. This finding suggests no significant differences in levels of Perceived Self Efficacy between clergy who had training in mental health and those that did not have mental health training thus we reject the hypothesis.

#### ***4.3.3.8 Gender and perceived counselling self-efficacy***

There are no significant differences { $t(50) = -0.325$ ;  $p = 0.740$ } in perceived counselling self-efficacy between males (N= 39 mean 47.71 s.d 7.76) and females (N= 25 Mean 46.92 s.d 7.23) in the study.

#### **4.4 Summary**

This study demonstrated no statistically significant relationship between counselling self-efficacy and frequency of counselling by clergy. The study also demonstrated no statistically significant correlation between the incidence of emotional and psychological difficulties and perceived counselling self-efficacy. Additionally, the differences between perceived counselling self-efficacy and demographic variables (age, gender, type of training, mental health training, type of mental health training, level of education, size of congregation and type of parish.) were examined. While there was a statistically significant difference in the levels of perceived counselling efficacy for clergy possessing different levels of education, no other variable indicated statistically significant differences in the clergy's levels of perceived counselling efficacy.

## **Chapter 5 Qualitative Results**

This chapter presents the study findings describing the perceived role of clergy in helping parishioners experiencing emotional and psychological problems in South Africa.

The clergy questionnaire had an open-ended question where participants asked to describe briefly a case that they encountered where they had offered counselling. Semi-structured interviews were also carried out. The answers that were generated by the open ended question and semi-structured interview questions were content analysed. The analysis involved counting the frequency of appearances of allocated codes within the short descriptions given on how clergy had offered counselling. Two methods of counting units were used a) using the statement unit b) using the whole paragraph as a counting unit. Extracts of content were also used to illustrate and augment the findings.

### **5.1 Perception of incidence of parishioner's psychological difficulties and how often clergy counsel**

The qualitative data from the clergy questionnaire supported the findings of the semi-structured interview questions. The participants described in detail the kinds of cases that they encountered. The most described incidences included bereavement with four out of thirty-three (12%) who responded to the last item of the survey questionnaire, marital and relationship problems including divorce four out of thirty-three (12%) and drugs and substances three out of thirty-three (9%). Unlike in the structured interview where suicide was rated as one of the least encountered psychological problems three out of thirty-three (9%) described how they dealt with parishioners who were suicidal. Severe psychological disorders like depression, violent behaviour, eating disorders and delusions were each described in detail by one out of the thirty-three (3%) participants. Other life adjustment difficulties like cultural issues, teen-headed households, old age were each described by one out of thirty-three 33(3%). These findings are consistent with (Leavey et al., 2007) that clergy have contact with people experiencing emotional and psychological difficulties. (Leavey et al., 2007 p. 550) stated that “commonly, clergy appear to counsel and support community members through distressing life events. In relation to more enduring or serious mental illness, although such cases are less common, all clergy had occasional or regular contact of varying degrees of intensity with such people” Table 5.1 shows the frequencies of how often clergy counselled for psychological difficulties.

Table 5.1 *Percentage frequencies of how often clergy counselled for psychological difficulties per item (original number cases encountered in brackets)*

Cases encountered		How often clergy counsel	
1	Bereavement	12%	(4)
2	Marital/divorce/relationship difficulties	12%	(4)
3	Drugs and substance abuse	9%	(3)
4	Suicide	9%	(3)
5	Depression	3%	(1)
6	Violent behaviour	3%	(1)
7	Eating disorders	3%	(1)
8	Cultural issues	3%	(1)
9	Teen-headed households	3%	(1)
10	Old age	3%	(1)

Moran et al. (2005) showed that marriage and family problems are among the most frequent problems presented in pastoral counselling, apart from spiritual concerns. Studies of clergy from various denominations have also found that marital problems are the most common of problems that clergy encounter in pastoral counselling (Mannon & Crawford, 1996). This study's findings are consistent with previous research mentioned above.

## **5.2 Methods of offering help**

One of the research aims was to investigate how clergy offer help to parishioners presenting with emotional and psychological difficulties of their parishioners. The participants in the present study had a range of actions they employed to help parishioners experiencing emotional and psychological problems. Several techniques were identified: communicating understanding, stating feelings and helping recognise feelings and emotions, creating the setting and contracting, exploring, offering support, psychology-religion interface, use of community resources and referrals. Clergy in the research sample described similar methods to those used in basic counselling. Collectively, clergy relied on the basic tenets of

counselling and very basic counselling techniques. From the 33 descriptions, codes were developed based on the basic counselling techniques.

### **5.3 Actions taken in the sessions**

#### **5.3.1 Attending to the client, listening and exploring**

Six out of thirty-three participants mentioned listening to the client as one of the main actions they take in the process of helping parishioners.

Participant 8

*My first step was to show her that I will value all that she is going to say and I made sure that I listen to what she has to say.*

Participant 29

*I gave the person enough time to express herself to me by listening...I made the person relaxed and be able to talk freely.*

*Extract 8*

*Participant 33*

*Listen attentively, ask open-ended questions*

#### **5.3.2 Communicating understanding, stating feelings and helping recognise feelings and emotions**

Seventeen out thirty-three participants (52%) described in detail how they communicated understanding and helped the parishioner to recognize feelings and emotions. The extracts of actual content in the descriptions illustrate:

Participant 4

*I helped the parishioner to recognise feelings of powerlessness and underlying anger.*

Participant45

*I identified emotional deep-seated hurt.*

Participant 27

*It became clear that there is an angry child within him. We talked about the need for him to take care and nurture his inner child.*

Participant 12

*...young man who was suicidal as a result of being rejected by a Pentecostal church because of his homosexuality status. I spent time mostly listening to him describing his feelings.*

Participant 3

*[I helped] one bereaved person to be able to recognise [the] need to mourn.*

In the above extracts, the participants expressed how they used empathy, which is considered one of the pathways for healing in counselling and psychotherapy (Weiner, 1997). This finding highlights Greason and Cashwell's (2009) assertion that empathy is a mediating factor in counselling efficacy. Hence clergy are justified to rate themselves as effective in helping their parishioners presenting with emotional and psychological difficulties. This suggests that clergy may have insight into the requirements of basic counselling. This finding should be treated with caution given the small sample size.

### **5.3.3. Offering support**

One of the main roles of clergy mentioned in the literature review is to offer support. Clergy is concerned for the total wellbeing of a person mentally, physically, emotionally and socially. Ten out of thirty- three (30%) participants cited offering support as one of the many roles they play. Clergy also offered social support structures by directing parishioners to other organisations in the community like Alcoholics Anonymous and Society for Mental Health among others. These are illustrated in the extracts below.

Participant 18

*I offered spiritual and emotional support as an on-going process.*

Participant 31

*I have walked the journey with those who are infected and affected by HIV/AIDS, TB, alcoholism, mental difficulties and premarital conflict.*

Participant 8

*Give positive support in society if those next to the [parishioners] are negative.*

Participant 24

*My strategy was to put her in a home group led by me....She grew and changed noticeably through the love and support of others in the group.*

#### **5.3.4 Use of prayer, spirituality**

The use of prayer is not a conventional counselling technique or skill. Fifteen per cent of clergy in the sample (five out of thirty-three) participants reported relying on prayer in the process of counselling their parishioners.

Participant 28

*I prayed with him and referred and had him in a place of safety, where he worked with a therapist/social worker... I continue with prayer.*

People's religious beliefs make them desire to seek help from clergy. Literature on religious coping also points out that religion helps people to cope with mental illness from knowing that there is someone praying for them and that God is working through others (Mental Health Foundation Report, 2007). The extract below highlights how a parishioner insisted on seeing the priest consistently even in home groups, despite the priest emphasizing that he was not a psychologist.

Participant 13

*We had a number of sessions together which I stressed the fact that I am not a psychologist but I could help by listening, prayer and offer spiritual guidance.*

Clergy in the sample also integrate spirituality with other counselling techniques when helping their parishioners as illustrated in the extract below.

Participant 24

*I allowed him to verbalise his situation, to express his feelings and his current feelings. I accepted his explanation... allowed him to bounce his emotions... After [exploring feelings and looking for alternatives] I spoke to him about God and His love for him and how special he is in the eyes of God....this was followed by prayer.*

### **5.3.5 Use of referrals and community resources**

The extracts below highlight that clergy seem to be aware of their limitations in their role in counselling for emotional and psychological difficulties. Fifty-four percent of the clergy in the sample referred their parishioners to a doctor, a psychologist, a psychiatrist, a social worker or other community resources. Three percent of the participants (one out of thirty-three) did not mention where they referred to and 21 percent (seven out of thirty-three) participants referred to a psychologist or psychiatrist for further assessment and medication. Twenty two percent of the participants did not mention “referrals” in their descriptions.

Participant 18

*I referred to a psychologist / psychiatrist for a diagnosis after observing certain behaviours that warranted referral.*

Participant 11

*I mainly listen, look at options and then refer*

Participant 33

*When it becomes evident, that there is an emotional problem, I refer to trained psychologist.*

The use of community resources was also highlighted by clergy as a way of helping their parishioners. The community resources that were mentioned by clergy in the sample include marriage enrichment groups, bereavement and grief counselling groups, society for Mental Health, Lifeline, Hospice, as well as faith based organisations. Twenty-four per cent of the clergy in the sample mentioned working closely with these organisations exchanging referrals. This finding is consistent with literature that clergy play a role as the gate keepers to mental health care.

### **5.4 Emotional and psychological difficulties presented to clergy for counselling**

The sub-sample of ten participants in the follow-up interviews reported attending to the same problems that are attended to by psychologists. Generally, most participants found severe psychopathology as the most difficult to counsel for. Thirty percent of clergy in the sub sample identified cases where the individuals were under medication for mental illness and they offered a supportive role. A further 30 percent of the participants identified problems that could be traced back into the parishioners’ childhood as difficult to counsel for.

Participant B

*The person said to me was hearing voices in the head. Now with my little psychological knowledge I thought what this person needed was beyond me*

Participant G

*It was someone, a woman who has been abused as a child... and yes all the ramifications it has in her life...she behaved in ways she did not fully understand...and this kind behaviour related back to that experience.*

For all cases that were deemed difficult to counsel with, appropriate referrals were made and support and encouragement was offered. All clergy seemed more confident to counsel for family issues and particularly marital problems, infidelity and divorce.

### **5.5 Perceived counselling self-efficacy and competence**

In as much as most participants judged themselves as effective in the clergy questionnaire, participants who took part in the follow-up interviews highlighted several inadequacies. There is a general feeling of inadequacy and helplessness especially when it comes to counselling for more severe emotional and psychological difficulties.

Participant Z from a rural parish commented:

*There is a great sense of helplessness when it comes to certain issues. As Africans you go to elders who have good insight to some of the issues [Marital and family]. There is a great feeling of inadequacy; we are forced to do more research, not your kind of research [scientific] but as in finding more information from the elders. The other problem is not to know who to refer to.*

Participant B said:

*I would do with more training. The last time I went for a seminar for counselling was ....2003. I deal with 300 heads of people; each of them has a story to tell. At times I feel helpless, hopeless and inadequate. The clergyman is finding himself in this area [of counselling]. You can't always go to default mode saying let's pray because people want more from you...*

Participant J illustrated a scenario where he felt the necessity for more cultural competence:

*When someone comes and says there is a[n] [u] Mthakhathi [witch] but also points out a breakdown in social relationships between them and the neighbours, but it is expressed through this cultural milieu. How would one deal with this?*

There are also instances when clergy in the sample felt quite confident and competent to counsel.

Participant J

*I tend to counsel the best way I can within the context of the cultural milieu. I find it easier to counsel white people. It is strange; when I am counselling a Mlungu [white person] it is quite different. I think in psychological categories.*

Participant S

*Yes [I am confident] I am not sure that I am doing it well, I will probably say I am doing the best I can.*

Participant B

*I feel quite confident [to counsel], I know when to pull the plug and refer.*

Clergy demonstrated varying levels of counselling self-efficacy. Four of the participants rated themselves as good and of the same four, three highlighted feelings of inadequacy and helplessness in the face of severe psychological problems or cases that seemed to have underlying personality disorder and cases that warranted medical intervention.

## **5.6 Challenges faced**

This section describes challenges faced by clergy in the sub-sample of ten clergy in the follow up interviews.

### **5.6.1 Cultural aspects**

Government funded psychological services do not seem to reach out to the people probably because of the way the system is structured. For example, the appointment system was cited to be problematic for disadvantaged rural folk. Also cited as a challenge by two participants is the lack of knowledge as to who to refer to, as there are few black psychologists, and the

expense involved to receive the service for rural people living in poverty. In the end all these cases land in the priest's office.

Participant Z who serves a rural parish commented:

*The other problem is not knowing whom to refer to. There is a problem with the hospital appointment system, which does not seem to work well with us Africans in terms of keeping time and getting there at allocated times to see the counsellors at the hospital. It is too expensive for people in rural areas to afford. The waiting period is too long and people tend to need help now and not on the appointment date. All these things bring strain and pressure to the priest.*

Participant J

*When I am counselling a Mlungu [white person], it is quite different, I think in psychological categories....I know very well it is not going to work in a Zulu cultural context... I do not know of a black psychologist that I would have referred them to. Even if I referred them to one, there is always a question of medical aid...*

### **5.6.2 Separating personal issues from counselling issues/ personal limitations**

Two of the participants mentioned personal limitations as interfering with their engagement in counselling. One participant mentioned crying with the parishioner as a way of expressing empathy.

Participant M

*The kind of experiences that I have been through have been similar to the experiences they have been through....sometimes I cry a lot, I do not know if it is a right or wrong thing, but that what I do. It happens not because I want to cry, but it is part of my nature of feeling with the people... I think I want to run away when it is time for counselling, because it is too much [having to help others and you have own struggles you are dealing with].*

Participant L

*It's not that all clergy engage in counselling, we are not gifted. When some of us attempt to do it, we destroy everything...we have our own problems, our personal*

*problems which makes it difficult to go and correct things outside when you do not do it inside. That's another issue that stands in between doing counselling.*

### **5.6.3 Ethics/boundaries/confidentiality**

Three of the participants mentioned experiencing difficulties around and defining boundaries and maintaining confidentiality given the unstructured nature of clergy's work. Also the challenge of counselling people whom you are familiar with was mentioned.

Participant B commented:

*I was asked to counsel a couple who were having difficulties[they were sitting] in the same room with others....Sometimes family members think it is fair to hear the gory details of the [couple]. As clergy you [request] other family members to leave the room or you make an appointment to see the couple later. You learn skills as you go on.*

Participant Z

*Counselling people that I know, especially meeting them after the madness [domestic violence] is over.*

### **5.6.4 Issues of self-care and burnout / Lack of support from the church**

Four of clergy who participated in the follow-up interviews mentioned stress, pressure and strain as some of the challenges they face in their involvement in counselling for emotional and psychological problems. Some clergy serve big parishes. One participant reported serving 14 rural outstations that are far apart. One participant mentioned suffering from emotional and information overload. It is interesting to note that no mention of supervision or self-care was mentioned by participants in this study, in the wake of possible burnout. Two of the participants mentioned that the church is not playing a leading role in supporting its clergy in matters regarding counselling.

Participant B commented:

*The church does not invest a lot in terms of clergy [development] in terms of counselling, it takes individuals to advance themselves.*

Participant Z made a similar point

*As Archdeacon, I have spoken to the Bishop from the top to help us with workshops to deal with these issues [counselling skills development].*

### **5.6.5 Inadequate training/ lack of knowledge**

Forty percent of clergy expressed concern about clergy training, that it does not fully equip clergy for what they have to deal with in the parish.

Participant L commented:

*You know some of clergy nowadays do not do courses like counselling [it is offered as an elective course]....some of them do not even attend college, they read out staff and come out of that knowing how to do counselling?*

It appears there is a huge discrepancy between the training of clergy and what they actually deal with in their parishes. The extracts below illustrate.

Participant K

*Not knowing how rigorous counselling is... I did not know what I did not know [ignorance of the blind side].*

Participant L

*Seminary trained us elementary cases- that was 1962-1965. It's not modern enough. May be we are not educated [to be able to do counselling]... we do not know how to do it [counselling]. That the other problem.*

Participant B

*There seem to be middle age [archaic]training of clergy, [Focussed] on saying mass [theologically based]without actually equipping them[clergy] with how to deal with the 21<sup>st</sup> century person, who has a huge debt...the church is not equipping its clergy in technological advances.*

### **5.7 Factors enhancing counselling for emotional and psychological problems**

Ten participants in the sub-sample identified several ways that they felt enhanced their self-efficacy in counselling for psychological and emotional difficulties. The following themes emerged:

- consulting with church elders
- relying on personal experiences
- personal advancement
- relying on their experience in ministry
- relying on support from fellow clergy
- exposure to psychology and mental health training
- relying on own therapy and cultural knowledge

- feedback from parishioners.

## **Chapter 6 Discussion**

This chapter discusses the study results, limitations and implications for clergy's involvement in counselling for mental health difficulties. The aims and significance of this study will be revisited. The findings of the study will be discussed in a way that elucidates and attempts to understand the phenomena under study and to offer a platform for future research and developments in this area.

This chapter will be organised in the same way the themes in the literature review were structured. It will go on to consider the research findings made in relation to the involvement of clergy in counselling, the context in which clergy are operating before discussing findings around clergy's perceived counselling self-efficacy.

### **6.1 The aims and rationale of the study revisited**

The research design for this project has been descriptive. It was envisioned that the research might give a description of the extent of clergy's involvement in counselling focusing on clergy's perception of counselling self-efficacy and factors that have enhanced and impeded their perceived counselling self-efficacy. Knowledge garnered from this research may be applied to improve the skills of clergy and map out ways in which they may be useful as community resources for mental health care. Secondly, the knowledge can contribute towards the literature on clergy involvement in counselling in the South African context, which is scarce. This research has been motivated by the limitations and ineffectiveness of the present mental health system (Neethling, 2003; Pillay & Kramers, 2003). Further if clergy are to be considered as a resource in mental health care, then there is a call to establish and understand how they respond to their parishioners' emotional and psychological difficulties.

### **6.2 Religion, spirituality, counselling and psychology**

This study highlighted the resurgence of spirituality and the emphasis on religion as a way of coping with mental illness. It also highlighted the involvement of clergy as mental health care helpers in the developed world. It was conjectured that clergy, by the very nature of their work, will be involved in counselling for parishioners experiencing emotional and psychological difficulties. This appears to be the case in South Africa against a backdrop of a mental health system that is strained by inadequate resources. Consistent with research findings from abroad (Weaver, 1995; Weaver, 2003; Pargament, 1997; Millar & O'Kane, 2001; Leavey, et al., 2007) clergy in South Africa are involved in the provision of mental health care (Trump & Hugo, 2006). South Africa has regulations that specifically relegate

counselling to psychologists (Health Professions Council of South Africa) thus clergy's role in counselling for emotional and psychological difficulties is not recognized.

A considerable number of people experiencing emotional and psychological difficulties tend to consult alternative and parallel health care providers such as traditional healers (Havennar, 2007) and religious leaders (Trump & Hugo, 2006). A study by Bushel (2008) on help-seeking behaviours found that people tend to seek help from informal social networks including the church and church leaders. Following through this argument, church members, like any section of society, may experience emotional and psychological problems and tend to look to the church for assistance. This is consistent with Trump & Hugo's (2006) findings that 17 percent of their participants experiencing emotional and psychological problems sought help from religious leaders in South Africa. All clergy who were interviewed reported having dealt with a parishioner whose problem they considered to be psychological.

### **6.2.1 Clergy as counsellors for emotional and psychological problems**

The first finding in this study concerned psychological difficulties that are presented to clergy by parishioners and the frequency of counselling for these difficulties by clergy. They take up a role as counsellors within the religious and spiritual contexts for people.

Difficulties that were presented to clergy are similar those which could be presented to any counsellor, psychologist or social worker, including loss, grief, addiction, depression and death of a loved one amongst others. Difficulties that parishioners "most frequently" sought help for were bereavement, HIV/AIDS, family and marital difficulties, alcohol and substance abuse and depression. These difficulties were consistent with those that Moran et al., (2005) investigated in a survey of clergy's pastoral care activities in New York and Connecticut. Moran et al. (2005) found grief, death and anxiety as "the most frequent" difficulties that clergy counselled for. Young, Griffith & Williams, (2005) found grief, marital and family physical illness, alcohol, unemployment, work related difficulties and adolescent problems as counselled for by clergy "more often and fairly often". This is comparable to the findings of this study.

In South Africa alcohol and substance abuse are reported to be the "most frequent problems" pegged at 9.6% and 13.5% lifetime prevalence respectively in the South African Stress and Health (SASH) study. It is therefore not surprising to find that alcohol and substance use are among the frequently presented problems for counselling by parishioners. On the contrary, alcohol/drugs problems were less frequently presented to clergy in United States (Ingram &

Lowe, 1989; Lowe, 1986; Wood, 1996; Wright, 1984 as cited in Grimm & Basset, 2000; Mannon & Crawford, 1996), whereas in the South African context, alcohol and drug problems were considered to be frequent.

In this current study, the “least frequent” psychological difficulties were suicide, sexual orientation issues, mental illness and child/sexual abuse. This is consistent with other studies in the United States, where severe mental illness and suicide were rather “rare” (Ingram & Lowe, 1989; Lowe, 1986; Wood, 1996; Wright, 1984 as cited in Grimm & Basset, 2000). Mannon and Crawford (1996) also found the same difficulties were perceived to be rarely presented to clergy for counselling. In the current study, clergy “seldom” counselled for these problems.

HIV/AIDS was among the most “frequently” encountered difficulty by clergy in South Africa, unlike clergy in the US study. Moran et al. (2005) found that HIV was one of the less “often” encountered problem by clergy. The high prevalence of HIV/AIDS infections in Africa may be implicated for the differences. HIV/AIDS may not be epidemiologically prevalent in the United States as it is in Africa. The socio-economic status of Africans, poverty and problems with access to health care may also explain the differences.

Findings from the interviews suggest that clergy find more severe psychological problems harder to deal with. This is consistent with Moran et al. (2005)’s findings which grouped difficulties into factor 1 and factor 2, where factor 2 difficulties were more severe psychological difficulties. This was also confirmed in the follow up interviews when clergy highlighted more severe emotional problems like suicide and psychosis as difficult to deal with. Leavey et al. (2008) and Millar & O’Kane (2001) also found that the more severe psychological problems were considered difficult to deal with by clergy in UK. This comes as no surprise as clergy are not trained to deal with more severe mental health issues.

Although all these difficulties were presented to clergy, it must be noted that counselling is not the only intervention method applied by clergy. In addition, not every parishioners who approaches the priest requires counselling (Millar & O’ Kane, 2001). This could explain why there was no significant correlation between the parishioners’ psychological problems and the frequency at which clergy counselled in this study. The case in point is alcohol and substance abuse. Clergy do not seem to engage in counselling with parishioners concerning

alcohol and drug issues. This could highlight that clergy are not keen to counsel for alcohol and substance abuse or alternatively they refer them. It may also have to do with clergy's own convictions towards the morality of alcohol consumption.

The findings in this study suggest that clergy counsel their parishioners for a range of psychological and emotional difficulties. All the psychological difficulties isolated in this study were encountered and counselled for by all priests, at one point or another. In terms of the types of problems more frequently encountered, the findings of this study support those of Weaver et al. (1997), who found marriage-related issues, bereavement and addiction to be those most "commonly" presented issues to clergy. The difficulties listed in this study that clergy counsel for confirms Neethling's (2003) notion that clergy counsel for psychological difficulties that other mental health professionals attend to in the South African context. However, the efficacy of their intervention cannot be ascertained and was beyond the scope of this discussion.

### **6.2.2 Therapeutic approaches used by clergy**

In addition to ascertaining the extent to which clergy were involved in counselling, the study also sought to investigate how clergy offer help to people in their parish with emotional and psychological difficulties. The therapeutic approaches used by clergy were content analysed from the interviews. A common trend that emerged was that clergy tended to combine both spiritual and psychological strategies in their counselling sessions. The most common theme among all clergy from the open-ended questions and from the interview transcripts was the use of empathy, listening and showing care and support. This was consistent with the approaches that were cited by Young (2005) and Leavey (2008). Clergy in this sample also indicated that they would resort to prayer or use of scripture. It appeared this was a challenge for some clergy, trying to marry the two different philosophies, the psychology and the theology. It also emerged from the interviews that clergy's understanding showed recognition of emotional and psychological problems and that clergy had a level of psychological literacy that allowed them to make appropriate referrals.

### **6.3 Perceived counselling self-efficacy**

This sample's mean score for perceived counselling self-efficacy was reasonably high. Clergy may have been judging their own efficacy based on what they thought their peers were doing. There is no comparison sample to contrast the results of this sample's counselling self-efficacy. This could be attributed to the fact that clergy are spiritual beings.

Self-efficacy is tied to optimistic beliefs in one's abilities and the anticipation of expected positive outcomes (Bandura, 1977, 1986, 1997). Spiritual practices have the potential of making individuals more mindful, positive, and connected to others. Greason & Cashwell (2009) found that mindfulness was a significant predictor of counselling self-efficacy. Priests may be considered spiritually-minded people. It is a possibility that they are optimistic and always anticipate positive outcomes, consistent with Bandura's qualities of an efficacious individual. In addition, Bergin, Masters, and Richards (1987) reported that intrinsic religiosity was related to lower anxiety. Lower levels of anxiety in counselling have been found to correlate positively with counsellor self-efficacy (Greason & Cashwell, 2009).

In the light of high perceived self-efficacy reports by clergy in the current study, Mannon and Crawford (1996) addressed the issue of clergy's confidence to provide counselling. They noted that clergy felt most confident to counsel for spiritual and moral issues, marriage and family concerns, life adjustments issues and emotional problems. While self-reported confidence and self-reported effectiveness were not the same index, Grimm & Bassett (2000) also established that areas where clergy felt most confident were spiritual concerns, marital issues, separation and divorce and premarital counselling, which was consistent with Mannon and Crawford's (1996) findings. In counselling parishioners for emotional and psychological problems, priests may be engaging in counselling practices that exceed their actual level of competence.

Self-efficacy is affected by the optimistic belief in one's abilities to perform, with successful outcomes, support and encouragement, and reduced emotional arousal (Bandura, 1986). This could be because the more confident clergy feel about counselling, the more they commit themselves as predicted by self-efficacy theory that individuals with high levels of efficacy persist in face of challenges (Bandura; 1977, Bandura, 1986; Bandura, 1997).

### **6.3.1 Perceived counselling self-efficacy and training**

According to self-efficacy theory, counsellor training is cited by Larson and Daniels (1998), Daniels and Larson (2001) and Melchert et al. (1996) as contributing to enhancing self-efficacy. While clergy receive intensive training, most do not have mental health training. Among the many courses they study, the courses do not equip them to counsel for emotional and psychological difficulties (Kane 2003). Self-efficacy is, in part, determined by knowledge and skills. In the context of this study, it was hypothesized that seminary training

would give clergy superior training compared to clergy who are not seminary trained in terms of pastoral counselling. The results from this study did not reveal statistically significant differences between clergy who were seminary trained and those who did not.

It can also be inferred that the training only equipped clergy to counsel for spiritual matters and not psychological and emotional issues. Virkler (1979) highlighted that, clergy deem their seminary training to be fairly sufficient in preparing them to deal with grief, death, marital problems and somewhat inadequate in preparing them to deal with depression, alcohol/drug problems, and suicide. This view has been consistently supported by more recent research (Leavey et al. 2007; Millar & O’Kane, 2001; Kane, 2003; Wang, Berglund, & Kessler, 2003; Moran et al., 2005). New developments in counsellor self-efficacy research highlight the importance of other internal cognitive skills in developing counsellors (Greason & Cashwell, 2009). Effective counselling requires more than the basic counselling skills offered in pastoral counselling.

A comparison was also done for clergy with mental health training and those with no mental health training. No statistically significant differences were revealed in the levels of perceived counselling self-efficacy. For the purpose of comparison with international research findings, mental health training was treated as a proxy equivalent of Clinical Pastoral Care. The results from this study were inconsistent with the Moran et al. (2005) findings. In that study, clergy who had Clinical Pastoral Education training had significantly higher confidence in their ability to deal with a variety of presenting problems.

However, the findings regarding training in this study are consistent with Burgess’ (1998) findings that, regardless of training and type of counselling education received, clergy reported similar levels of competence. The possibility could be that the kind of training participants in this sample received was either inadequate or at too low a level to influence their perceived counselling self-efficacy (Larson et al. 1999). The self-efficacy theory suggests that self-efficacy is resistant to training effects when there is a mismatch in skill increase and the development in confidence to execute the task (Bandura, 1977). Clergy may have acquired some skills in counselling but their confidence in counselling may not have been developed. Another reason to explain the lack of differences in perceived counselling

self-efficacy for clergy with mental health training and those with no mental health training may be the small sample of clergy with mental health training (n = 14).

### **6.3.2 Perceived counselling self-efficacy and education**

This study indicated significant differences in the levels of perceived counselling self-efficacy for clergy with different levels of education. Priests with higher levels of education had higher levels of perceived counselling efficacy. These results are comparable to Melchert et al. (1996) where level of education accounted for 43% variance in counselling self-efficacy. There is a linear relationship between number of years spent pursuing education and perceived counselling self-efficacy. Israelashvili & Socher (2007) found that past experiences or other educational experiences yielded significant differences in perceived counselling self-efficacy. According to self-efficacy theory people, who see themselves as efficacious in one domain, are likely to be efficacious in other domains.

### **6.3.3 Perceived counselling self-efficacy and supervision**

Support for clergy counselling for psychological and emotional difficulties was less easily documented and articulated by clergy. However, clergy mentioned that they speak to fellow priests for support or other lay people who have a psychology background regarding their counselling work. The possibility of this being some kind of supervision is highly unlikely. This raises concerns around the provision of a counselling service by clergy and, indeed, for the welfare of clergy in undertaking this type of work. Research cited supervision as a method of enhancing counselling self-efficacy through feedback and verbal persuasion. It is a possibility that clergy get feedback and persuasion from their parishioners who approach them for help. Another source of supervision for clergy could be the spiritual directors.

### **6.4 Contextual factors and clergy counselling**

The congregational system may place pressure on clergy to counsel. Self-efficacy theory cites verbal persuasion as one of the sources of counselling self-efficacy. Clergy take up the role in counselling as an extension of the parishioners' family especially in disadvantaged communities. Haveennar et al. (2007) pointed out that due to the expenses involved in seeking help in government established health systems, people tend to seek help from other alternative sources. It had been conjectured that there would be differences in clergy's perceived counselling self-efficacy for rural, township and urban parishes. Contrary to what was expected, there were no differences between the counselling self-efficacy of clergy in rural and urban parishes. Voss, (1996, cited in Grimm & Basset, (2000) had argued that clergy play a very significant role in the mental health needs of rural populations that are

underserved by psychological services that are concentrated in urban areas. This study did not determine any significant differences in the frequency of counselling as well as the perceived counselling efficacy of clergy in rural and urban parishes. This finding is consistent with Grimm and Basset's (2000) study. However, the lack of differences may not imply that clergy in the rural areas do not serve as gate-keepers for psychological and emotional difficulties.

In South Africa, the macrosystem present a scene of suffering brought about by violence, social and moral break-down and the sheer pace of modern life (Van Niekerk & Prins, 2001). In the South African context, in the scourge of HIV/AIDS, road traffic accidents, crime, poverty and unemployment, there is a recurring pain in bereavement and post-traumatic stress. These situations are related to depression and anxiety. Clergy are directly involved with these people. They have a responsibility to their parishioners. Clergy have to help alleviate the pain experienced by their parishioners. With this in mind the size of congregation was considered to influence frequency of counselling and perceived levels of counselling efficacy. It was therefore hypothesized that there would be differences in levels of perceived counselling self-efficacy in clergy serving in big and small parishes. However, there were no significant differences revealed. In discussing these results it must be noted the small sample sizes may have led to Type 1 error.

In South Africa socio-emotional coping with the daily challenges for parishioners may be compromised by contextual factors like poverty and HIV/ AIDS especially for those in previously disadvantaged communities. The commercialized and urbanised form of psychology together with the emphasis on curative medical model has divorced psychology from the daily experiences of people (Vogelman, Perkel & Strebel, 1992), thus people tend to turn to alternative sources of help like clergy. Clergy may therefore play an influential role in helping to strengthen protective influences at individual, interpersonal and community levels.

Nevertheless, the professionalization of counselling, making it a domain for psychologists, was coupled with a consequent loss of confidence of clergy in the work that they have always done. Clergy are aware of their limitations. It could not be ascertained from this study if their training does not equip them to counsel for emotional and psychological difficulties which were brought to their office. However, many clergy regarded their training as inadequate and limited. In order to effectively mitigate their shortcomings some clergy relied on personal

advancement to acquire the necessary skills in order to effectively help their parishioners. Others had to tailor-make their interventions to suit the cultural contexts in which they work. Nonetheless, many clergy seemed confident and comfortable to counsel their parishioners.

Although clergy reported being able to manage their own emotions in the clergy questionnaire, there were concerns raised regarding managing dual relationships with parishioners. In counselling, the relationship plays an important therapeutic role and the counsellor is expected to respond in particular ways, managing the transference and counter-transference (Weiner, 1975).

The individual characteristics of clergy, their age and gender were also considered and comparisons were made with regard to frequency of counselling and the levels of perceived counselling self-efficacy. Consistent with previous research (Grimm & Basset, (2000) counselling self-efficacy gender and age did not seem to influence perceived counselling self-efficacy.

## **6.5 Limitations**

In drawing conclusions from this study, there were several limitations which must be noted. These have included limitations in the construction of the instrument, the way the instrument was used, how it was administered to the sample members and the selection of the sample.

This study was carried out in one region and restricted to one denomination of clergy. It was based on a very small sample of clergy who took part in the study on a voluntary basis. Therefore, it is possible that clergy already engaged in counselling practice were more likely to respond. There is high thus a possibility of response bias. This could skew the results as respondents might appear more highly efficacious than a random sample of clergy. Self-report measures presented in questionnaire format. Self-report measures pose the problem of social desirability. Clergy might score themselves as self-efficacious in an effort to present themselves in a more positive light.

While 54 questionnaires were collected, only 52 could be use; this would not be considered an adequate sample size to assure generalizability for the entire population of clergy. There was sample bias as most participants were White. Race was not included in the demographic section of the questionnaire. There were also possible participants who refused to take part in the study. This was probably because the process of getting permission compromised the data

collection process and was met with antagonism. The research may have been construed to be bishop's ploy to monitor clergy involvement in pastoral duties thus resistance to participate in the study by some clergy.

When permission to carry-out the study was granted, the bishop sent out an email informing clergy of the researcher's intentions. The method of data collection may also have contributed to the low response rate; clergy were targeted during their meetings and they may have been more focussed on the business of their meeting. They were allowed to post the survey at a later date. Only a few surveys were posted back to the researcher. The small sample size is of great concern although the interview was used to augment the questionnaire. In addition, the researcher was a female, black non South African who may have been treated with suspicion and bias. Therefore, these data are only representative of the specific sample studied. As such, there is the concern of making a Type I error

The instrument was self-developed, although it was based on Bandura (2005) guide for constructing self-efficacy scales. It was adapted from the Counsellor Self-Efficacy Scale which was not normed for a South African population. Israelashvili and Socher (2007) highlighted the possibility of cultural bias and contextual bias that could impact on the measurement of counsellor efficacy. The Counsellor Self-Efficacy Scale was not culturally validated, the role played by cultural differences in counselling self-efficacy were not controlled for, therefore the results of the study should be interpreted in that context. Israelashvili & Socher, (2007), suggested that culture influences counsellor self-efficacy. The familiarity of terms that were used in the questionnaire is also of concern. Terms like "behaviour change", "client exploration of issues" and "crisis intervention" may not have been familiar with clergy and their interpretation may have influenced the research findings. Even "Depression" needed to be distinguished from mental health problems.

The amount of experience clergy have in ministry was not asked for in the clergy questionnaire. Experience has been documented as predictive of counselling self-efficacy (Larson, 1998). This was an oversight on the part of the researcher. This was addressed by the follow-up interview that addressed factors that clergy perceived to have influenced their counselling efficacy. The study also did not clearly define kind of mental health training and the follow-up question to investigate the kind of training did not yield the desired results. There is a high possibility that some clergy considered their training in pastoral counselling

as mental health training. Furthermore, clergy are not generally trained to assess mental health problems. The questionnaire required them to rate the prevalence of particular emotional and psychological problems, and this poses a challenge on the reliability of clergy in identifying the emotional and psychological problems.

There was a lack of a comparison group, for example, comparing the counselling self-efficacy with another group of mental health professionals. No behavioural observations were made to validate the Perceived Counselling Self-Efficacy Scale. The study only examined clergy's perception of their role without also examining parishioners' views of the role their priest play in their communities.

## **Chapter 7 Conclusion and Recommendations**

This research set out to explore the perceptions of clergy of their role in counselling parishioners for emotional and psychological problems in the South African context.

Research in this area has been motivated by the lack of significant research in this area especially in the South African context. It was hoped that this research might shed some light on the need for on-going research in this areas within a South African context by giving an overview of clergy involvement in mental health care provision.

### **7.1 Clergy involvement in counselling**

Since members of the congregation consult clergy with their problems “clergy are in an ideal position to identify mental illness in their communities. Clergy may be able to help with “less serious emotional issues on their own but they must be able to determine when people should be referred to mental health professionals” (Flannelly, Stern, Costa, Weaver & Koenig, and (2006. p.551). Haug, (1999) stated that it could be of benefit to both parishioners and clergy if clergy could be afforded an opportunity to engage in comprehensive training, at least in the use of counselling skills and managing dual relationships. A large number of clergy in this study were keen to effect referrals, thus “formal training in managing the referral process could be of benefit” (O’Kane & Millar, 2001, p.334) to clergy in South Africa. It is also important to investigate if clergy are interested in being a community resource for mental health. Referring to other mental health professionals may suggest that clergy are overwhelmed by parishioners’ psychological problems on top of their usual load of pasturing the flock (Leavey, 2008).

### **7.2 Supervision for clergy counsellors**

Clergy who engage in counselling for emotional and psychological problems “require on-going support through effective local supervision. It is likely that parishioners will continue to seek help from their local priests for a range of problems” (O’Kane & Millar, 2001, p.334) because priests are well positioned to play a pivotal role in alleviating low key emotional and psychological problems. More effort could be made by support groups and mental health professionals to educate clergy on symptoms and treatments available for mental illness Trump & Hugo, (2006). Knowledge on when to refer, what to expect after referral and how to manage dual relationships may be the topics that need to be addressed (Farrell & Goebert (2008). Clergy may also need some kind of formal supervision.

### **7.3 Conclusion**

Clergy's role in mental health care is not sufficiently recognised because the mental health system in South Africa restricts the involvement of clergy in counselling in a context that is under resourced. There is a need to further investigate this area of clergy and mental health, in order to map out ways of maximising every resource. This study may be treated as a pilot study for subsequent studies on what clergy actually do when parishioners present with mental and psychological problems. The possibility of future research would be to validate the PCSES and this could go a long way toward establishing a model for supervision for clergy counsellors.

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## **Appendices**

### **Appendix A**

#### **Introductory letter**

My name is Rumbidzai Chidzonga, a student psychologist at the University of KwaZulu-Natal. I am married to Revd Barnabas Nqindi, the Rector of St Matthew's, Estcourt.

I am conducting a study on clergy perceptions of their role in dealing with parishioner emotional and psychological difficulties. The information will benefit the church and mental health workers in forging a partnership in ameliorating psychological difficulties.

By completing this questionnaire you are agreeing to participate in the study. Your identity will be kept confidential and all answers to all questions will never be linked to you in any way. It is anticipated that there are minimal risks to you as a participant. However, the questionnaire may contain issues that may not be in line with your beliefs, for example, issues on sexuality. If you have any questions regarding this study, or experience any negative effects from your participation contact me or my supervisor Professor Lance Lachenicht to facilitate counselling.

You may withdraw from this study at any time without penalty. I am looking forward to receiving your completed questionnaire. If you would like to know the findings of the study, indicate in the consent form, I will be happy to send you a summary of the findings when the study is completed. A feedback seminar will be organized through the Bishop's office.

Thank you in advance for your help and time

Rumbidzai Chidzonga

**Appendix B**  
**Informed Consent Form**

**Researcher Information**

I am Ms Rumbidzai Chidzonga, a student psychologist at University of KwaZulu Natal, Pietermaritzburg Campus. I humbly request your participation in my research study investigating clergy perceptions of their roles in counselling parishioners for emotional and psychological difficulties. I am embarking on this study for academic purposes, and it will be pursued in the Diocese of Natal. The study is conducted under the supervision of Professor Lachenicht in the Department of Psychology.

I can be contacted at 072 966 3505 during office hours or by e-mail [208515841@ukzn.ac.za](mailto:208515841@ukzn.ac.za).  
Professor Lachenicht can be contacted on (033) 260 5670

I intend to gather data for this study through questionnaires and structured interviews. Participants are assured that their information will be treated confidential. Pseudonyms will be used in interviews and write up.

**Consent Form** *Please sign*

I, ..... consent to participate in the study and to be interviewed by Ms Rumbidzai Chidzonga. I agree that the data gathered for this study may be published for academic purposes.

I further understand that:

- Participation in this study is voluntary.
- I may refuse to answer any questions I would prefer not to.
- I may withdraw from the study at any time.
- No information identifying me may be included in the research report, and my responses will remain confidential.

Please tick in the box below if you would like to receive a summary of the research findings.  
( ) I would like to receive a summary of the research findings when the study is complete.

Signed:

.....Date:.....Place.....

**Appendix C**  
**Clergy Questionnaire**

**Section A**

**Personal information**

Please tick in the number that apply to you

- I. Age group
- 1 20-29 ( )
  - 2 30-39 ( )
  - 3 40-49 ( )
  - 4 50-49 ( )
  - 5 60+ ( )
2. Gender
- 1 Female ( )
  - 2 Male ( )
3. Did you attend seminary
- 1 Yes ( )
  - 2 No ( )
4. Highest level of education
- 1 Less than Matric ( )
  - 2 Matric/Matric Equivalent ( )
  - 3 Diploma ( )
  - 4 University Degree ( )
  - 5 Masters Degree ( )
  - 6 Doctoral Degree ( )
5. Do you have specialized training in the area of mental health
- 1 Yes ( )
  - 2 No ( )
6. If Yes above, was it a
- 1 Continuing education classes ( )
  - 2 One year course ( )
  - 3 Degree program ( )
  - 4 Other ( ) specify .....
7. How Large is congregation
- 1 1 -200 ( )
  - 2 201-400 ( )
  - 3 401-600 ( )
  - 4 601-800 ( )
  - 5 801-1000 ( )
  - 6 1001+ ( )
8. The parish is
- 1 Urban suburban ( )
  - 2 Urban township ( )
  - 3 Rural ( )

**Section B**

From the given scale, tick one response that is close to describing the situation in your parish.

9. How prevalent are these issues in your parish

		very rare	rare	moderate	frequent	very frequent
1	Alcohol/ Substance abuse					
2	HIV/AIDS					
3	Marital difficulties					
4	Premarital conflicts					
5	Suicide tendencies/ideations					
6	Family relations problems					
7	Bereavement					
8	Depression					
9	Mental illness					
10	Teenage problems					
11	Life adjustment issues					
12	Child abuse					
13	Sexual orientation					
14	Any other (specify)					

10. Can you estimate how many parishioners with psychological problems you counsel each month ..... Parishioners.

From the given scale tick the one that closely describe the situation in your parish

11. Approximately how often do you counsel parishioners for emotional and psychological difficulties?

		Never	seldom	sometimes	frequently	always
1	Alcoholism					
2	HIV/AIDS					
3	Marital difficulties					
4	Premarital conflicts					
5	Suicide tendencies/ ideations					
6	Family relations problems					
7	Bereavement					
8	Depression					
9	Mental illness					
10	Teenage problems					
11	Life adjustment issues e.g. empty nest/ loneliness					
12	Child/sexual abuse					
13	Sexual orientation					
14	Unemployment					
15	Aging					
16	Any other (specify)					

### Section C Perceived Self-Efficacy Scale

Using the scale below, tick the number that corresponds with how you feel about the statements given in the table below. There is no wrong or right answer.

1 Strongly disagree    2 disagree    3 neutral    4 agree    5 strongly agree

1	I believe I can counsel for emotional and psychological difficulties.	1	2	3	4	5
2	My knowledge of psychological difficulties is adequate for counselling effectively.	1	2	3	4	5
3	My knowledge for behaviour change is not adequate.	1	2	3	4	5
4	I am not able to counsel for psychological and emotional problems to professional standards.	1	2	3	4	5
5	I can communicate knowledgeably with mental health professionals.	1	2	3	4	5
6	I am able to recognize major psychological conditions.	1	2	3	4	5
7	I am able to effectively develop a therapeutic relationship with parishioners.	1	2	3	4	5
8	My knowledge regarding crisis intervention is not adequate.	1	2	3	4	5
9	I am not able to accurately identify my own feelings and emotional reactions to clients.	1	2	3	4	5
10	I can effectively facilitate, appropriate goal development with parishioners.	1	2	3	4	5
11	I am able to keep my personal issues from negatively affecting my counselling .	1	2	3	4	5
12	I am able to make appropriate referrals to other services in my community.	1	2	3	4	5
13	I get a lot of support from other priests .	1	2	3	4	5
14	My training equipped me to deal with psychological problems.	1	2	3	4	5
15	I can effectively facilitate client exploration.	1	2	3	4	5

In your own words describe how you have assisted a parishioner who presented with an emotional, relationship or psychological difficulty. (You may use the back of the questionnaire for more space.)

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**Please ensure that you have completed all sections of the questionnaire. Thank you very much for taking part in this study.**

## **Appendix D**

### **Semi-structured interview questions**

Have you ever had a parishioner who came to you with a problem that you felt it was a psychological?

Tell me more about the case without including names and any identifying details

Tell me about specific instances when you felt you knew enough psychology and you really needed that knowledge to help the parishioner.

Tell me about specific instances when you felt you did not know enough psychology and you really needed the knowledge to help the parishioner.

How do you offer help to your parishioners experiencing emotional and psychological difficulties?

In your own opinion do you think you are capable of performing the task of counselling?

What challenges do you face in providing this service?

What has enhanced your sense of efficacy in the challenges that you face?

