AN INVESTIGATION OF THE PSYCHOSOCIAL WORK ENVIRONMENT OF MINISTERS IN THE DUTCH REFORMED CHURCH, IN THE WESTERN CAPE AND KWAZULU-NATAL

BY

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A research report submitted to the Faculty of Health Sciences, University of the Witwatersrand, Johannesburg, in partial fulfilment of the requirements for the degree of Master of Science in Nursing qualification of the Department of Nursing

Signed on 19 November 2015, Johannesburg

DECLARATION

I, **Lindie Louise Jansen van Rensburg**, declare that this Research Report is my own work. It is being submitted for the Degree of Master in Nursing at the University of the Witwatersrand, Johannesburg. It has not been submitted before for any degree or examination at this or any other University.

Work used or cited in this research report has been appropriately indicated and acknowledged both within the text and by means of complete references.

Signature _____

Lindie Louise Jansen van Rensburg

_____ Day of _____ 20_____ in _____

The research report has been approved for submission by the supervisor, Ms. Annalie van den Heever

ABSTRACT

Background: According to the Occupational Health and Safety Act, no 85 of 1993, Section 8, employers need to ensure a healthy and safe environment for employees to work in. Anecdotal evidence shows that the only psychosocial support ministers receive is from their peers.
Purpose and objectives: The purpose of the study was to explore and describe the psychosocial work environment of ministers in the Dutch Reformed Church**.** The objectives are to explore the psychosocial work environment; to describe the existing psychosocial support for and to establish preferred supporting programmes in dealing with stress, regarding psychosocial health care programmes for ministers in the Dutch Reformed Church in the Western Cape and KwaZulu-Natal.
Research design and method: A quantitative survey study, with a self-administered questionnaire has been e-mailed to the total sample of respective participants using the REDCap system**.**
Data analysis: Descriptive statistical methods were used to describe the socio-demographic information. Data was exported using Redcap and outcome data was presented with tables; numerical data was described using means (with standard deviations) and categorical data was presented using frequencies (counts) and percentages. Open questions were analysed and emerging themes were identified.
Findings: High emotional work demands, poor leadership quality and ineffective social support were some of major indicators of ill health, burnout and stress in this study of the psychosocial work environment.
Conclusions: The findings of the study highlighted the need for an occupational health programme due to the fact that ministers in these regions are exposed to psychosocial hazards in the work environment.
Key words: Dutch Reformed Church, psychosocial work environment, ministers, occupational health

DEDICATION

This work is dedicated to these exceptional and precious people in my life:

My husband, Riaan Jansen van Rensburg

who supported me in every possible way to make this dream come true

My daughters, Emily and Jessica Jansen van Rensburg

for understanding and encouragement every step of the way

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My Heavenly Father for His blessings

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NOMENCLATURE

BCEA	Basic Conditions of Employment Act, No. 75 of 1997
COIDA	Compensation for Occupational Injuries and Diseases Act, No 130 of 1993
COPSOQII	Copenhagen Psychosocial Questionnaire II
EAP	Employee Assistance Programme
ILO	International Labour Organization
NCD	Non-communicable diseases
OHN	Occupational health nursing
OHNP	Occupational health nursing practitioner
OHSA	Occupational Health and Safety Act, No. 85 of 1993
OHRA	Occupational Health Risk Assessment
RSA	Republic of South Africa
SD	Standard Deviation
WHO	World Health Organisation

1.0 CHAPTER ONE: OVERVIEW OF THE STUDY

1.1 Introduction and background

Western industrial countries have experienced numerous and important changes in working conditions, and the demands on employees in the workplace are also changing rapidly (Nübling, Stößel, Hasselhorn, Michaelis & Hofmann, 2006; "Psychosocial risks and work-related stress", 2014). The consequences of these demands are seen in increased psychological stress which leads to increased sick leave usage and cost of treatment in the work environment. Other consequences include musculo-skeletal disorders, cardiovascular diseases, mental disorders, stress, burnout, decreased quality of life, increased labour turnover, decreased motivation and decreased productivity. According to Nübling et al (2006) workplace health promotion is mandatory to minimize health risks caused by psychosocial work overloads of the employees.

Like most other religious institutions, the Dutch Reformed Church employs ministers, administrative and other personnel, which lead to the automatic inclusion of these employees in the Labour laws e.g. Labour Relations Act No. 66 of 1995, Basic Conditions of Employment Act No. 75 of 1997, as well as the Occupational Health and Safety Act, No. 85 of 1993 (OHSA) of South Africa. The OHSA requires of all employers, including the Dutch Reformed Church, to provide a workplace that is safe and without risks (as are reasonable practicable) to the health of their employees (Republic of South Africa, 1993a). To ensure a healthy and safe workplace the potential hazards must be identified by means of hazard identification and risk assessment and then is the responsibility of the employer to take all reasonable practicable steps to eliminate and mitigate any potential hazards. These hazard groups may include: physical, biological, chemical, mechanical, ergonomical and psychosocial aspects (Acutt, Hattingh & Bergh, 2011).

As part of the key performance areas for a minister, it is expected of them to do pastoral work for example home visits, supporting people in emergencies, crisis counselling, marriage and family accompaniment, supporting the frail and visiting the elderly. In addition, liturgical work, planning and rendering of sermons, intercession, serving of sacraments, funerals, weddings, preaching, teaching, education, bible

study, baptismal catechesis and marriage catechesis form part of their workday (Dutch Reformed Church, 2011: 3). Personal development and continuous education, staying healthy – physically and mentally, as well as administration and management are to mention only a few of their activities in addition to their daily tasks. (NG Kerk, 2006: 36)

While occupational health is generally provided in a very structured manner in larger companies such as factories and mines, there is no formal structure in place for managing occupational health and safety including occupational injuries and diseases within the Dutch Reformed Church. There is however reference made to the management of occupational injuries, diseases and medical examinations as an inherent job requirement (NG Kerk, 2010: 49). The Church Council is seen as the employer in the Dutch Reformed Church (Dutch Reformed Church, 2011) and the presbyteries apply policies and procedures on the Church Council as suggested by the Synod (Dutch Reformed Church, 2011: 4)

Tomic, Tomic & Evers (2004) state that psychological stress and burnout are known risks in the vocation of ministers. These psychosocial risks often lead to high healthcare costs to the ministers, their families as well as the congregation (Buys & Rothmann, 2010; Proeschold-Bell, LeGrand, Wallace, James, Moore, *et al.*, 2012). In self-care the ministers are responsible for their own spiritual, emotional, psychological, social, physical and material welfare, mentoring and theological training (NG Kerk, 2006). It is expected of ministers to be in a mentoring programme with a colleague. The responsibility is with the minister but the researcher feels that the parishioners, presbyteries and synod should also support this mentoring programme. Mentoring refers to accompaniment on spiritual, professional and relationship spheres (NG Kerk, 2006: 36).

The World Health Organization: Healthy workplaces: a model for action (2010): 6 define a healthy workplace as “one in which workers and managers collaborate to use a continual improvement process to protect and promote the health, safety and well-being of all workers and the sustainability of the workplace”. The following needs are identified by the WHO: health and safety concerns in the physical work environment; health, safety and well-being concerns in the psychosocial work environment, including organization of work and workplace culture; personal health resources in the

workplace; and ways of participating in the community to improve the health of workers, their families and other members of the community (WHO, 2010: 6). With reference to this definition, the psychosocial work environment is seen as playing a role in creating a healthy and safe work environment. A safe work environment also refers to values, attitudes, beliefs and organizational culture. When an employee struggles with poor work organization, structure in the organization, management of the workplace and lack of support in creating balance, it increases the psychosocial risk factors (WHO, 2010: 11)

After concluding their study in investigating the effects of job-demands and job-resources on ministers' burnout and engagement, Buys and Rothmann (2010) agree that the pace of work, the amount of work and emotional demands are indicators of burnout and ill-health. They also investigated the effect of congregational commitment and health as possible consequences of burnout and engagement. Exhaustion and other occupational related stressors in their study predicted somatic symptoms and depression among ministers of the Reformed Church in South Africa. Buys & Rothmann (2010) furthermore refers to studies done by Wright, Bonett & Sweeney (1993) that indicate that ministers often present with other symptoms or diagnosable illnesses related to these psychosocial hazards. These symptoms and diseases include but are not limited to exhaustion, somatic symptoms, depression, burnout, poor health, loss of self-esteem, hypertension, alcohol and/or drug consumption. According to Proeschold-Bell et al (2012) chronic diseases including obesity, hypertension, diabetes, asthma and arthritis also attribute to health related problems for ministers.

Literature has further highlighted possible measures that can be put in place, for example a personalised health care programme with due regard for culture, accessibility and effectiveness (Proeschold-Bell *et al.*, 2012: 247). Competencies for the ministers in how to act, organise and promote time management, can decrease stress. Coaching of young ministers by mentors (usually by the older, more experienced ministers) and stress prevention programmes including recognition of burnout for prompt and effective treatment (Tomic, Tomic & Evers, 2004); and an intervention for stress management for clergy as part of health promotion (Arumugam, 2003) are measures that can be implemented to increase coping skills.

In summary, research (Tomic *et al.*, 2004) has shown that ministers' tasks are experienced as weighty and demanding: preparing and writing a sermon, pastoral care and unfulfilled expectations from parishioners, catechism and time management may lead to a feeling that the work is never done. Tomic et al (2004) further state that personal traits including extroversion, introversion, emotional stability and lack of social support at home pose a risk in the workplace and their attitude towards health and well-being in ministers.

However, no formal study could be found which was done on the investigation of psychosocial work environments of the Dutch Reformed Church in South Africa, which prompted the researcher to explore the current psychosocial work environment for ministers in the Dutch Reformed Churches of KwaZulu-Natal and Western Cape.

1.2 Motivation for the research

Ministers are seen as someone who is on call 24 hours a day, whenever parishioners may need them. They must always be in good spirit and lead and support those around them, spiritually, physically and psychologically. The need for psychosocial support for ministers was identified after witnessing an episode of burnout in a minister from a Dutch Reformed Church. Although signs and symptoms of burnout were experienced by the individual, these were not managed appropriately by the Church Council and burnout occurred. This supports previous research findings that indicate the need for occupational health programmes with specific reference to psychosocial hazards for ministers (Tomic *et al.*, 2004). The investigation of the psychosocial work environment within the Dutch Reformed Church will attempt to provide information regarding the psychosocial work environment which can be used to make recommendations in order to address the psychosocial needs of the ministers.

1.3 Problem statement

No formal research has been undertaken into the psychosocial hazards in the work environment of ministers in the Dutch Reformed Church. Limited literature studies are available regarding the psychosocial work environment of ministers'. Although high risk of psychosocial hazards including that burnout and depression, are experienced in the vocation as a minister (Tomic *et al.*, 2004: 229) no official programme is in place in the Dutch Reformed Church to address these hazards. Limited programmes are

available to assist the ministers but are currently not utilised due to financial and time restraints.

As the Occupational Health and Safety Act, No 85 of 1993, stipulates, it is the employers' responsibility to ensure a healthy and safe environment to work in. This environment includes the psychosocial hazards.

1.4 Implications for occupational health nursing practice

As this is an unfamiliar field for occupational health and occupational health nurse practitioners, this study will aim to add to the body of knowledge regarding the psychosocial hazards in the work environment of ministers and contribute towards legal compliance for the employer as required by the Occupational Health and Safety Act, No. 85 of 1993, and a safe and healthy psychosocial work environment for ministers in the Dutch Reformed Church.

The research results can be used for international comparison to studies done in other parts of the world. If recommendations are implemented the COPSOQII questionnaire can be repeated by the employer to measure any changes that occurred, and to which extent.

1.5 Research question

The research is initiated to answer the following research question: How do ministers' in the Dutch Reformed Church of the Western Cape and KwaZulu-Natal, describe their psychosocial work environment? This will include hazard identification, current support and preferred psychosocial support to enable the researcher to make recommendations.

1.6 Purpose of the research

The overall purpose of this research is to explore and describe the psychosocial work environment including of ministers in the Dutch Reformed Church and make recommendations in order to address the psychosocial hazards in the psychosocial work environment.

1.7 Research objectives

In order to achieve the research purpose, the following objectives were achieved:

- To explore the psychosocial work environment of the ministers in the Dutch Reformed Church in the Western Cape and KwaZulu-Natal
- To describe the existing psychosocial support for ministers in the Dutch Reformed Church in the Western Cape and KwaZulu-Natal
- To establish preferred supporting programmes in dealing with stress, regarding psychosocial health care programmes for ministers in the Dutch Reformed Church in the Western Cape and KwaZulu-Natal, for recommendation

1.8 Demarcation of the research

The research is demarcated in terms of the following criteria: time, population and research setting as explained below:

Time dimension: The research was a cross-sectional survey study done in June/July 2015

Population: The total population did consist of all ordained ministers of the Dutch Reformed Church in the Western Cape and KwaZulu-Natal (N=457)

Research setting: The research study was conducted with the Dutch Reformed Church ministers in the Western Cape and KwaZulu-Natal. The Western Cape region includes the Southern Cape. The Dutch Reformed Church is a Christian denomination with 9 synods in South Africa and one synod in Namibia. The website of the Dutch Reformed Church state that every synod has a regional structure, called presbyteries, with a head office in the main town of each province. There are 1158 congregations, 144 presbyteries with a total membership of 1,074,765 parishioners. The Church Council and local ministers are responsible for pastoral care and ministry. There are a total of 1,602 ordained ministers in the Dutch Reformed Church in South Africa and Namibia (“Die NG Kerk”, 2015).

Research design and method: A quantitative survey was done and a self-administered questionnaire was mailed to potential participants using the REDCap system.

1.9 Operational definitions of key research variables

Ordained Minister of the Dutch Reformed Church: Ministers affiliated to a Dutch Reformed Church and who has the responsibility of worship services, edifying the congregation, teaching and training of believers for their ministry, the ministry of the congregation in the world, leading and organising the congregation, exercising Christian love and discipline and pastoral care.

Psychosocial hazards: factors that can negatively affect an individual's psychological and physical health including the effectiveness of the organisation that he/she works in. This refers to work-related stress and can include but is not limited to: organizational culture, workload, engagement, balance, recognition, reward, leadership, expectations, etc.

Psychosocial environment: daily activities and events in the work environment that affects the employees' physical and mental health including culture of company, beliefs, attitudes and values.

1.10 Conclusion

Chapter one gave an overview of the study. The introduction and background to the research and motivation for the research and the research problem was discussed. The purpose of the research with its objectives, research question and demarcation of the research was described. Operational definitions were given as well as the implications for occupational health nursing practice. Chapter two will describe the literature review done which focus on occupational health, legislation pertaining to the work environment, occupational health risk assessment, psychosocial work environment, psychosocial hazards, and the impact of psychosocial hazards on health and well-being and occupational health management.

The purpose of Chapter 3 is to describe the research design and methodology used by the researcher to explore and describe the psychosocial work environment of ministers in the Dutch Reformed Church. In Chapter 4 the research results will be analysed and presented and Chapter 5 will discuss the research results in relation to the objectives of the study.

2.0 CHAPTER TWO: LITERATURE REVIEW

2.1 Introduction

With this chapter, the researcher introduces the reader to a literature review regarding occupational health and safety, psychosocial work environment, impact of psychosocial hazards on health and well-being and occupational health management programme.

Most of our waking hours are spent at work. If you calculate the time since getting up and preparing to go to work, until you return home at night, most of us spend from 06:00 until 18:00 with activities related to going to work, work and return from work. Occupational health thus plays a major role as much of our time is devoted to work. The psychosocial hazards as in the work environment, as part of the hazards in occupational health, play a major role in the physical, psychosocial, spiritual and intellectual health of the employee (Government of Canada, 2011; Proeschold-Bell *et al.*, 2012).

Managing these hazards to create a healthy and safe work environment will have a positive effect on the health and productivity of the employee and ultimately have a positive effect on the workplace and output at work (Acutt *et al.*, 2011). Occupational health management is thus critical in ensuring a healthy and safe working environment.

The following sections will discuss the literature review applicable to this research. Section one discusses what occupational health and safety is with reference to legislation and occupational health risk assessment in the working environment. Section two focuses on the psychosocial work environment and the psychosocial hazards as identified by previous research. Section three focuses on the impact of psychosocial hazards on the health and well-being of ministers as researched and documented. Section four discusses the occupational health management as researched.

2.2 Occupational health and safety

Occupational health is concerned with the health of the employees' and the interaction with their work and work environment (Acutt *et al.*, 2011).

According to Acutt and Hattingh (2011:16) occupational health was defined by a joint committee of the International Labour Office (ILO) and the World Health Organization (WHO) (1986) as being concerned with:

- "The promotion and maintenance of the highest degree of physical, mental and social well-being of workers in all occupations

- The prevention of adverse health consequences for workers as a result of conditions in their workplaces

- The protection of workers at risk because of existing factors in their places of employment

- The placement and maintenance of workers in occupational environments that have been adapted to suit their physiological and psychological conditions"

The World Health Organization (WHO, 2010: 1) estimates that 2 million people die annually, worldwide due to occupational injuries and diseases. A further 268 million non-fatal workplace accidents occur and 8 % of the global burden of disease from depression is work related. Analysing these statistics from the WHO (WHO, 2010) we must remember that these are from registered business and that most small to medium enterprise business and the informal sector are not registered and thus the statistics will be much higher if all workplaces are registered and if all workplaces would notify the relevant authorities of incidents, injuries and diseases.

The WHO Healthy workplaces: a model for action has five objectives: "1. To devise and implement policy instruments on workers' health; 2. To protect and promote health at the workplace; 3. To promote the performance of, and access to, occupational health services; 4. To provide and communicate evidence for action and practice; 5. To incorporate workers' health into other policies" (WHO, 2010: 1)

The same document asks the question "Why develop a healthy workplace initiative?" Their reasons include: "1. It is the right thing to do: business ethics, 2. It is the smart thing to do: business case; 3. It is the legal thing to do: legal case" (WHO, 2010: 4)

Specific legislation in the Republic of South Africa (RSA) governs occupational health in South Africa.

2.2.1 Legislation

In the RSA occupational health is governed by various legislation and various government departments. Currently the Occupational Health and Safety Act No 85 of 1993 (OHSA) is being reviewed as well as some of the regulations including the Hazardous Chemical Substance Regulation, Lead Regulation and Asbestos Regulation.

The legislation forces the employers to create a healthy and safe environment for employees to work in and includes but is not restricted to the following: (Michell, 2011: 69)

- Labour law: for example the Labour Relations Act, Act No. 66 of 1995, Basic conditions of Employment, Act No. 75 of 1997 and Occupational Health and Safety Act, No. 85 of 1993;

- Social Security Law: for example Compensation for Occupational Injuries and Disease Act, Act No. 130 of 1993, Occupational Diseases in Mines and Works Act, Act No. 78 of 1973

- Health Law; for example the National Health Act No 61 of 2003, Healthcare professional legislation including Nursing Act, Act No. 33 of 2005, Health Professions Act, Act No 56 of 1974

- And all related regulations

For an occupational health practitioner to render an occupational health programme all legislation that is specific to the employees and their work environment must be incorporated into the occupational health service. Each of these legislations has an impact on occupational health programme rendered to employees in the work environment.

The purpose of the OHSA Act No. 85 of 1993 is to ensure that employees and other persons associated with the workplace have a safe and healthy environment in which

to operate and that they are protected against hazards associated with the workplace (Republic of South Africa, 1993a: 1). The duties of the employer in this Act prescribe that the employer shall create a work environment that is healthy and safe. Section 14 describes the duties of the employees at work and that he/she also have a responsibility to ensure a healthy and safe environment at the workplace.

Section 8 (d) of the OHSA Act No. 85 of 1993 refers to the responsibility of the employer to carry out a hazard identification and risk assessment of the work environment. An occupational health risk assessment (OHRA) should be carried out within an interdisciplinary team. A medical surveillance plan will then be drafted after the OHRA has been completed. Medical surveillance means "a planned programme of periodic examinations (which may include clinical examinations, biological monitoring or medical tests) of employees by an occupational health practitioner or, in prescribed cases, by an occupational medicine practitioner" as defined by the OHSA (Republic of South Africa, 1993a: 5).

With the completion of the OHRA and execution of the medical surveillance plan the occupational health practitioner (OHP) will be able to render a preventative and promotive programme to protect and restore the health of employees in their work environment (Acutt *et al.*, 2011: 247) rather than a curative service. Occupational health is a preventative health service and not curative. If an injury or disease was encountered the occupational health clinic will be part of the curative and rehabilitative process.

Should the unfortunate occur and an employee meets with an occupational injury or disease the Compensation for Occupational Injuries and Diseases Act No. 130 of 1993 (Republic of South Africa, 1993b: 1) will come into effect. This Act prescribes the procedure on how and when to notify the Compensation Commissioner and the Department of Labour of any occupational injuries and/or diseases. Section 65 (1)(b) states that an employee is entitled to compensation should the Director-General agree to it that "the disease has arisen out of and in the course of his or her employment" (Republic of South Africa, 1993b).

The Basic Conditions of Employment Act (BCEA) No 75 of 1997 (Republic of South Africa, 1997: 1) describes the right to fair labour practices. This Act refers to leave and

regulation of working time. Ordinary hours of work are discussed under Section 9(1) and Section 10 discusses overtime. Section 12 discusses “Averaging of hours of work”. The BCEA thus regulates all hours at a workplace. Night work is defined as work performed after 18:00 and before 06:00 (Republic of South Africa, 1997)

A code of good practice on the arrangement of working time has been issued by the Department of Labour (DOL) (Department of Labour, 1997) According to Sieberhagen et al, (2009) the working time of an employee has an impact on the health and safety of the employees. By regulating the working time and adhering to the code of good practice the employees’ health is protected and promoted (Department of Labour, 1997).

A risk assessment for psychosocial issues should be done at the workplace (Sieberhagen, Rothmann & Pienaar, 2009). This would ensure that all hazards are taken into consideration and be addressed to create a healthy and safe work environment.

2.2.2 Occupational Health Risk Assessment

The first step when doing an occupational health risk assessment (OHRA) is that the occupational health practitioner (OHP), as part of the interdisciplinary team, should gather information regarding employees and their work environment. Information needed to do an OHRA includes a situational analysis and all information pertaining to health and safety.

The following information should be gathered at the first meeting: the type of business, organogram with total employees, employee list (socio-demographics details e.g. name, surname, age, gender, job title), shift work, hours of work, rest periods, absenteeism statistics, injury on duty and occupational diseases records, surveys of the environment (ventilation, lighting, noise levels, hazardous chemicals, etc.), current policies and procedures and access to current health facilities (Guild, Ehrlich, Johnston & Ross, 2001; Acutt *et al.*, 2011).

Hazard identification and risk assessment should then be done by means of a walk through (Acutt *et al.*, 2011: 149). A hazard is defined as anything that has the potential to cause harm (Acutt *et al.*, 2011) Different hazard groups exist: Physical,

Chemical, Biological, Ergonomical, Mechanical and Psychosocial (WHO, 2010: 10). Examples of these hazards include but are not limited to: *Physical*: noise, radiation; *Chemical:* solvents, tobacco smoke, pesticides; *Biological:* Tuberculosis, hepatitis B; *Ergonomical:* repetition, skeletal and muscular stress, fatigue; *Mechanical:* machine hazards; Psychosocial: poor work organization, shift work and stressful environments (Guild *et al.*, 2001; WHO, 2010: 10).

After identifying the hazards, the OHP must identify the employees who will be exposed to these hazards. A risk rating must then be done taking into account the current measures that are in place to protect the employees against these hazards. Different risk matrixes or risk rating models exist. Risk rating is where the consequence rating is multiplied by the likelihood rating (Guild *et al.*, 2001: 75). Consequence is constructed on how severe the harm or damage to the employees' health can be if it occurs. Likelihood is the possibility that the hazard can occur multiplied by how long the exposure is. Different values are given by different risk rating models. The outcome (calculated risk) is then classified. The example used by Guild et al (2001) includes: intolerable risk, very high risk, high risk, potential risk and tolerable risk. Each risk classification requires a specific corrective action. The highest risk classification needs priority in addressing these issues. The procedure of risk rating is followed for each hazard identified.

Acutt et al (2011) states that the next step after risk assessment is risk management. The first step in managing the risk is to eliminate the hazard if possible. If the hazard cannot be eliminated or substituted, reduce the risk with engineering controls. An example will be to enclose a noise source to reduce the risk of noise induced hearing loss. After engineering controls, administrative controls should be applied. This may include company policies, safe work procedures, regular maintenance, monitoring the health of the employees, education and training. As a last resort personal protective equipment should be issued to the employees.

The occupational health risk assessment is the basis on which a risk-based occupational health programme should function. As one of the hazard groups which the research focuses on, psychosocial hazards are defined as the interaction between the employees' qualifications, competencies and needs versus the key performance of the job, the work organisation and management within the environment and other

conditions. If an imbalance exists it can have a hazardous impact on the employees' health. (Joint ILO/WHO Committee on Occupational Health, 1986; Leka & Jain, 2010: 4)

2.3 Psychosocial work environment

Occupational health is a dynamic field and always changing. Legislative changes, although slow, occur frequently in order to keep up with the changing work environment. Globalization, information technology development and the changing nature of work has an impact on the modern work environment (European Agency for Safety and Health at Work, Brun & Milczarek, 2007: 4; Leka & Jain, 2010: 4).

The WHO (2010) defines a healthy workplace as: " A healthy workplace is one in which workers and managers collaborate to use a continual improvement process to protect and promote the health, safety and well-being of all workers and the sustainability of the workplace by considering the following, based on identified needs:

- health and safety concerns in the physical work environment;
- health, safety and well-being concerns in the psychosocial work environment, including organization of work and workplace culture;
- personal health resources in the workplace; and
- ways of participating in the community to improve the health of workers, their families and other members of the community." (WHO, 2010: 6)

Occupational health now has a holistic approach and includes the psychosocial aspect of employees, whereas in the past occupational health focused more on the physical work environment. The healthy workplace model of the WHO focus on four areas: physical work environment, psychosocial work environment, personal health resources and enterprise involvement in the community. Figure 1 illustrates the interaction needed to create a healthy workplace.

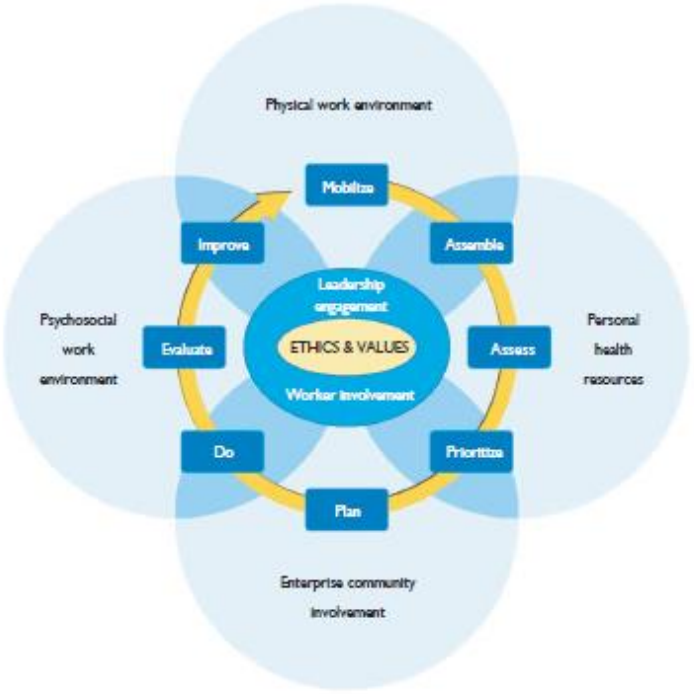

Figure 1.1 WHO healthy workplace model: avenues of influence, process and core principles (WHO, 2010: 8)

With reference to the workplace of the minister in the Dutch Reformed Church, the Church Order, Article 9 describes the following responsibilities of the ministers: ministry of the Word in all its forms; ministry of the sacraments; worship services; teaching and training of parishioners; leading and organising the congregation; pastoral care (home visits, supporting client's in crisis's, counselling, marriage and family accompaniment, supporting the frail, visiting the elderly), to name a few. In addition, liturgical work, planning and rendering of sermons, intercession, funerals, weddings, preaching, bible study groups, baptismal catechesis and marriage catechesis form part of their workday (Proeschold-Bell *et al.*, 2012: 247).

2.3.1 Psychosocial Hazards

The following psychosocial hazards have been identified by the European Agency for Safety and Health at Work (2007, p. 24) as emerging risks: "New forms of employment contracts and job insecurity; the ageing workforce; work intensification; high emotional demands at work and poor work-life balance".

2.3.1.1 Employees are contracted for a certain period of time or hours of work instead of given a permanent position with the normal employee benefits. This is one

type of new employment contract. These workers usually have the more hazardous work and also less training as the permanently employed person and thus have a greater risk of occupational disease or injury. Due to these contracts the employees have a feeling of job insecurity which would increase work-related stress (European Agency for Safety and Health at Work, 2007).

2.3.1.2 The ageing employee is seen as vulnerable. This now occurs with the higher retirement age and the ageing population. If lifelong learning isn't engaged the ageing worker will not be able to meet all the demands and physically is not as adaptable as the younger worker. The older worker is seen as the employee over the age of 45 (Michell, 2011: 192).

The development of information technology is making more demands on the employees. This leads to higher work intensification. They are now always "available" and working longer hours to meet all the different demands. Being always available and/or on call has a direct impact on the work-life balance of an employee (European Agency for Safety and Health at Work, 2007: 25)

2.3.1.3 Employees' fear of losing their work is placing high emotional demands on employees especially in the health care and service sector. Employees also hide the fact that they are not coping, which is adding stress to the employee in the workplace. Bullying and violence place high emotional demands on the employees in the workplace. (European Agency for Safety and Health at Work, 2007: 26)

2.3.1.4 As changes in the work organisation are demanding more flexibility of employees more pressure is experienced by employees and this is affecting their private life. To balance work and private life adds additional stress to the employee especially if the family and social support is poor or in cases of single parent households. (European Agency for Safety and Health at Work, 2007: 24).

The following table (Leka & Jain, 2010: 5) describes some more examples of psychosocial hazards.

Table 2.1 Psychosocial Hazards (Leka & Jain, 2010: 5)

Job Content	Lack of variety or short work cycles, fragmented or meaningless work, under use of skills, high uncertainty, continuous exposure to people through work
Workload & work pace	Work overload or under load, machine pacing, high levels of time pressure, continually subject to deadlines
Work schedule	Shift working, night shifts, inflexible work schedules, unpredictable hours, long or unsociable hours
Control	Low participation in decision making, lack of control over workload, pacing, etc.
Environment & equipment	Inadequate equipment availability, suitability or maintenance; poor environmental conditions such as lack of space, poor lighting, excessive noise
Organisational culture & function	Poor communication, low levels of support for problem solving and personal development, lack of definition of, or agreement on, organisational objectives
Interpersonal relationships at work	Social or physical isolation, poor relationships with superiors, interpersonal conflict, lack of social support, bullying, harassment
Role in organisation	Role ambiguity, role conflict, and responsibility for people
Career development	Career stagnation and uncertainty, under promotion or over promotion, poor pay, job insecurity, low social value to work
Home-work interface	Conflicting demands of work and home, low support at home, dual career problems

Work related stress is seen as a psychosocial hazard and is defined as an individual's response and ability to cope when they do not have the competency in meeting the work demands placed on them (Leka & Jain, 2010: 4). Burnout, due to a poor psychosocial environment is defined as: "as a state of physical, emotional and mental exhaustion that results from long-term involvement in work situations that are emotionally demanding" (Leka & Jain, 2010: 4).

Tomic, Tomic & Evers (2004) researched "*A question of burnout among Reformed Church ministers in The Netherlands"* and found that younger ministers, between the age of 30 – 40 years seem to have higher levels of burnout; the ministers indicated that the pressure of work was too high and suggested that the employer can lower the stress by delegating tasks, decrease the number of meetings the minister must attend, lessen the workload by decreasing the total services and sermons a minister must present and to support the minister with administrative functions.

In a research study investigating the effects of job-demands and job-resources on ministers' burnout and engagement, Buys & Rothmann (2010) also found that tempo, workload and emotional demands were indicators of burnout in ministers'. As can be seen by research findings on psychosocial hazards these have an impact on the psyche of the employee. If the employee does not cope with the psychosocial hazards it will have an impact on the health and well-being of the employee.

2.4 Impact of psychosocial hazards on health and well-being

If the working environment is not engaging in health promotion and keeping the employee healthy and safe, the psychosocial hazards can have a negative effect on the employee (Nübling *et al.*, 2006). Each individual will also experience symptoms related to psychosocial hazards differently. Effects of work stress are experienced on a physical and/or psychological level. According to Leka et al, (2003) employees can present with the following: become irritable, unable to relax or concentrate, have difficulty sleeping, feeling tired all the time, feeling depressed and anxious cannot think logically and struggle to make decisions. Physical problems include heart disease, disorders of the digestive system, increased blood pressure, headaches and musculo-skeletal disorders (lower back ache and upper limb disorder).

Leka, Griffiths and Cox (2003) state that a healthy working environment isn't just where no hazards exist but where health promotion is done at a large scale. As occupational health is a preventative and promotive concept to increase the health of the employee and keep the employee safe, the work environment should contribute to this.

Employees' now try to cope with these negative health effects and may engage in unhealthy activities such as use and/or abuse of alcohol, drugs and smoking (Leka, Griffiths & Cox, 2003: 8).

Research by Proeschold-Bell & LeGrand (2010) revealed that chronic diseases are prevalent under United Methodist clergy. The United Methodist clergy in North Carolina suffer from diabetes, arthritis, hypertension, angina and asthma more than there non-clergy counterparts. The need for health interventions to address these non-communicable diseases was identified by the researcher (Proeschold-Bell & LeGrand, 2010: 260).

The impact of the psychosocial work environment can affect the employee and employer in every sphere of his/her life. The one aspect of the impact of psychosocial hazards for the employer is a financial one. A decrease in productivity and increase in absenteeism and presenteeism will have a negative impact on business. Should these be managed appropriately the company can save money by increasing productivity, increase employee morale, decrease absenteeism, decrease presenteeism, decrease occupational injuries and diseases, decrease staff turnover, etc. (Hassard, Milczarek, Europejska Agencja, Unia Europejska, Urząd Publikacji, Europejskie., 2014).

2.5 Occupational health management

Managing employees with an occupational health programme has many advantages. It is not only the right thing, smart thing or legal thing to do (WHO, 2010: 4). If the company does not create a healthy and safe work environment psychological hazards can lead to a loss of productivity, increase in cost (direct and indirect), increase in turnover, decrease in staff morale, increase in absenteeism and increase in presenteeism. Ultimately this can lead to increased risk for injuries and diseases, and liability for legal claims against the employer.

The research done by Tomic et al (2004) suggested that burnout among ministers in the Reformed Church in The Netherlands can benefit by preventive measures being put in place. Suggestions include that ministers are trained in the relation between their personality and burnout; stress management and early identification of the signs

and symptoms of burnout; before burnout develops. Another suggestion is to teach ministers time-management and organizational skills. Coaching young ministers with tutors (older ministers) can assist the younger ministers and mentor them. Tomic et al (2004) also suggests that the Church Council should be able to recognize burnout and act preventively rather than with curative measures.

In a study done by Proeschold-Bell et al (2012: 246 - 247) in the United States of America, the need of pastors and district superintendents for a specific health programme was explored. The author identified the following areas for the health programme: “health club memberships, retreats, personal trainers, mental health counselling, and spiritual direction”. With the qualitative analysis the following was identified as a need for health programmes: health should be addressed holistically; flexible schedule; having access to health programmes in the rural areas; health programmes to be cost-effective; support from the institution; education on physical health and to work with other on their health issues. Another issue was to find a balance between health and work. For these health programmes to be effective it must be sensitive to the different cultures and environments in which the pastors work. The environment in the Proeschold-Bell et al (2012) study is defined as their family, church, larger United Methodist ministry and the community.

According to the Healthy workplaces: model for action (WHO, 2010) after identifying the hazards with either a survey or interviews the hazards can be eliminated by addressing the issues identified. An occupational health management programme should be risk based, and can be describe after conduction an occupational health risk assessment. A medical surveillance plan will be based on this occupational health risk assessment and will address all hazards that need to be managed.

2.6 Conclusion

The literature reviewed by the researcher in Chapter 2 describes how legislation impacts on the psychosocial work environment. Psychosocial hazards and the psychosocial work environment were defined and the impact of the psychosocial hazards on the health and well-being of the employee were discussed. The importance of identification and management of occupational health risks with specific

reference to the psychosocial work environment of ministers were highlighted. The research design and methodology will be described in chapter 3.

3.0 CHAPTER THREE: RESEARCH METHOD AND DESIGN

3.1 Introduction

The purpose of this chapter is to describe the research design and methodology used by the researcher to explore and describe the psychosocial work environment of ministers in the Dutch Reformed Church. The research design and methodology aided in meeting the objectives of the research study.

3.2 Research design

A quantitative cross sectional survey study, with a self-administered questionnaire has been used to realize the aim and objectives of this study. The research method refers to techniques that are used by researcher in order to structure a study to be able to gather and analyse information relevant to the research question (Polit & Beck, 2012). The quantitative design used in this study assist the researcher to be objective and use quantifiable information. This information can then be used for generalizations by deductive reasoning. The term survey is used in two ways within scientific thought. It is used in a broad send to mean any descriptive or correlations study; in this sense, survey tends to mean non-experimental. In a narrower sense, survey is used to describe a technique of data collection in which questionnaires (collected by mail or in person) are used to gather data about an identified population (Burns & Grove, 2005)

The motivation for this survey is that the self-administered questionnaire is a valuable and suitable collection method to gather data on the phenomena that cannot be directly observed. It is a cost effective way with minimal infrastructure necessary to be able to gather data in a single snapshot of time.

3.3 Research setting

The research study was conducted among the population of Dutch Reformed Church ministers in the Western Cape and KwaZulu-Natal. The Dutch Reformed Church is a Christian denomination with 9 synods in South Africa and one synod in Namibia. The website of the Dutch Reformed Church states that every synod has a regional structure, called presbyteries, with a head office in the main town of each province. There are 1158 congregations, 144 presbyteries with a total membership of 1,074,765 parishioners. The Church Council and local ministers are responsible for pastoral care

and ministry. There are a total of 1,602 ordained ministers in the Dutch Reformed Church in South Africa and Namibia ("Die NG Kerk", 2015).

3.4 Population and sample

A population is the entire combination of cases in which the research are interested (Polit & Beck, 2012). Polit and Beck (2012) describes a sample as a division of the population. The target population is the entire set of individuals or elements who meet the sampling criteria (Burns & Grove, 2005); an accessible population is the portion of the target population to which the researcher has reasonable access and which meets the inclusion criteria (Burns & Grove, 2005).

The total population consisted of all ordained ministers of the Dutch Reformed Church in the Western Cape and KwaZulu-Natal in South Africa. Note should be taken that the Southern Cape region is incorporated in the Western Cape region as per the current system of the Dutch Reformed Church.

The Western Cape and KwaZulu-Natal regions were selected by the researcher because these regions were familiar and a working relationship with the Synod could be fostered. Due to cost and time constraints only these two regions were selected.

3.4.1 Sampling method

Purposive sampling, also referred to as judgement all or selective sampling, involves the conscious selection by the researcher of certain subjects, elements or events (Burns & Grove, 2005). Ministers were purposively selected to participate in the study. The synods were contacted for the contact list of ministers meeting the inclusion criteria.

A total sample (N=457) of ministers have been invited to participate in the study. All the ministers within the congregations in the Western Cape and KwaZulu-Natal were contacted via email, using REDCap, for possible participation in the survey. Due to the fact that there was no additional cost involved with the sending of e-mails, the decision was made to include the total sample in order to give us the greatest sample size.

3.4.1 Inclusion criteria

Potential participants have been included when they met all of the following criteria:

- Ordained ministers within the Dutch Reformed Church or affiliated with the Dutch Reformed Church

- The minister should be actively involved in a congregation and/or community of the Church by means of rendering sermons, pastoral care, counselling, serving of sacraments, weddings, funerals

3.4.2 Sample size for this research

A total sample was decided on for this research. As the instrument was a self-reported online questionnaire and e-mail addresses were available, all ministers in both the regions could be contacted without any additional cost and with the benefit of covering a larger geographical area, and to ensure a larger response rate

3.5 Data collection

3.5.1 Data collection instrument

The data collection instrument used in this study had two parts. First the socio-demographic questionnaire was developed by the researcher and was added online to the Copenhagen Psychosocial Questionnaire II (COPSOQII) (Nübling *et al.*, 2006). Twenty eight features of the participants, their work environment and support structures were collected to describe the profile of the respondents. This questionnaire was pretested involving ministers' and other professionals and their opinions and input was included.

Information gathered with the socio-demographic questionnaire (Appendix G) (including the work environment and support) are for example: province, marital status, age, years in current congregation, total number of members in the congregation, familiarity of the contents of the Occupational Health and Safety Act, No. 85 of 1993 if a Labour Relations Commission is part of the Church Council, a pre-populated list of possible support systems or solutions to assist in dealing with stress at the workplace and a rating of social support structure.

An open ended question concluded the socio-demographic part of the questionnaire:

“Please tell me how you would like to be supported in dealing with stress or stressful situations in the workplace?”

The second part of the questionnaire, the Copenhagen Psychosocial Questionnaire II (COPSOQ II) is a public domain and scientifically validated questionnaire for the investigation of psychosocial work environment, health, and well-being. The COPSOQ II short version was used for this research (Pejtersen, Kristensen, Borg & Bjorner, 2010) (Appendix D). The short version has 7 domains which are described by 23 dimensions and 44 questions. Table 3.1 describes these domains and dimensions. It is a standard self-administered survey instrument therefore no interviewer bias is relevant. A scoring system can determine the mean scores for each individual and region. Feedback will only be given for both regions as a whole and not for each individual or each region.

Table 3.1 Domains and dimensions of the COPSOQII questionnaire.

Domains x7	Dimensions x 23	Questions x 44 (Appendix G) Examples
Demands at work	Quantitative work demands	Do you get behind with your work?
	Work pace	Is it necessary to keep working at a high pace?
	Emotional work demands	Does your work put you in emotionally disturbing situations?
Work organization and job contents	Influence on work	Do you have a large degree of influence concerning your work?
	New skill development	Does your work require you to take the initiative?
	Meaningful work	Is your work meaningful?
	Commitment to workplace	Do you feel that your place of work is of great importance to you?
Interpersonal relations and leadership	Predictability	Do you receive all the information you need in order to do your work well?
	Appreciation & Recognition	Are you treated fairly at your workplace?
	Role clarity	Does your work have clear objectives?
	Leadership quality	To what extent would you say that your immediate superior is good at work planning?
	Social support from superiors	How often do you get help and support from your nearest superior?
Work-individual interface	Job satisfaction	How pleased are you with your job as a whole, everything taken into consideration?
	Work-family conflict	Do you feel that your work drains so much of your energy that it has a negative effect on your private life?
Values at workplace level	Management/worker trust	Can you trust the information that comes from the management?
	Justice & Respect	Is the work distributed fairly?
Health and well-being	Self-rated health	In general, would you say your health is: Excellent, very good, good, fair or poor
	Burnout	How often have you felt worn out?
	Stress	How often have you been stressed?
Offensive behaviour	Sexual harassment	Have you been exposed to undesired sexual attention/threats of violence/physical violence/bullying at your workplace during the last 12 months? If yes, from whom? Colleagues, supervisor. Subordinates, clients?
	Threats of violence	
	Physical violence	
	Bullying	

3.5.2 Data collection

The REDCap system of The University of the Witwatersrand was used to send out e-mails with a link to the survey. The REDCap system of The University of the Witwatersrand would ensure that anonymity and confidentiality are maintained. Only the researcher, statistician and the supervisor have access to the data. The data is secured by a password protected account and site encryption with a backup system to secure data.

After identifying the two regions that would be part of the study, the two synods were contacted. The researcher requested from the synods a name list with e-mail addresses to be sent to the researcher. Furthermore that only ordained ministers that are eligible as per inclusion criteria should be on the list.

A meeting with the ministers' care support co-ordinator from the Western Cape and KwaZulu-Natal Synod was scheduled and the purpose and procedure of the study was explained. An information sheet (Appendix F) was sent to the co-ordinators. Consent was obtained from the Western Cape and KwaZulu-Natal Synod.

The researcher met ministers at the KwaZulu-Natal Synod meeting where the aim and objectives of the study were discussed with a request to participate when they do receive the e-mail with the link to REDCap and the questionnaire. Unfortunately the researcher could not meet with the Western Cape group but forwarded a presentation (Appendix J) to the co-ordinator who presented it to the ministers. The potential participants were informed of the following: Procedure that will be followed; the purpose of the research; the questionnaire that would be used; the time it would take to complete the questionnaire online; the confidentiality of data and the participants and how the results of the study will be disseminated.

The ministers' care support co-ordinator in the Western Cape wrote an introduction and request to complete the questionnaire which was distributed to all the potential participants via e-mail and with the information sheet and link to REDCap and the online questionnaire.

The questionnaire was e-mailed to all the ministers using REDCap on the 3rd of June 2015. This date was chosen as it was after the Pentecost and traditionally is not as busy as the rest of the year. A reminder was e-mailed on the 27th of June 2015 and a final reminder was sent on the 6th of July 2015.

Study data was collected and managed using REDCap electronic data capture tools hosted at The University of the Witwatersrand. REDCap (Research Electronic Data Capture) is a secure, web-based application designed to support data captured for research studies, providing 1) an intuitive interface for validated data entry; 2) audit trails for tracking data manipulation and export procedures; 3) automated export procedures for seamless data downloads to common statistical packages; and 4) procedures for importing data from external sources (Harris, Taylor, Thielke, Payne, Gonzalez, Conde, 2009)

3.5.3 Scoring system

For interpretation of the questionnaire the COPSOQII has a scoring system. See Table 3.2. Each dimension e.g. quantitative work demands is made up by one or two questions. Most of the questions have five responses. Participants where requested to mark each of these questions on a scale. These are: Always, Often, Sometimes, Seldom, Never/hardly ever or To a very large extent, To a large extent, Somewhat, To a small extent, To a very small extent. (Appendix G). Each of these responses has a score. Each question was scored individually and then added together to represent the dimension (Arbejdsmiljoforskning, 2007: 1).

The interpretation and colour codes of the questionnaire are explained in Table 3.2 below:

Table 3.2: Scoring system for COPSOQII (Arbejdsmilj0 Instituttet, 2011)

Quantitative work demands	0	1	2	3	4	5	6	7	8
Work pace	0	1	2	3	4	5	6	7	8
Emotional work demands	0	1	2	3	4	5	6	7	8
Influence on work	0	1	2	3	4	5	6	7	8
New skill development	0	1	2	3	4	5	6	7	8
Meaningful work	0	1	2	3	4	5	6	7	8
Commitment to the workplace	0	1	2	3	4	5	6	7	8
Predictability	0	1	2	3	4	5	6	7	8
Appreciation & Recognition	0	1	2	3	4	5	6	7	8
Role clarity	0	1	2	3	4	5	6	7	8
Leadership quality	0	1	2	3	4	5	6	7	8
Social support from superiors	0	1	2	3	4	5	6	7	8
Job satisfaction			0	1	2	3			
Work-family conflict		0	1	2	3	4	5	6	
Management/worker trust	0	1	2	3	4	5	6	7	8
Justice & respect	0	1	2	3	4	5	6	7	8
Self-rated health			0	1	2	3	4		
Burnout	0	1	2	3	4	5	6	7	8
Stress	0	1	2	3	4	5	6	7	8

Coding: Green – Good; Red – Bad; Yellow – zone requiring attention

After the respondents completed the individual questionnaires, average scores for the entire group of respondents were calculated. Mean values for the group were not rounded as per suggestion from the instruction for users, and the first digit was used for interpretation in the scoring system. For the purpose of this study RED is seen as a high risk, YELLOW as a medium risk and GREEN as a low risk.

3.5.2 Validity and Reliability of the Instrument

The Copenhagen Psychosocial Questionnaire II (COPSOQII) is an instrument developed and validated by the Danish National Institute for Occupational Health in Copenhagen with the aim of assessing and improving the psychosocial work environment. Validity of a test is established if the instrument measures what it is intended to measure (Polit & Beck, 2012). Reliability of a test is the degree of

consistency with which the instrument measures an attribute (Polit & Beck, 2012). The COPSOQII is a validated tool (Nübling *et al.*, 2006). Cronbach alpha was found to be between 0.50 and 0, 89. The construct validity was confirmed by correlation analysis and factor analysis. Criterion validity was tested during construction of the original tool.

3.6 Presentation of results

Results will be described and presented in Chapter 4 by means of tables and graphs.

3.7 Ethical considerations

The research protocol was then submitted to The University of the Witwatersrand Faculty of Health Sciences Postgraduate Committee for permission to conduct the research and permission was subsequently granted (Appendix H).

Application was also made to the University's Human Research Ethics Committee (HREC) (Medical) for clearance to conduct the research. Ethical clearance was given to continue with the research (Protocol number: M150306; Appendix I).

Permission to do the study was sought from the Dutch Reformed Church Synod in the Western Cape and KwaZulu-Natal concerned. Western Cape consent was obtained (Appendix B). KwaZulu-Natal consent was obtained (See Appendix C).

Permission to use COPSOQII (Appendix A) as the instrument of choice was sought and granted.

Completed and returned questionnaires will be seen as informed consent to participate in the research study. A research information sheet was attached to the e-mail (Appendix F) explaining the procedure of the research.

To ensure confidentiality and anonymity of the respondents, the REDCap system was used for data collection and reporting.

Participation in the study was voluntary and participants were permitted to withdraw from the study at any time unless the questionnaire had been submitted online.

Data will be stored safely on the REDCap system of the University of the Witwatersrand for 3 to 6 years, where only the researcher, supervisor and statistician can access the data, thus, ensuring privacy and confidentiality of the respondents.

This study conforms to the requirements of the National Health Act (Republic of South Africa, 2003) , since it pertains to the performance of “health research” as defined in the Act. The following are specifically mentioned:

Beneficence: Participants will not necessarily directly benefit from participation in the study. For individual respondents, a list of resources will be made available (Appendix E) with contact details of counsellors who can be called if needed.

Non-maleficence: This study does not include any intervention. Therefore, no person would be harmed as a result of participation. It is however recognised that participation in the study may increase anxiety levels and hence the list of resources being made available. Consent had been obtained from the Support Task Team of the Dutch Reformed Church to enable participants to contact them for support should they feel the need for support while being part of this research study.

Justice: Selection of respondents for this study did not take race, gender or other personal factors into account. Therefore all the respondents who met the criteria were eligible for inclusion to the study, irrespective of race, culture and gender.

Autonomy: Participants had full control regarding their participation in the study. No person was coerced into participation and could opt out of participation during any stage of the study (even if initially consenting to participation). Such withdrawal of consent would not have any negative consequences. No explanation was required for withdrawal from the study.

Ministers selected for the survey were provided with information related to the study as well as implied consent for electronic questionnaire. Completion of the questionnaire was accepted as consent to participate in the study.

Confidentiality: To ensure confidentiality and anonymity of the participants, no names appeared on the questionnaire. Likewise, no identifying details will be used in publications emanating from this study (Polit & Beck, 2012).

3.8 Data Analysis

Descriptive statistics was used in consultation with a biostatistician. The data was exported from REDCap. REDCap and Microsoft Excel were used to analyse data. The demographic and outcome data was described using tables'. Numerical data was described using means (with standard deviations). Categorical data was described using frequencies (counts) and percentages as appropriate (age, gender, congregation size, etc.).

COPSOQ II scores were calculated by using the REDCap system. The different questions were totalled for each individual to determine the first 19 dimensions. Mean values for all the participants were calculated and the first digit was used for interpretation (COPSOQII- Appendix A– Pejtersen et al, 2010). The last 4 dimensions were described using frequencies and percentages.

The answers to the open ended questions were analysed with qualitative descriptive method to identify emerging themes and subthemes, which are interpreted and described in the next chapter.

3.9 Conclusion

Chapter 3 discussed the research design and methodology with reference to the sampling, population, data collection instrument, and ethical considerations and data analysis. Chapter 4 will describe the research findings with regards to response rate, the socio-demographic profile, work environment demographics, current support structure and the COPSOQII questionnaire results.

4.0 CHAPTER FOUR: RESEARCH FINDINGS

4.1 Introduction

In chapter three the research design and methodology were discussed. In this chapter, the research results will be analysed and presented. Socio-demographic information from the questionnaires will be described and statistical data obtained from the questionnaires is presented in tabular form. Responses to the open ended questions will be described according to themes and subthemes which were coded and described after analysis.

4.2 Response rate

The Western Cape and KwaZulu-Natal Synods sent the researcher a total of 457 e-mail addresses of ordained ministers in their regions which the researcher could contact as potential participants (Total = 457: Western Cape, 391 and KwaZulu-Natal, 66).

Only 414 of those ministers met the inclusion criteria and were invited to participate in the study. Table 4.1 below, shows the reasons why not all the participants met the inclusion criteria and could not take part in the research study:

Table 4.1 Sample realisation

Reason for not completing survey	Total	% of total sample
On leave	8	1,75%
No time to complete	3	0,66%
Retired	1	0,22%
Not involved with a congregation	10	2,19%
Not interested	4	0,88%
Resigned	2	0,44%
Moved	1	0,22%
Wrong e-mail address	6	1,31%
Not available	4	0,88%
More than one e-mail address	2	0,44%
Struggled with online functionality	2	0,44%
Total not taking part in study	43	9,41

Of the 414 invitations and questionnaires sent out, 158 responses were received. Of the 158 returned questionnaires (38.16% response rate) through REDCap, 20 were incomplete; therefore the data obtained from of N=138 (33,33% valid response rate) questionnaires was analysed and presented as follows:

4.3 Research results

The results of the research are described in terms of the following:

- Socio-demographic profile of the respondents is presented as demographic data for example geographic area, gender and qualifications

- The work environment profile for example the size of a congregation and years that ministers have been working in the congregation

- Information on support as selected from the pre-populated list by the respondents

- Open ended questions

- COPSOQII questionnaire

4.3.1 Socio-demographic profile of the respondents

The socio-demographic profile of all respondents (N=138) is described in Table 4.2. From the demographic data in Table 4.2 it is clear that the majority of respondents reside in the Western Cape (80, 43%). Predominantly the respondents are male (92.03%) and of the age group 55 – 64 (42, 75 %) with a mean age of 50, 88 (SD 9, 88). Most of the respondents are married (95, 65%), have 0-2 dependants (71, 74%) and have children who are presently studying on a tertiary level (30, 43%). All respondents have a basic degree and 41,30% are employed by means of a fixed term contract.

Table 4.2 Socio-demographic profile of respondents (N=138)

		Total (n)	%	Total	M	SD
1. Province	KwaZulu-Natal	27	19,57%			
	Western Cape	111	80,43%	138	-	-
2. Area	Rural	68	49,28%			
	Urban	70	50,72%	138	-	-
3. Gender	Male	127	92,03%			
	Female	11	7,97%	138	-	-
4. Age	25-34	11	7,97%			
	35-44	23	16,67%			
	45-54	40	28,99%			
	55-64	59	42,75%			
	65-73	5	3,62%	138	50,88	9,88
5. Qualification	Degree	138	100,00%			
	Masters	93	67,39%			
	PhD	17	12,32%			
	Counselling	23	16,67%			
	Psychology	9	6,52%	138	-	-
6. Position	Fixed Term	57	41,30%			
	Tent maker	7	5,07%			
	Contract	11	7,97%			
	Proponent	0	0,00%			
	Emeritus	0	0,00%			
	Missionary	2	1,45%			
	Pastoral Minister	50	36,23%			
	Other	11	7,97%	138	-	-
7. Marital Status	Single	5	3,62%			
	Married	132	95,65%			
	Divorced	1	0,72%	138	-	-
8. Dependants	Nil – Two	99	71,74%			
	Three – Four	38	27,54%			
	Five - Seven +	1	0,72%	138	-	-
9. Developmental stages of children	Baby	5	3,62%			
	Toddler	15	10,87%			
	Middle childhood	25	18,12%			
	Adolescence	34	24,64%			
	Young adulthood	42	30,43%	138	-	-

N=total; M=mean; SD=Standard Deviation; %=percentage

4.3.2 Work environment of respondents

The findings regarding the work environment of the respondents (Table 4.3) revealed that the majority of the respondents have been in ministry between 21 – 30 years (39,13%). Most of the respondents (54,35%) have been at their current congregation between 0 – 10 years. The majority congregations (27, 54%) have less than 500 members and most congregations have between two and four ministers working at a congregation (54,35%). Most respondents (94,21%) had a holiday in the last 6 months and spent it away from home. Respondents indicated that 77,54% of them only have one weekend off per term.

Self-reported health issues were identified by the respondents of which the majority (52, 90%) reportedly suffer from work-related stress. Most of the ministers (56, 52%) indicated that they have thought of leaving the ministry.

Table 4.3 Work environment (N=138)

		Total (n)	%	Total	M	SD
1. Years in ministry	0 – 10	18	13,04%			
	11 to 20	30	21,74%			
	21 to 30	54	39,13%			
	31 to 42	36	26,09%	138	23,31	9,71
2. Years in current congregation	0 to 10	75	54,35%			
	11 to 20	23	16,67%			
	21 to 30	31	22,46%			
	31 to 42	9	6,52%	138	12,89	10,26
3. Total number of members in congregation	<500	38	27,54%			
	501 – 1000	35	25,36%			
	1001 – 1500	23	16,67%			
	1501 – 2000	12	8,70%			
	2001 – 2500	11	7,97%			
	>2501	19	13,77%	138	-	-
4. Total number of ministers working at congregation	1	56	40,58%			
	Two to Four	75	54,35%			
	Five to Eight	7	5,07%	138	-	-
5. Contracted hours per week	<45 per week	80	57,97%			
	>45 per week	58	42,03%	138	-	-
6. Average overtime hours per month	<40 per month	122	88,41%			
	>40 per month	16	11,59%	138	-	-
7. Weekends off per term	0	7	5,07%			
	1	107	77,54%			
	>2	24	17,39%	138	-	-
8. When last did you have a Holiday	3 months ago	66	47,83%			
	6 months ago	64	46,38%			
	> 9 months ago	8	5,80%	138	-	-
9. Where was the holiday spent	Away	109	78,99%			
	Home	29	21,01%	138	-	-
10. Symptoms experienced	Hypertension	38	27,54%			
	Diabetes Mellitus	6	4,35%			
	Asthma	7	5,07%			
	Epilepsy	2	1,45%			
	Anxiety	31	22,46%			
	Work-related Stress	73	52,90%			
	Burnout	36	26,09%			
	Depression	41	29,71%	-	-	-
11. Have you ever thought of leaving the ministry	Yes	78	56,52%			
	No	60	43,48%	138	-	-

N=total; M=mean; SD=Standard deviation; %=percentage

4.3.3 Preferred support structures

Most respondents (n=99; 71, 74%) indicated that they have a good social support structure; above 7, 1 on the Likert scale out of 10 (Appendix G). Majority of the congregations (n=112; 81, 16%) have a Labour Relations Commission as part of their Church Council. Only 20, 29% (n=28) are familiar with the Occupational Health and Safety Act, No. 85 of 1993 and only 7, 79% (n=11) are part of an occupational health care programme. The majority of employees paid for services including medical evaluation and counselling. With reference to preferred support choices which the respondents could choose from a pre-populated list the majority chose spiritual development (n=88; 63, 77%) then mentor support (n=78; 56, 52%) and thirdly retreats without family but with colleagues (n=67; 48, 55%). Table 4.4 describes the preferred support structure that the ministers chose from the pre-populated list.

Table 4.4 Preferred support structure rating

		Total (n)	%	Total
1. Social support structure	0-30 (Likert 0 – 100)	4	2,90%	
	31-70 (Likert 0 -100)	35	25,36%	
	71-100 (Likert 0 -100)	99	71,74%	138
2. Labour Relations Commission present	Yes	112	81,16%	
	No	26	18,84%	138
3. Are you familiar with the Occupational Health and Safety Act	Yes	28	20,29%	
	No	110	79,71%	138
4. Are you part of an OH care Programme?	Yes	11	7,97%	
	No	127	92,03%	138
5. Did you have any of the following in the last two years	Medical evaluation	91	65,94%	
	Immunization	15	10,87%	
	Debriefing	5	3,62%	
	Peer counselling	23	16,67%	
	Counselling	29	21,01%	
6. Who paid for these services	Employer	20	14,49%	
	Employee	118	85,51%	
7. Preferred support choices	Courses on psychosocial hazards	40	28,99%	
	Mentor support	78	56,52%	
	Admin/Secretarial support	31	22,46%	
	Retreats (alone)	67	48,55%	
	Marriage/family retreats	31	22,46%	
	Mental health counselling	20	14,49%	
	Financial advice seminars	19	13,77%	
	Health education	17	12,32%	
	Spiritual development	88	63,77%	

4.3.4 Open ended question regarding other support not listed before

Respondents were given the opportunity to report on the support that they would prefer other than mentioned in the pre-populated list above. The question was:

> *"Please tell me how you would like to be supported in dealing with stress or stressful situations in the workplace other than above mentioned?"*

The responses were analysed and the emerging themes include: Support, trust and training.

Support was the one area that most of the respondents indicated as lacking in the work environment. The support they desired was from Church Council, Labour Relations Commission, spiritual support (prayer, retreats), leadership, marriage, administrative duties, gym contract, financial, family and friends. There also is a request for an employee assistance programme (EAP). Responses included:

> *"I think that leadership support is a shortfall in my present situation, as well as a lack of support and encouragement from Labour Relations Commission"*

> *"I would like a better understanding from members of the diversity of the work ministers are expected to perform, from the obvious such as to produce theologically sound, relevant, interesting, funny and entertaining sermons to grief counselling, hospital ministry, youth evenings and camps. The expectation of ministers are also extended to numerous other often unrelated issues but relevant to a congregation*"

Trust was the second theme that was identified. Responses included that they needed to be protected in the congregation from people who have too much power. A request for an objective mentor, safe space to be able to express stress and experiences, honest and sincere people and an independent psychologist just reiterate their need to have a safe work environment where trust can form part of the work environment. Lack of trust in leadership was highlighted as a problem area. Responses stated:

> "*'n Veilige ruimte om presies te kan sê hoe ek die stress ervaar*"

"The minister must be protected in the congregation. Some people have too much power and use it against the minister. The church office must protect the minister but it doesn't' always happen. Especially in the rural areas there is no protection."

Education was the third theme identified in the feedback received from the respondents. Except for leadership courses there was also a suggestion of more effective coaching during the student years to better prepare ministers to work in ministry. Specific mention was made of an informal course that a minister is running with much success in handling the everyday stressors in life ("Geloofsreis").

4.3.5 COPSOQII Scores

The scores obtained from the COPSOQII questionnaires are described in Table 4.5. Rounding of the scores was done according to the COPSOQII scoring system. The colour code indicate: green as good, yellow as requiring attention and red bad (Arbejdsmilj0 Instituttet, 2011). For this study green is low risk, yellow medium risk and red high risk.

Table 4.5 Scores obtained from 19 of 23 dimensions of COPSOQII

Measuring	Domain		Psychosocial Dimension of COPSOQII	Total score	Mean Score	COPSOQII Rounding
Workplace	Demands at work	1	Quantitative work demands	474	3,43	3
		2	Work pace	709	5,14	5
		3	Emotional work demands	769	5,57	5
	Work organization and job contents	4	Influence on work	693	5,02	5
		5	New skill development	734	5,32	5
		6	Meaningful work	762	5,52	5
		7	Commitment to workplace	661	4,79	4
	Interpersonal relations and leadership	8	Predictability	646	4,68	4
		9	Appreciation & recognition	661	4,79	4
		10	Role clarity	602	4,36	4
		11	Leadership quality	495	3,59	3
		12	Social support from superiors	707	5,12	5
Work-Individual	Work-individual interface	13	Job satisfaction	313	2,27	2
		14	Work-family conflict	457	3,31	3
	Values at workplace level	15	Management/worker trust	906	6,57	6
		16	Justice & respect	790	5,72	5
Individual – outcome	Health and well-being	17	Self-rated health	376	2,72	2
		18	Burnout	479	3,47	3
		19	Stress	477	3,46	3

Red: high risk (bad); Yellow: medium risk (zone requiring attention); Green: low risk (good)

Scores obtained in the COPSOQII questionnaire from the first 19 dimensions was calculated and the mean of each dimension was established. The mean score of each dimension for the group was allocated a risk rating. After colour coding the different mean scores the following was identified: Red dimensions needs immediate attention (high risk) and includes: Emotional work demands and Leadership quality. Yellow areas that are in need of attention (medium risk) includes: Work pace, Meaningful work, Commitment to workplace, Predictability, Appreciation and recognition, Role clarity, Social support from superiors, Work-family conflict, Self-rated health, Burnout

and Stress. The only areas that are seen as “good” (low risk) includes Quantitative work demands, Influence on work, New skill development, Job satisfaction, Management/worker trust and Justice & respect.

The last four dimensions of the COPSOQII questionnaire are part of the Offensive behaviour domain and include: Sexual harassment, Threats of violence, Physical violence and Bullying. The respondents had to indicate if they were exposed to any of these four dimensions and to which extent and by whom.

Bullying, for example means that “a person repeatedly is exposed to unpleasant or degrading treatment, and that the person find it difficult to defend himself or herself against it” (Kristensen, Hannerz, Høgh & Borg, 2005) (Appendix G). Table 4.6 shows that the respondents (n=29, 17,39%) were exposed to bullying in the last 12 months and mostly by colleagues (n=12; 50%). Threats of violence were experienced by the respondents (n=10; 7,25%) and well as physical violence (n=2; 1,45%). Female respondents (n=6; 4,35%) acknowledge that sexual harassment was experienced.

Table 4.6 Dimensions (4 of 23) of the COPSOQII which assessed the offensive behaviour domain

	How often		By whom?				
Dimensions	A few times	Weekly	Colleagues	Manager/ Supervisor	Subordinates	Clients/ Customers/ Patients	% of total (n=138)
Sexual harassment	6	0	3	0	0	3	4,35%
Threats of violence	10	0	0	1	0	6	7,25%
Physical Violence	2	0	0	0	0	2	1,45%
Bullying	24	5	12	9	1	10	17,39%

The second open question of the questionnaire:

> *"Here you may write more about your working conditions, stress, health, etc."*

was analysed and a need for support was expresssed as they received no support from colleagues and/or the Church Council but feelings of gratefulness at other congregations and good working environment were also mentioned.

> *"In the one-man congregation in a rural area where I work - most of the initiative, goals, measuring of 'success', tasks, management come from me as pastor of the congregation. It is a tough environment to manage expectations (of different generations, the bigger church, the community, God and self). I would appreciate a management that is more hands on in terms of clear objectives and tasks"*

Although some ministers describe that they are on call 24/7 as they work for the Lord, others said that the long hours are placing stress on their families.

> *"The question about contracted working hours per week does not apply to my profession - pastors are in service for unlimited hours. Working many hours per month is not valued as 'over time.'"*

Another theme was an expression of the costs and benefits of being a minister, which were either seen as financial or emotional cost to the minister and his family but for the benefit of others:

> *"Few congregations and council members really have a clear picture of what a pastor does. Financial compensation is out of sync with what is expected in the contract post that I am filling - this causes a lot of stress as the output is much more than the rewards reaped"*

"The problem is that one give every day widely on an emotional level. There are always people with problems and one is every night out on visits and meetings. Your own family pays a big price..."

Some respondents felt that they can manage stress with God's help and although they are busy they can prioritize and organise.

"Enough said. I enjoy my work. The working environment is pleasant. I have a wonderful colleague and we have good relationships with the rest of the personnel. I look after my health and minimalize stress as far as possible. I have 1 life, and I live it to the fullest."

4.4 Conclusion

In this chapter the findings of the research were presented with the use of tables and descriptive statistics and the qualitative descriptive answers to open questions was analysed. The socio-demographic profile of the respondents was presented and described which included information on their work environment and social support. Numerical data was described using means (with SD). The findings of the research will be discussed in Chapter 5.

5.0 CHAPTER FIVE: DISCUSSION OF FINDINGS, SUMMARY, CONCLUSIONS, LIMITATIONS AND RECOMMENDATIONS

5.1 Introduction

Chapter 4 was concerned with the data analysis and the data was presented and described. In this chapter the research results will be discussed in relation to the research objectives.

Identifying the psychosocial hazards in the work environment of the ministers in the Dutch Reformed Church as one of the major hazards in the work environment is necessary for legal compliance (Republic of South Africa, 1993a). It is the duty of the employer, as described in the Occupational Health and Safety Act, No. 85 of 1993, to create a healthy and safe work environment. To comply with the relevant legislation an assessment should be done to identify risks and to promote safety at all levels. A medical surveillance plan have a preventative and promotive purpose in protecting and restoring the health of the employee (Republic of South Africa, 1993a Section 12 (2)). By exploring the psychosocial work environment in this study, the first steps are taken to ensure a healthy and safe work environment for ministers in the Dutch Reformed Churches of the Western Cape and KwaZulu-Natal.

5.2 Discussion of the findings

The profile of the ministers reveal that most are middle aged men with a family consisting of a wife and 2 children at a tertiary institution, which could be seen as a person with not only responsibilities towards the congregation, but also a financial and emotional role as a father and husband. Although a degree is necessary to practice as a minister, ongoing training and development is needed at all levels, which not only demand time but also are an additional financial burden which could lead to stress.

What became clear is that despite taking a holiday regularly, away from home, the average (52,90%) reported that they have work-related stress and even more of the ministers (56,52%) want to leave the profession. The reason why so many ministers' do not want to be in the profession is an aspect which could be investigated with further research.

Only a few of the ministers are familiar with the Occupational Health and Safety Act, No. 85 of 1993, and even less have an occupational health programme in place. It can be inferred from the data that there are no programmes in place and that very little is done to ensure the health and safety of this specific group of employees. By implementing a programme, many of the identified hazards in this study could be addressed and managed accordingly, leading also to legal compliance.

5.2.1 Psychosocial work environment

The need for support and mentoring was mentioned in various areas of the questionnaire, which is an interesting aspect considering the work environments where ministers' are seen as mentors and support in the communities they work in. Working as a spiritual helper and the fact that they always need to be available to assist others, it is distressing that the ministers themselves do not have support. They clearly feel that they give a lot to others, while receiving little in return towards their own emotional and physical well-being. Majority of ministers have self-reported that they experience work-related stress, anxiety, burnout and depression. A third of the respondents also indicated that they already suffer from hypertension, which has previously been linked to these stressors (Spruill, 2010).

High emotional demands at work are evident in the daily work of the minister. As many of the roles that the minister plays as preacher, pastor, administrator, etc. in this helping profession, exposure to high emotional work demands can be seen as an inherent part of their job. Some of the key performance areas for a minister that relates to work include crisis counselling, assistance in emergencies, marriage and family accompaniment, supporting the frail, attending to the terminally ill, grief counselling, end of life guidance, funerals, to mention a few. High emotional work demands correlates with poor health and well-being outcomes such as ill-health, burnout and stress. Gyntelberg, Hein and Suadicani as well as Buys and Rothman studies correlates with this study in showing that emotional demands are identified as indicators of burnout (Buys & Rothmann, 2010; Gyntelberg, Hein & Suadicani, 2012). Ministers need to have high emotional well-being to be able to assist the parishioners in their needs. At times the paradox of rendering a service at a funeral and then visiting a family to prepare them for baptisms of a new baby requires emotional maturity. The emotional maturity of someone in a human service profession is the basis of pastoral activities (Tomic *et al.*, 2004: 230). This vocation is emotionally

challenging and place high emotional demands on the ministers and it could be assumed that these demands be one of the reason why 56,52% of the ministers indicated that they thought of leaving the ministry.

Ministers indicated that work pace also places high demands on them at the workplace. The finding of this study corresponds with Buys & Rothmann (2010) who also found that work pace is indicative of burnout.

An interesting finding of this study is that even though all ministers work overtime the quantitative work demands did not pose a risk to them. Feedback from the ministers indicated that they have a higher calling, and work hours are not applicable to them. Aside from for the fact that the Basic Conditions of Employment Act, No. 75 of 1997 is not complied with, with regards to working hours, overtime and time off this will have a financial and physiological impact, as no one can work 24/7 and be on call always without having a negative effect on health and well-being. Working longer hours without the necessary breaks therefore increases the psychosocial risk of those ministers who participated in the study.

Influence in the workplace can increase or decrease psychosocial stress. According to Gyntelberg, Hein and Suadicani (2012) if ministers have influence on the workplace with regards to decision making and work organization, less psychosocial stress will be experienced by them. By allowing ministers to play a bigger role in influencing the workplace would decrease psychosocial hazards e.g. the amount of work assigned to them.

As ministers are answering to a higher calling their work should be meaningful to them and not create a feeling of worthlessness in their daily activities. This study found that ministers do not feel that their work is meaningful and they do not hold the workplace in high regard. As part of their continuous development, new skills should be learned but due to the fact that they do not receive the support (time and finances) to develop new skills this is an area that possibly can create psychosocial stress although this study did not identify this as a risk area.

Leadership quality was identified as a high risk area in this study. With the analysis of the open ended question it was identified that leadership is lacking. Some ministers

said that even though they have someone to talk to about their stressors nobody seems to actually be doing anything about it. This indicates that they aren't communicating with a person with authority and addressing the issues or that the leader has no authority when they are aware of concerns. The respondents feel that leaders in the church are not taking as much responsibility as what is expected of them, which is ironic given the role of the ministers and the church in the lives of the parishioners. There were also requests for leadership programmes. Due to a lack of leadership, ministers are not part of the decision making processes and they feel that they are not receiving all the information and support to enable them to answer their calling. No clear objectives and tasks are communicated with the ministers. Role clarity will assist in decreasing the psychosocial risk. This study found that ministers feel they are not treated fairly and aren't recognised or appreciated at the workplace by their superiors and /or parishioners.

The finding in this study that poor social support from supervisors and others leads to an increase in psychosocial risk correlates with the findings of Gyntelberg, Hein and Suadicani (2012). Even though the majority of the ministers rated the social support from their supervisor above 7 out of 10 on the Likert scale, analysis indicates that support is lacking. This is an indication that ministers feel that they are receiving support but they are still developing ill-health, stress and/or burnout. Current support is therefore not the most beneficial type of support the ministers' are receiving.

Due to the nature of the work that ministers do, job satisfaction is high but even with job satisfaction, ill-health, burnout and stress occurs. Work-family conflict was identified. Functioning as minister is time and energy consuming and can have a negative effect on their private life. Some of the respondents rely on their families for support, while others have little children who are dependent on them as the father and provider of the family.

A thought-provoking outcome of this study is the lack of trust amongst ministers as seen in the analysis. From a spiritual and psychosocial perspective, trust is an important aspect of any relationship; however ministers would prefer to talk to someone outside of the church setting about their problems. As a religious person, their trust is in God but trust as a basis of a relationship is also necessary between ministers', their colleagues and their employer. This study found that ill-health, stress

and burnout are identified with the presence of psychosocial hazards. Self-reported health issues also indicate that the health and well-being of the ministers in this study requires attention as they are caring for others but not for themselves.

Ministers reported to have been subjected to sexual harassment (mostly females), threats of violence, physical violence and bullying which is a psychosocial risk in the work environment. This is indicative of an unsafe work environment. Further investigation could be done on how to create a safe environment e.g. with home visits where female ministers might be in a position where she is alone with a male client, etc.

The European Agency for Safety and Health at Work (2007, p 24) has identified age as a psychosocial hazard. The majority of the ministers in this study fall in the older age group 45 – 64 which is significant because older workers were found to more vulnerable and susceptible to psychosocial stress (Acutt *et al.*, 2011: 509).

5.2.2 Existing psychosocial support

Existing psychosocial support can be described as having a mentor and receiving some form of counselling. Ministers in rural areas struggle with access to a mentor and are therefore, due to time and financial constraints not receiving mentoring as necessary and when the need arises.

On a national level there is a team to whom the Labour Relations Commission can prescribe for support. Although most Church Councils have a Labour Relations Commission the burnout, stress and ill health still occurs as is evident with this study.

Only 20, 29% of the ministers are familiar with the Occupational Health and Safety Act, No. 85 of 1993 and only 7,97% are part of an occupational health care programme. Most of the interventions in the last two years were paid by the employee him or herself and mostly includes medical evaluations and some kind of counselling (peer counselling, counselling). This is in contrast with what legislation demands from the employer. The employer must create a healthy and safe environment and the cost thereof is for the employer, in this instance, the Church Council (Republic of South Africa, 1993a).

Self-reported symptoms of work-related stress, burnout, depression, anxiety and hypertension are reported. This correlates with previous studies (Kristensen *et al.*, 2005: 438) that consequences of psychosocial hazards include cardiovascular diseases, mental disorders, stress, burnout, reduced quality of life etc. This proves that existing psychosocial support is not effective in assisting ministers.

5.2.3 Recommended psychosocial health care programme

In order to create a psychosocial health care programme the basic principles of risk assessment should be adhered to. Once a risk assessment has been done including a risk rating, the hazards should be prioritized and addressed accordingly. As it is the employers (Church Council) responsibility to create a healthy and safe environment, it is their responsibility to implement a programme.

Resources to manage psychosocial hazards could include occupational health services (including the occupational health nurse practitioner and the occupational health medical practitioner), human resource management, clinical psychologist and employee assistance programme (EAP). A health promotion programme should be investigated and offered to the ministers' and should include stress management activities.

Health circles are one strategy to address the psychosocial hazards. Health circles are discussion groups at a workplace that meets in working hours to address psychosocial and organisational factors as identified by the health surveillance data and surveys (Birgit Aust, 2004). The assumption when using the health circles is that the employee knows his job best and would be able to assist in assessing issues and address these by suggesting alternatives (Birgit Aust, 2004: 259).

The chosen psychosocial support in order of priority, as from the pre-populated list are: spiritual development, mentor support, retreats on their own, courses on psychosocial hazards, administrative/secretarial support, marriage/family retreats, mental health counselling, financial advice seminars and health education.

With the qualitative descriptive analysis of the open ended question on what other options they would prefer, three major themes emerged: support, trust and education. Support including from the Church Council, Labour Relations Commission, spiritual

support (prayer, retreats), leadership, marriage, administrative duties, gym contract, financial support, and support from family and friends. A request was also made for an EAP. This finding correlates with the findings of Proeschold-Bell et al (2012) regarding what support ministers prefer to receive in their study on tailoring a health care programme for ministers.

The following are suggestions from the ministers' which could be added to the supporting programme for the ministers:

- Provide and assist with spiritual development – prayer, fasting, bible reading, retreats (alone, with family and/or partner)

- Mentor support to be co-ordinated, also in the rural area. Mentors should not always be colleagues from the same congregation. This was specifically highlighted with the analysis of the open ended question.

- Support meetings to be held with others whom ministers trust and can share their daily frustrations

- Counselling session with psychotherapy and pharmacology if necessary

- Investigate current support rendered by Church Council and Labour Relations Commission

- Educating the Church Council regarding psychosocial hazards and early signs or recognising the risks associated

- Leadership programmes

- Education re health, early signs of psychological ill-health

- Assist in financial analysis of budgets, budget planning, planning for retirement seminars

- Administrative and/or secretarial support

- Educating the congregation regarding the roles and functions of the minister to ensure a better understanding of the circumstances under which they work and what can be expected of them

- The COPSOQII short questionnaire can be repeated with the current respondents after intervention to measure if any improvement has taken place in the workplace

- Support in care (physical, social, psychological) for ministers' themselves as well as for their family

5.3 Limitations of the research

The following were the limitations of the research:

- Only 138 respondents, and two regions of the RSA were included in the study, therefore the findings cannot be generalised to other Dutch Reformed Churches in South Africa

- A threat to the internal validity of the research was posed by factors such as the use of self-report methods. A risk regarding an online survey is a low response rate, as well as the possibility of the respondents not completing the questionnaire themselves.

- Triangulation of research instruments, instead of just utilising the self-report method, might have added further useful insights to the research. For instance, in-depth interviews with the ministers or focus groups

5.4 Recommendations (for possible future research)

In light of the findings of this research, future research prospects should focus on a number of key areas:

To the Synod

- Investigate current support rendered by Church Council and Labour Relations Commission

- Comprehensive risk assessment on all the hazards in the work environment of the ministers'

- Financial analysis, budget planning and planning for retirement

- Educating the congregation regarding the roles and functions of the minister to ensure a better understanding of the circumstances under which they work and what can be expected of them

- The COPSOQII short questionnaire can be repeated with the current respondents after intervention to measure if any improvement has taken place

Further research

- Similar research needs to be conducted in other regions and different denominations

- When conducting research in future, the longer COPSOQII questionnaires should be used as a more in depth research study will give more information on the psychosocial hazards e.g. cognitive demands, sensory demands, behavioural stress, somatic stress and personalities.

- Further statistical analysis with associations between socio-demographic and COPSOQII variables to be demonstrated by the Chi square test for contingency tables (and the Fishers' Exact test when the individual cell frequencies were too low).

- The researcher recommends that further investigation could be done regarding the relationship between trust in God and coping with daily challenges and the effect on the health of the individual.

5.5 Conclusion

This study has found that psychosocial hazards do exist in the work environment of ministers in the Dutch Reformed Church in the Western Cape and KwaZulu-Natal region. This finding correlates with (García-Herrero, Mariscal, Gutiérrez & Ritzel, 2013) research which has proven that if high demands (e.g. emotional work demands) are present in the work environment with low resources (e.g. social support), it can lead to ill-health (psychological and/or physical) and an impact on the organization (e.g. absenteeism, etc.).

The current psychosocial support is not effective as ill health, burnout and stress is present in the work environment of ministers in the Dutch Reformed Church in the Western Cape and KwaZulu-Natal. A further finding of this research study demonstrated a gap in legal compliance with the Occupational Health and Safety Act, No. 85 of 1993 in creating a healthy and safe environment for the ministers (employees) to work in.

Recommended support as preferred by the ministers should be addressed as part of the occupational health programme in the workplace.

This research, although small, contributed to the body of knowledge of the psychosocial work environment of the ministers and the researcher believes the research findings will help create an awareness of creating a healthy and safe work environment not because it is the legal thing to do but the smart and ethical thing to do.

As these religious ministers are the pillars of the community who have made it their life mission and purpose to care for their neighbour, should be supported in care for themselves and their family.

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APPENDICES

APPENDIX A

-----Original Message-----
From: Matthias Nübling [mailto:nuebling@ffas.de]
Sent: 16 October 2014 05:03 PM
To: lindie@emmica.co.za; Tage Søndergaard Kristensen
Subject: Re: Mail von der Website COPSOQ

Dear Lindie

welcome to the COPSOQ-club!

There is no restriction for the use of COPSOQ - despite the correct quotation of the source.

Best contact for the English version is Tage S. Kristensen.

The international network with a lot of further information is found at copsoq-network.org.

all the best
Matthias

> *Name* Lindie *E-Mail** lindie@emmica.co.za *Nachricht** Morning,
> I'm a masters student in occupational health in South Africa. I
> would like to make use of the COPSOQ II questionnaire. Do I need to
> get permission and who do I contact?
>
> Kind regards
> Lindie
>

--
****
Dr. Matthias Nübling
Studienleiter COPSOQ Deutschland
FFAS: Freiburger Forschungsstelle Arbeits- und Sozialmedizin (Freiburg research centre for occupational and social medicine) Bertoldstr. 27
D- 79098 Freiburg
T: 0049 (0)761 894421
F: 0049 (0)761 83432
nuebling@ffas.de
www.ffas.de www.copsoq.de
****

APPENDIX B

COMMUNITAS
IZIKO LOKUCETYISWA KWAMABANDLA
NETWERK VIR GEMEENTEBEDIENING

Diensgroep vir Gemeentebegeleiding Dorpstraat 171 Stellenbosch 7600

Sr Lindie Jansen van Rensburg,
We have received your request to do research as part of your studies at Wits University:
An investigation of the psychosocial work environment of ministers in the Dutch Reformed Church in the Western Cape, South Africa.
We approve the study and the task team for Pastoral Accompaniment will assist you. Dr Pierre Goosen (pmgoosen@sun.ac.za) and miss Adrienne Bester (bestera@sun.ac.za) are the persons that will support you.

Thank you for your interest in wellbeing of our pastors.

Frederick Marais
Diensspanbestuurder
Communitas: Netwerk vir Gemeentebegeleiding
Posbus 3322, Matieland 7602
(T) 021-808 3265 ~ (S) 083 380 1657 ~ (F) 086 530 0839
jfm@sun.ac.za
www.communitas.co.za

APPENDIX C

From: NG Kerk [mailto:ben@ngkzn.org.za]
Sent: 24 February 2015 06:04 PM
To: Lindie Jansen van Rensburg
Subject: Re: FW: Consent for research

Hallo Lindie,

Ja, ons sal dit waardeer as jy die studie doen en aan ons die resultate kan deurgee.

(Content deleted)

Met seënwense.

Ben.

Predikant in Sinodale Diens
NG Kerk in KZN
Posbus 649, Pietermaritzburg, 3200
Tel 072 143 8838
Faks 086 777 0086

APPENDIX D

Psychosocial factors at work

Copenhagen Psychosocial Questionnaire II (COPSOQ II)

A questionnaire on psychosocial working conditions, health and well-being (the short version)

2007 edition

The questionnaire

Please note the rules regarding the completion of this questionnaire::

- **Participation is voluntary**
- **Completing and submitting of these questionnaires will be seen as consent**

Thank you for taking the time to complete this and being part of this research.

The following questions are about your psychosocial work environment. Please choose the answer that fits best to each of the questions.

Always times	Often	Some-	Seldom hardly ever	Never/
1A. Do you get behind with your work?	☐	☐	☐	☐	☐
1B. Do you have enough time for your work tasks?	☐	☐	☐	☐	☐

1A and 1B. Total number of points:_____
(Between 0 and 8 points)

	Always	Often	Some-times	Seldom	Never/ hardly ever
2A. Is it necessary to keep working at a high pace?	☐	☐	☐	☐	☐
2B. Do you work at a high pace throughout the day?	☐	☐	☐	☐	☐

2A and 2B. Total number of points:_____
(Between 0 and 8 points)

	Always	Often	Some-times	Seldom	Never/ hardly ever
3A. Does your work put you in emotionally disturbing situations?	☐	☐	☐	☐	☐
3B. Do you have to relate to other people's personal problems as part of your work?	☐	☐	☐	☐	☐

3A and 3B. Total number of points:_____
(Between 0 and 8 points)

	Always	Often	Some-times	Seldom	Never/ hardly ever
4A. Do you have a large degree of influence concerning your work?	☐	☐	☐	☐	☐
4B. Can you influence the amount of work assigned to you?	☐	☐	☐	☐	☐

4A and 4B. Total number of points:_____
(Between 0 and 8 points)

	To a very large extent	To a large extent	Some-what	To a small extent	To a very small extent
5A. Do you have the possibility of learning new things through your work?	☐	☐	☐	☐	☐
5B. Does your work require you to take the initiative?	☐	☐	☐	☐	☐

5A and 5B. Total number of points:_____
(Between 0 and 8 points)

	To a very large extent	To a large extent	Some-what	To a small extent	To a very small extent
6A. Is your work meaningful?	☐	☐	☐	☐	☐
6B. Do you feel that the work you do is important?	☐	☐	☐	☐	☐

6A and 6B. Total number of points:_____
(Between 0 and 8 points)

	To a very large extent	To a large extent	Some-what	To a small extent	To a very small extent
7A. Do you feel that your place of work is of great importance to you?	☐	☐	☐	☐	☐
7B. Would you recommend a good friend to apply for a position at your workplace?	☐	☐	☐	☐	☐

7A and 7B. Total number of points:_____
(Between 0 and 8 points)

	To a very large extent	To a large extent	Some-what	To a small extent	To a very small extent
8A. At your place of work, are you informed well in advance concerning for example important decisions, changes, or plans for the future?	☐	☐	☐	☐	☐
8B. Do you receive all the information you need in order to do your work well?	☐	☐	☐	☐	☐

8A and 8B. Total number of points:_____
(Between 0 and 8 points)

	To a very large extent	To a large extent	Some-what	To a small extent	To a very small extent
9A. Is your work recognised and appreciated by the management?	☐	☐	☐	☐	☐
9B. Are you treated fairly at your workplace?	☐	☐	☐	☐	☐

9A and 9B. Total number of points:_____
(Between 0 and 8 points)

	To a very large extent	To a large extent	Some-what	To a small extent	To a very small extent
10A. Does your work have clear objectives?	☐	☐	☐	☐	☐
10B. Do you know exactly what is expected of you at work?	☐	☐	☐	☐	☐

10A and 10B. Total number of points:_____
(Between 0 and 8 points)

	To a very large extent	To a large extent	Some-what	To a small extent	To a very small extent
11A. To what extent would you say that your immediate superior gives high priority to job satisfaction?	☐	☐	☐	☐	☐
11B. To what extent would you say that your immediate superior is good at work planning planning?	☐	☐	☐	☐	☐

11A and 11B. Total number of points:
(Between 0 and 8 points) _____

	Always	Often	Some-times	Seldom	Never/ hardly ever
12A. How often is your nearest superior willing to listen to your problems at work?	☐	☐	☐	☐	☐
12B. How often do you get help and support from your nearest superior?	☐	☐	☐	☐	☐

12A and 12B. Total number of points:_____
(Between 0 and 8 points)

	Very satisfied	Satisfied	Un-satisfied	Very unsatisfied
13. Regarding your work in general. How pleased are you with your job as a whole, everything taken into consideration?	☐	☐	☐	☐

13. Number of points:_____
(Between 0 and 3 points)

The next two questions are about the way your work affects your private life and family life.

	Yes, certainly	Yes, to a certain degree	Yes, but only very little	No, not at all
14A. Do you feel that your work drains so much of your <u>energy</u> that it has a negative effect on your private life?	☐	☐	☐	☐
14B. Do you feel that your work takes so much of your <u>time</u> that it has a negative effect on your private life?	☐	☐	☐	☐

14A and 14B. Total number of points:_____
(Between 0 and 6 points)

The next four questions are not about your own job but about *the whole company* you work at.

	To a very large extent	To a large extent	Some-what	To a small extent	To a very small extent
15A. Can you trust the information that comes from the management?	☐	☐	☐	☐	☐
15B. Does the management trust the employees to do their work well?	☐	☐	☐	☐	☐

15A and 15B. Total number of points:_____
(Between 0 and 8 points)

	To a very large extent	To a large extent	Some-what	To a small extent	To a very small extent
16A. Are conflicts resolved in a fair way?	☐	☐	☐	☐	☐
16B. Is the work distributed fairly?	☐	☐	☐	☐	☐

16A and 16B. Total number of points:_____
(Between 0 and 8 points)

The following five questions are about your *own* health and well-being. Please do not try to distinguish between symptoms that are caused by work and symptoms that are due to other causes. The task is to describe how you are in general.

The questions are about your health and well-being during <u>the last four weeks:</u>

	Excellent	Very good	Good	Fair	Poor
17. In general, would you say your health is:	☐	☐	☐	☐	☐

17. Number of points:_____
(Between 0 and 4 points)

	All the time	A large part of the time	Part of the time	A small part of the time	Not at all
18A. How often have you felt worn out?	☐	☐	☐	☐	☐
18B. How often have you been emotionally exhausted?	☐	☐	☐	☐	☐

18A and 18B. Total number of points:_____
(Between 0 and 8 points)

	All the time	A large part of the time	Part of the time	A small part of the time	Not at all
19A. How often have you been stressed?	☐	☐	☐	☐	☐
19B. How often have you been irritable?	☐	☐	☐	☐	☐

19A and 19B. Total number of points:_____
(Between 0 and 8 points)

	Yes, daily	Yes, weekly	Yes, monthly	Yes, a few times	No
20. Have you been exposed to undesired sexual attention at your workplace during the last 12 months?	☐	☐	☐	☐	☐

	Colleagues	Manager/ supervisor	Sub-ordinates	Clients/ customers/ patients
If yes, from whom? (You may tick off more than one)	☐	☐	☐	☐

	Yes, daily	Yes, weekly	Yes, monthly	Yes, a few times	No
21. Have you been exposed to threats of violence at your workplace during the last 12 months?	☐	☐	☐	☐	☐

	Colleagues	Manager/ supervisor	Sub-ordinates	Clients/ customers/ patients
If yes, from whom? (You may tick off more than one)	☐	☐	☐	☐

	Yes, daily	Yes, weekly	Yes, monthly	Yes, a few times	No
22. Have you been exposed to physical violence at your workplace during the last 12 months?	☐	☐	☐	☐	☐

	Colleagues	Manager/ supervisor	Sub-ordinates	Clients/ customers/ patients
If yes, from whom? (You may tick off more than one)	☐	☐	☐	☐

Bullying means that a person repeatedly is exposed to unpleasant or degrading treatment, and that the person finds it difficult to defend himself or herself against it.

	Yes, daily	Yes, weekly	Yes, monthly	Yes, a few times	No
23. Have you been exposed to bullying at your workplace during the last 12 months?	☐	☐	☐	☐	☐

	Collea-gues	Manager/ supervisor	Sub-ordinates	Clients/ custo-mers/ patients
If yes, from whom? (You may tick off more than one)	☐	☐	☐	☐

There are no more questions.

At this page you may write more about your working conditions, stress, health, etc.

APPENDIX E

Contact details for counsellors:

WESTERN CAPE

Pierre Goosen
Cell:
E-mail: pmgoosen@sun.ac.za
Deon Bruwer

KWAZULU NATAL

Ds Gawie van Jaarsveld
Cell: 082 895 6949
E-mail: gawievj@telkomsa.net

APPENDIX F

Dear Participant,

I am Lindie Jansen van Rensburg, a master student at the University of the Witwatersrand, conducting a study in the psychosocial work environment of ministers in the Dutch Reformed Church, in the Western Cape and KwaZulu-Natal, South Africa. This study is part of my academic requirement to obtain my MSc (Nursing) in Occupational Health.

The study aims to explore and describe the psychosocial work environment of the ministers in the Dutch Reformed Church and to make recommendations regarding the psychosocial health care programmes for the ministers.

All the ministers in the Western Cape and KwaZulu-Natal will be contacted to participate in the study.

I hereby request you to participate by completing the web based questionnaires. There are no wrong or right answers.

Participation is strictly voluntary. You should not feel under pressure to participate. The individual is anonymous. The results will be calculated for groups so the individual responses cannot be identified. You may withdraw from the study at any given time.

All information will be protected at all times and be kept confidential. All information provided will only be used for research purposes.

The questionnaire will take approximately 20 minutes to complete. You will be able to save and exit at any time and be able to continue at a later stage. Completion of the questionnaire will be seen as informed consent.

Your response is important and I would like to thank you for your willingness to participate. You may contact my study supervisor, Annalie van den Heever at the University of the Witwatersrand at: 011-488 4061, if you have any queries.

Thank you

RESEARCHER
Lindie Jansen van Rensburg, School of Health Sciences, University of the Witwatersrand
Email: lindie@emmica.co.za

APPENDIX G

Psychosocial Work Environment

Voltooi asb elke vraag. Soms kan meer as een opsie gekies word, sien instruksies by elke vraag.
Dankie! Please complete each question and follow instructions where more than one option can be chosen. Thank you!

1) PROVINCE
- ◯ KZN
- ◯ Western Cape
- ◯ Southern Cape

2) AREA
- ☐ Urban
- ☐ Rural

(Area of work)

3) GENDER
- ◯ Male
- ◯ Female

4) AGE _____

5) QUALIFICATION
- ☐ Degree
- ☐ Masters
- ☐ PhD
- ☐ Qualification in counselling
- ☐ Qualification in psychology

(You can choose more than one)

6) POSITION
- ☐ Fixed Term Tent
- ☐ maker Contract
- ☐ Proponent
- ☐ Emeritus
- ☐ Missionary
- ☐ Pastoral Minister
- ☐ Other
- ☐

7) YEARS IN MINISTRY _____

8) YEARS IN CURRENT CONGREGATION _____

9) TOTAL NR OF MEMBERS IN YOUR CONGREGATION _____

10) TOTAL NR OF MINISTERS WORKING AT THE CONGREGATION _____

11) MARITAL STATUS
- ◯ Single
- ◯ Married
- ◯ Divorced
- ◯ Widowed
- ◯ Seperated

12) DEPENDENTS/CHILDREN LIVING AT HOME
- ◯ 0
- ◯ 1
- ◯ 2
- ◯ 3
- ◯ 4
- ◯ 5
- ◯ 6
- ◯ 7 & MORE

(Including partner)

13) DEVELOPMENTAL STAGE OF CHILDREN

- ☐ Baby
- ☐ Toddler
- ☐ Primary School
- ☐ Secondary School
- ☐ Tertiary Institution
- ☐ Not applicable

(Choose more than one if neccessary)

14) CONTRACTED HOURS PER WEEK _____

15) AVERAGE OVERTIME HOURS PER MONTH _____

16) WEEKENDS OFF PER TERM _____

17) WHEN LAST DID YOU HAVE A HOLIDAY

- ◯ 3 Months ago
- ◯ 6 Months ago
- ◯ 9 Months ago
- ◯ 1 year or longer ago

18) WHERE WAS THE HOLIDAY SPENT

- ◯ At home
- ◯ Away

19) HOW WOULD YOU RATE YOUR SOCIAL SUPPORT STRUCTURE (friends and family)

0 5 10

(Place a mark on the scale above)

20) ARE YOU FAMILIAR WITH THE OCCUPATIONAL HEALTH AND SAFETY ACT No 85 of 1993?

- ◯ Yes
- ◯ No

21) ARE YOU PART OF AN OCCUPATIONAL HEALTH CARE PROGRAMME AT WORK?

- ◯ Yes
- ◯ No

22) DID YOU HAVE ANY OF THE FOLLOWING IN THE LAST TWO YEARS?

- ☐ Medical evaluation
- ☐ Immunization
- ☐ Debriefing
- ☐ Peer counselling
- ☐ Counselling
- ☐ None

(You can choose more than one)

23) WHO PAID FOR THESE SERVICES?

- ☐ Employer
- ☐ Employee
- ☐ Not applicable

24) HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING SYMPTOMS?

- ☐ Hypertension (High blood pressure)
- ☐ Diabetes Mellitus (Sugar)
- ☐ Asthma
- ☐ Epilepsy
- ☐ Anxiety
- ☐ Work-related Stress
- ☐ Burnout
- ☐ Depression
- ☐ None

(You can choose more than one)

25) IS A LABOUR RELATIONS COMMISSION ("Diensverhoudingskommissie") PART OF YOUR CHURCH COUNCIL TO SUPPORT YOU AS MINISTER?

- ◯ Yes
- ◯ No

26) HAVE YOU EVER THOUGHT OF LEAVING MINISTRY?

- ◯ Yes
- ◯ No

27) PLEASE TELL ME HOW WOULD YOU LIKE TO BE SUPPORTED IN DEALING WITH STRESS OR STRESSFUL SITUATIONS IN THE WORKPLACE?

- ☐ Courses on psychosocial risk factors e.g. Time management, stress prevention, recognition of burnout
- ☐ Mentor support
- ☐ Administrative and secretarial support
- ☐ Retreats (alone)
- ☐ Marriage/family enrichment retreats
- ☐ Mental health counselling
- ☐ Financial advice seminars
- ☐ Health education/coaching
- ☐ Spiritual development

28) Please tell me how would you like to be supported in dealing with stress or stressful situations in the workplace other than above mentioned?

_____

The following questions are about your psychosocial work environment. Please choose the answer that fits best to each of the questions

		Always	Often	Sometimes	Seldom	Never/Hardly ever
29)	Do you get behind with your work?	○	○	○	○	○
30)	Do you have enough time for your work tasks?	○	○	○	○	○
31)	Is it necessary to keep working at a high pace?	○	○	○	○	○
32)	Do you work at a high pace throughout the day?	○	○	○	○	○
33)	Does your work put you in emotionally disturbing situations?	○	○	○	○	○
34)	Do you have to relate to other people's personal problems as part of your work?	○	○	○	○	○
35)	Do you have a large degree of influence concerning your work?	○	○	○	○	○
36)	Can you influence the amount of work assigned to you?	○	○	○	○	○
37)	Do you have the possibility of learning new things through your work?	○	○	○	○	○

		To a large extent	Somewhat	To a small extent	To a very small extent
38)	Does your work require you to take the initiative?	○	○	○	○
39)	Is your work meaningful?	○	○	○	○
40)	Do you feel that the work you do is important?	○	○	○	○
41)	Do you feel that your place of work is of great importance to you?	○	○	○	○
42)	Would you recommend a good friend to apply for a position at your workplace?	○	○	○	○
43)	At your place of work, are you informed well in advance concerning for example important decisions, changes, or plans for the future?	○	○	○	○
44)	Do you receive all the information you need in order to do your work well?	○	○	○	○
45)	Is your work recognized and appreciated by the management?	○	○	○	○
46)	Are you treated fairly at your workplace?	○	○	○	○
47)	Does your work have clear objectives?	○	○	○	○
48)	Do you know exactly what is expected of you at work?	○	○	○	○
49)	To what extent would you say that your immediate superior gives high priority to job satisfaction?	○	○	○	○
50)	To what extent would you say that your immediate superior is good at work planning?	○	○	○	○

		Always	Often	Sometimes	Seldom	Never/hardly ever
51)	How often is your nearest superior willing to listen to your problems at work?	○	○	○	○	○
52)	How often do you get help and support from your nearest superior?	○	○	○	○	○

		Very satisfied	Satisfied	Unsatisfied	Very unsatisfied
53)	Regarding your work in general. How pleased are you with your job as a whole, everything taken into consideration?	○	○	○	○

The next two questions are about the way your work affects your private life and family life

	Yes, certainly	Yes, to a certain degree	Yes, but only very little	No, not at all
54) Do you feel that your work drains so much of your ENERGY that is has a negative effect on your private life?	○	○	○	○
55) Do you feel that your work takes so much of your TIME that it has a negative effect on your private life?	○	○	○	○

The next four questions are not about your own job but about THE WHOLE COMPANY YOU WORK AT

	To a very large extent	To a large extent	Somewhat	To a small extent	To a very small extent
56) Can you trust the information that comes from the management?	○	○	○	○	○
57) Does the management trust the employees to do their work well?	○	○	○	○	○
58) Are conflicts resolved in a fair way?	○	○	○	○	○
59) Is the work distributed fairly	○	○	○	○	○

The following five questions are about your OWN health and well-being. Please do not try to distinguish between symptoms that are caused by work and symptoms that are due to other causes. The task is to describe how you are in general. The questions are about your health and well-being during the LAST FOUR WEEKS:

	Excellent	Very good	Good	Fair	Poor
60) In general, would you say your health is:	○	○	○	○	○

	All the time	A large part of the time	Part of the time	A small part of the time	Not at all
61) How often have you felt worn out?	○	○	○	○	○
62) How often have you been emotionally exhausted?	○	○	○	○	○
63) How often have you been stressed?	○	○	○	○	○
64) How often have you been irritable?	○	○	○	○	○

	Yes, daily	Yes, weekly	Yes, monthly	Yes, a few times	No
65) Have you been exposed to undesired sexual attention at your workplace during the last 12 months?	○	○	○	○	○

	Not applicable	Colleagues	Manager/supervisor	Sub-ordinates	Clients/customers/patients
66) If yes, from whom? (You may tick off more than one)	☐	☐	☐	☐	☐

	Yes, daily	Yes, weekly	Yes, monthly	Yes, a few times	No
67) Have you been exposed to threats of violence at your workplace during the last 12 months?	○	○	○	○	○

	Not applicable	Colleagues	Manager/supervisor	Sub-ordinates	Clients/customers/patients
68) If yes, from whom? (You may tick off more than one)	☐	☐	☐	☐	☐

	Yes, daily	Yes, weekly	Yes, monthly	Yes, a few times	No
69) Have you been exposed to physical violence at your workplace during the last 12 months?	○	○	○	○	○

	Not applicable	Colleagues	Manager/supervisor	Sub-ordinates	Clients/customers/patients
70) If yes, from whom? (You may tick off more than one)	☐	☐	☐	☐	☐

Bullying means that a person repeatedly is exposed to unpleasant or degrading treatment, and that the person finds it difficult to defend himself or herself against it.

	Yes, daily	Yes, weekly	Yes, monthly	Yes, a few times	No
71) Have you been exposed to bullying at your workplace during the last 12 months?	○	○	○		

	Not applicable	Colleagues	Manager/supervisor	Sub-ordinates/patients	Clients/customer
72) If yes, from whom? (You may tick off more than one)	☐	☐	☐	☐	☐

73) Here you may write more about your working conditions, stressors, health, etc. _____ .

APPENDIX H

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

Private Bag 3 Wits, 2050
Fax: 027117172119
Tel: 02711 7172076

Reference: Ms Thokozile Nhlapo
E-mail: thokozile.nhlapo@wits.ac.za

14 April 2015
Person No: 775335
PAG

Mrs LL Jansen Van Rensburg
Po Box 4138
Willowton Hub
3200
South Africa

Dear Mrs Jansen Van Rensburg

Master of Science in Nursing: Approval of Title

We have pleasure in advising that your proposal entitled *An assessment of the psychosocial work environment of minsters in the Dutch Reformed Church, in the Western Cape and KwaZulu-Natal, South Africa* has been approved. Please note that any amendments to this title have to be endorsed by the Faculty's higher degrees committee and formally approved.

Yours sincerely

Mrs Sandra Benn
Faculty Registrar
Faculty of Health Sciences

Appendix I

R14/49 Mrs Lindie Louise Jansen van Rensburg

HUMAN RESEARCH ETHICS COMMITTEE (MEDICAL)

CLEARANCE CERTIFICATE NO. M150306

NAME: (Principal Investigator)	Mrs Lindie Louise Jansen van Rensburg
DEPARTMENT:	Nursing Education Dutch Reformed Church of the Western Cape and KwaZulu Natal
PROJECT TITLE:	An Investigation of the Psychosocial Work Environment of Ministers in the Dutch Reformed Church, in the Western Cape and KwaZulu-Natal
DATE CONSIDERED:	27/03/2015
DECISION:	Approved unconditionally
CONDITIONS:	
SUPERVISOR:	Annalie van den Heever

APPROVED BY:
Professor P Cleaton-Jones, Chairperson, HREC (Medical)

DATE OF APPROVAL: 03/05/2015

This clearance certificate is valid for 5 years from date of approval. Extension may be applied for.

DECLARATION OF INVESTIGATORS

To be completed in duplicate and ONE COPY returned to the Secretary in Room 10004, 10th floor, Senate House, University.

I/we fully understand the conditions under which I am/we are authorized to carry out the above-mentioned research and I/we undertake to ensure compliance with these conditions. Should any departure be contemplated, from the research protocol as approved, I/we undertake to resubmit the application to the Committee. I agree to submit a yearly progress report.

Principal Investigator Signature Date

PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES

An investigation of the psychosocial work environment of minsters in the Dutch Reformed Church, in the Western Cape and Kwazulu-Natal

- Objectives:
- To explore the psychosocial work environment of the ministers in the Dutch Reformed Church in the Western Cape and Kwazulu-Natal
- To describe the existing psychosocial support for ministers in the Dutch Reformed Church in the Western Cape and Kwazulu-Natal
- To make recommendations to the ministers' support task team and synod regarding psychosocial health care programs for ministers in the Dutch Reformed Church in the Western Cape and Kwazulu-Natal

Link to multi choice questionnaire will be mailed in June.