

CRISES AND ILLNESS AND SEEKING PROFESSIONAL HELP: A PASTORAL PERSPECTIVE

by

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Dedication

I dedicate this work to my lovely family consisting of Nancy Tintswalo Mabasa (wife), Lwandla Mabasa (son), Ntivo Mabasa (daughter) and Nhlulo Robert Mabasa-Jr. (son); lastly to my second family, Shigalo Tabernacle Worship Centre for allowing me to be your leader, also affording me the platform to do this work. God bless.

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Summary

The context of this research is the Shigalo Tabernacle Worship Centre, where the researcher is currently ministering. The faith community is within Shigalo Village in the town of Malamulele in the Vhembe District, which has been plagued by numerous forms of violence, inflicting emotional, physical and psycho-spiritual pain on the community. Yet it has been the observation of the researcher that very few members of the community, particularly members who are also members of the faith community, seek professional help – help that is freely offered to the community by medical and other professionals, psychologists, social workers as well as pastors.

The narrative that the researcher has identified in his involvement with this faith community was that some members of the faith community choose to rather suffer, by keeping all their physical, emotional, psychological, social and spiritual problems to themselves than to seek professional help. In the community there are various possibilities of seeking professional help – from doctors to psychologists, social workers as well as pastors.

The research journey explores and describes how families of Shigalo Tabernacle Worship Centre perceive (view) professional help (counselling). The research sought to understand this perception within the context of their faith and their culture, trying to determine what narratives informed this perception.

The objective of the research was first to understand this practice and second to seek ways in which these attitudes and perceptions can be overcome. To do this research, a sample of members was chosen, together with various professional caregivers: Two nurses, two social workers, two educators, two pastoral counsellors, one Medical doctor and a psychologist, who have been in the field of their specializations for more than five years and who are from the Malamulele area within the Thulamela Municipality of Vhembe district. The research was mainly to listen to the stories of the members and complementing these stories with the stories of the professional caregivers, trying to understand how these families constructed their view of faith and how it relates to seeking professional help.

Keywords

Crisis/crises

Community of faith

Counselling

Culture

Illness

Professional help

Reality Constructions

Shigalo Tabernacle Worship Centre

Declaration

I, Robert Bumani Mabasa, declare that the mini-dissertation entitled “Crises and illness and seeking professional help: A pastoral perspective” is my own work that I am submitting to the University of Pretoria for assessment, and that it contains no section copied in whole or in part from any other source, unless explicitly identified in quotation marks and with detailed, complete and accurate referencing.

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Certificate of the editor

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CHAPTER 1

INTRODUCTION

1.1 Background of the Study

Crises and illness are almost an inescapable part of human life. Illness is an unusual human condition (De Jongh van Arkel 2000:81). Every day, people are plunged into crises, which they cannot surmount without help (De Jongh van Arkel 2000:243). People's lives go through various developmental stages and transitions, like starting a new job, being fired, retirement, birth of children, or children leaving home. The following moments of transition or change are examples of a crisis: death, suicide, grave illness and dismissal from work (De Jongh van Arkel 2000:243).

Cox-Gedmark describes this adjustment in terms of the chronic phase of the typical process of bereavement where the patient must say farewell to his or her previous lifestyle and adapt to a new one. The process "starts with a shocking discovery and denial where a believer goes through a phase of questioning God. The process can be clearly comprehended in the description or defining of crises and illness" (Cox-Gedmark 1980:14). De Jongh van Arkel (2000:81) describes illness as an unusual human condition which disrupts a person's life, poses danger to the normal course of that life, and isolates the patient from his or her familiar environment and social contacts.

The psychological experience is inward rather than outward, leading to the patient's inner life becoming stormy. The intellectual and emotional effects of the effort to come to terms with the conditions can result in extreme emotional liability and instability (De Jongh van Arkel 2000:86). This condition can bring forth a feeling of inadequacy, triggering questions about one's self, the people around one, and God (De Jongh van Arkel 2000:81).

Deducing from this, one gets to understand the effects of illness in human life. According to De Jongh van Arkel (2000:80-93), these effects range from physical changes to environmental, social, religious (faith and God), and psychological

aspects. This highlights the patient's perception of illness and the effects thereof on the course of diseases. How do they perceive illness in relation to their faith and culture? Using a scheme or diagram, Moos and Tsu (1979:16) indicate how patients handle their illness or cope with it.

In everyday life, one would often hear someone refer to a "crisis", but many of these remarks do not denote a crisis in the sense implied by the crisis theory (De Jongh van Arkel 2000:243). Therefore, one needs to be very clear about what constitutes as a crisis. De Jongh van Arkel (2000:247) defines a crisis as a "temporary state of emergency when a person, or people, can perceive certain things or events as so threatening that their coping skills are not really equal to the threat. Their coping skills may furthermore be inadequate to dealing with the negative meaning attached to the stressor".

Caplan maintains that crises arise when changes in people's life space necessitate adaptations or adjustments in their relations with others, or in their self-perception (Caplan 1964:129). Boisen (1936), a pioneer in the field of pastoral care and pastoral counselling, states that "crises are not simply fraught with danger: they also offer opportunities for spiritual and emotional growth, since crisis management heightens emotional and intellectual activity".

Through a crisis, there can also be reintegration of personality, which results in great insight, a new perspective, and added strength (De Jongh van Arkel 2000:244). Yet, according to Switzer (1986:29), ". . . there are dangers, for if reintegration does not occur, there is decomposition, which can lead to mental illness".

The process of a crisis is one of choice, and the primary task of crisis intervention is not to remove all hazards, but rather to help people surmount their suffering by stimulating a process of growth and change (De Jongh van Arkel 2000:258). Hence Jacobson's (1980:7) description of crisis fits perfectly:

Crisis intervention is an approach based on theory that aims at a definitive resolution of crises in order to restore an optimum level of functioning. In addition, it involves ready access to a source of help without delay or any waiting lists, with the time-limited treatment

usually lasting no more than four to six weeks and often requires, in some of its forms, a high level of professional skills.

Professionalism comes into play when dealing with crises, because crises differ from each other referring to the source of stress and the time element associated with it (e.g. developmental crises and situational crises – accidental crises or sudden traumatic stress) (Switzer 1986:33; cf. De Jongh van Arkel 2000:249-250). How people define or interpret experiences will determine the intensity of a crisis. McCubbin & Patterson (1983:915), chip with the remark, “The definition or meaning that a person or family assigns to the experienced stressor(s) plays a crucial role in determining whether it will lead to a crisis”. De Jongh van Arkel (2000:253) elaborates on this under the subjective or irrational definition, or interpretative frameworks, that are used to appraise the event.

Gerkin (1979:33) argues:

The core of crisis experience is awareness of contradiction, finitude and vulnerability: and the elemental choice presented to the person is one of faith. To facilitate a grasp of faith in God, providence coming towards the person out of the very openness and contingency of the crisis situation is the fundamental purpose of crisis ministry.

This constitutes to the theological dimension of a crisis – of hope and future. The church and the pastors are in a special position to assist and support people in crisis (De Jongh van Arkel 2000:253). De Jongh van Arkel and Roos (1992:20) believe that “there are indications that the social integrations, or social support, found in religious communities are the reason why religion may positively affect health”.

Idler (1987:228), found out that these four mechanisms in both private and public religion have a positive effect on health: health behaviour, social cohesion, cognitive coherence and interactive theodicy. De Jongh van Arkel (2000:266) says,

When intervening in a crisis situation, all the facts about it have to be taken into account. Some of the important ones are the following:

a. A crisis is not an illness.

- b. A crisis is an internal reaction.
- c. A crisis is a cognitive and perceptual dysfunction.
- d. A crisis is also a short-term process.
- e. There are different genera (types) of crises, each with its distinctive character.
- f. A crisis arises when a person's coping mechanism cannot deal with the stress.
- g. A person's appraisal of a hazardous event largely determines the intensity with its experience.
- h. Crisis resolution should be turned into an opportunity of growth.
- i. Crisis intervention is a specific kind of help for a specific set of circumstances.

Crises and illness are no laughing matter. Many seem not to know how to deal and cope with such matters. The researcher has seen how the people of Shigalo Tabernacle Worship Centre respond to crises, illness, and specifically their perception regarding seeking professional help, which motivated this study, using the title "Crises, illness and seeking professional help: A pastoral perspective". The researcher would like to site some motivations and anecdotes that led to the development of the proposed study.

First Motivation: The Observation

During the past six years of pastoring the Shigalo Tabernacle Worship Centre Full Gospel Church of God in Southern Africa, located at Shigalo Village, the researcher has observed men and women – how boys and girls in families deal with the complexities of normal living in all spheres of life within this community of faith.

Some families and individuals flourished and grew socially, economically, and spiritually, while others floundered, dried up, and withered away. Families and individuals within this community of faith experienced problems with little or no professional help from professional counselling. Yet, counselling to my understanding is a great tool in helping people (families and individuals) to overcome crises and to live with illness. Furthermore, Ngonidzashe and Douglas (2014), as well as (Lartey 1997:56) agree that "counselling reduces the amount of stress in the

midst of challenging problems and ill-behavioural patterns that might be disruptive to the peace and stability of the family.”

One may wonder what prevents people from coming to that level of actualization and realization. The researcher has observed a growing number of negative attitudes and perceptions of families towards professional help (counselling) within this community of faith. Many community members would rather suffer – keeping all their problems to themselves without seeking any professional help. Not seeking professional help seems to be a norm in this community. For example, if a person is sick, he or she would not divulge the information to people, including some of the members of his or her family (Ngonidzashe & Douglas 2014:156).

Second Motivation: Anecdotes

The researcher would like to cite three anecdotes to support this view of the attitudes and perceptions of families towards crises, illness, and professional help (counselling) that resulted in this study. These three are not the only anecdotes, but handpicked to paint the contextual picture in terms of the extent of the problem, thus justifying the need for the proposed study.

- **The statutory rape case anecdote**

A father slept with his daughter for more than ten years. This went to the extent of fathering a child with her. When the matter came out of the closet, the father was arrested, and then released on a bail charge of R10, 000. Later, the case got cancelled, because the mother and the daughter decided to withdraw the case in the interest of financial sustainability of the family, since the father was the breadwinner. The family said that if they are to send him to jail, this would result in financial hardship for the family.

This incident affected the mother of the house psychologically. However, she never sought to get professional help. This became the talk of the town. She later went for help to one of the leaders in the church, who asked if the matter was reported to the pastor. In the process, the mother of the house was advised to seek professional help in counselling, but it was all in vain.

- **The hospitalised woman anecdote**

A lady lost her mother in 2013 during the month of May. After her loss, she withdrew from all her church activities for twelve months. She started questioning her faith in God. Her stress levels took a rise, until she was admitted to a hospital. The researcher approached her and suggested that she should consider counselling to ease her pain, but she refused and said that she will be okay. Finally, she had to be put on medication to control her post-traumatic stress.

- **The violent boy anecdote**

This anecdote is about a young man who lost his mother. This affected him to such an extent that he started talking to himself. He even became violent, destroyed school property, and hurt himself in the process. He bottled all the anger, bitterness, and rage in his life.

All the above incidents were results of keeping crises or illness to oneself, influenced by a number of different things such as faith, culture, and economic matters. The research battled with numerous questions during these observations. These questions are:

- How are the faith-community members dealing and coping with crises and illness?
- When do they seek professional help?
- What kind or types of help or services are currently available?
- Which ones are accessible?
- Do they have access to these services?
- Which of these services are scarce skills or commodities?
- What are the perceptions and attitudes toward crises, illness and seeking professional help with regard to faith, culture, etc.?

Previous studies found socio-cultural beliefs, such as the view that “counselling is a foreign or western practice amongst the people of colour” (Lartey 1997:55), a stigma attachment whereby one is considered to be weak in dealing with their problems if they resort to counselling to help them address their social challenges. This view is explained by McCarthy (2005:118) who states that “clients feel that, since it is a

problem within themselves, seeking counselling is a sign of weakness and failure”. Hence, in black communities, only a senior person can help to deal with the problem (Ngonidzashe & Douglas 2014:156).

However, in the researcher’s understanding of a postmodern world view, counselling should be done by both old and young professionals. Lastly, there are economic issues such as poverty and financial dependency of spouses, only to mention a couple, which influence the rise of this view and the attitudes and beliefs towards crises, illness, and professional help regarding these issues.

The context of this research revolves around the Shigalo Tabernacle Worship Centre, where the researcher is currently ministering. This faith community is within Shigalo Village in the town of Malamulele in the Vhembe District, which has been plagued by numerous forms of violence – inflicting emotional, physical and psycho-spiritual pain on the community. Yet, it has been the researcher’s observation that very few members of the community, particularly those who are also members of the faith community, seek professional help – help that is freely offered in the community by various professionals, medical professionals, psychologists, social workers, as well as pastors.

The problem that the researcher identified in his involvement with this faith community is that some members choose to rather suffer by keeping all their physical, emotional, psychological, social, and spiritual problems to themselves, rather than to seek professional help. In this community, there are various possibilities of seeking professional help, from doctors to psychologists, social workers, as well as pastors.

The research journey explores and describes how families of the Shigalo Tabernacle Worship Centre perceive professional help. The research seeks to understand this perception within the context of their faith and their culture, trying to determine what narratives inform this perception.

The objective of the research is, first, to understand this practice, and second, to seek ways in which these attitudes and perceptions can be overcome. To do this

research, a sample of members is chosen together with various professional caregivers: Two nurses, two social workers, two educators, two pastoral counsellors, one medical doctor, and a psychologist – all of them are in the field of their specializations for more than five years, and are from the Malamulele area within the Thulamela Municipality of the Vhembe District. The research consists of listening to the stories of the members and complementing these stories with the stories of the professional caregivers, trying to understand how these families construct their views of faith and how it relates to seeking professional help.

The proposed purpose of this study is to investigate how families of the Shigalo Tabernacle Worship Centre perceive crises and illness, and seek professional help. This study journeys to explore and describe how these families perceive professional help (counselling) from a pastoral perspective. The research seeks to understand this perception within the context of their faith and culture, trying to determine what narratives inform this perception.

In the construction of the study, the following research literature is drawn upon:

- *Transforming practice: Pastoral theology in an age of uncertainty* (Graham 1996).
- *A fundamental practical theology of descriptive and strategic proposal* (Browning 1991).
- *Narrative Therapy: the social construction of preferred realities* (Freedman & Combs 1996).
- *Maps of narrative practice* (White 2007).
- *An introduction to pastoral care* (Gerkin 1997).
- *The Church in the postmodern global village: Towards pastoral redemptive communities*. Volume One and Two (Meylahn 2010).
- *Narrative Means to Therapeutic Ends* (White & Epston 1990).
- *In Living colour: An intercultural approach to pastoral care and counselling* (Lartey 1997).

Most of the literature on cultures, common attitudes, and perceptions of clients, students, and parents on mental illness, online counselling, school surveys, and

family therapy are considered from a total of about thirty-two journals, books, and articles written by different scholars.

In the researcher's understanding, this serves to inform the study of the values that influence the faith community under study, which will later inform the cultural practices of the community members. Graham (1996) urges that "the proper focus of pastoral theology is not applied theology, or the works of an ordained pastor, but rather the critical study of values, or the purposeful practices of the faith community itself".

Hence, a study on crises, illness, and seeking professional help from a pastoral perspective is considered to be of great importance in addressing these challenges in a postmodern world view of social realities. This study also recommends resolutions on how to deal with negative attitudes and perceptions of families towards crises, illness, professional help, and the socio-cultural beliefs associated with professional help.

Browning (1991:27) discusses the pressure of modernity versus secularism. In his discussion, he shows how modernity seems to undermine these common themes of practice. He does that by stating that "pluralism in modern societies has the difficulty of maintaining a plausible structure that supports both religious belief and constant morals, and naturalism that questions all belief in realities that cannot be seen or measured" (Browning 1991:27) This helped in choosing a postmodern world view epistemology as a point of departure of this study.

The social construction of the preferred realities drawn from narrative therapy helped the researcher to stay in touch with the political, philosophical, and ethical consideration that provide the context for these ideas and practices (Freedman & Combs 1996).

1.2 Problem Identification

Shigalo Village is located in the north-eastern part of the Limpopo Province, which is one of the semi-developed areas in Malamulele with regard to infrastructure and developments such as businesses in the form of taverns – drinking and eating

houses. These taverns are associated with crimes such as rape, housebreaking, drug abuse, alcohol abuse, and death, leaving the community shattered, confused and grieving.

Families and individuals who were already affected by these crimes kept to themselves and went on with their lives without seeking professional help. This behaviour affects the health and life span of the community members whose lives get to be cut short by stress-related diseases like arterial hypertension and, in certain cases, high blood pressure and/or depression, which leads to suicide and mental illness, (Esch 2002:201)

1.3 The Importance and Rationale of the Study

The purpose of this study is to establish reasons for not using professional help (counselling) as a means of dealing with the above-mentioned problems. This study also seeks to explore factors contributing to perceptions and attitudes of families towards professional help (counselling), and the impact they have on the church community. Therefore, the findings of the study could alert the community members on the dangers of socio-cultural beliefs, and thus positively improve the attitudes and perceptions of families towards professional help (counselling).

This study may ultimately result in highlighting the need for the church in general, and pastors, in assisting community members to constructively deal with their social challenges. It may also assist relevant stakeholders in designing strategies to improve safe professional help provision, as well as ways to prevent a negative attitude and perceptions that may arise from the socio-cultural beliefs of families.

1.4 The Objectives of the Study

The proposed study seeks to:

- explore people's attitudes, and perceptions of families towards crises, illness, and professional help (counselling);
- determine the level of knowledge on the types of counselling;
- determine reasons for the community members' attitudes and perceptions towards crises, illness, and counselling;

- make recommendations on how negative attitudes and perceptions of families towards crises, illness, and counselling could be improved.

1.5 Research Questions

- How do people perceive professional help in relation to their faith and culture?
- What are the community members' attitudes towards family counselling?
- What are the dominant narratives that are used in the constructions of these perceptions and attitudes?
- What kind of realities do these constructions within their world views create, and do they offer narratives of hope for the future?
- How can these constructions be deconstructed to open the possibility for re-imagined stories of the future?

1.6 Definition of Terms

Factors

The number of things determining the outcome of a particular matter (Collins English Verb Tables 2011). For this study, a factor is anything that contributes casually to the end result (Collins English Verb Tables 2011).

Perception

The individual's interpretation of events or situations, based on personal beliefs, emotions, and intellectual positioning (Collins English Verb Tables 2011).

Illness

An unusual human condition which disrupts a person's life, poses danger to a normal cause of life, and isolates the patient from his or her familiar environment and social contacts (De Jongh van Arkel 2000:81).

Crisis

A temporary state of emergency when a person perceives certain things or events as so threatening that their coping skills are not equal to the threat. Their coping skills may furthermore be inadequate to dealing with the negative meaning attached to the stressor (De Jongh van Arkel 2000:247). For this study, a crisis is when the story of life no longer flows from the past, through the present, and into the future; in other words, the narrative resources of the past and present cannot adequately describe the happenings in the present, thereby bringing about a clouded or darkened view of the future.

Professional help

Help given by the professionals in their field of expertise who are qualified to do so by meeting the criteria required in that field (McCully 1962:18). For this study, “professional help” is help given by the professionals in their field of expertise, such as medical practitioners, professional nurses, psychologists, pastors, and educators who are qualified to do counselling.

CHAPTER 2

RESEARCH METHODOLOGY

2.1 Introduction

Chapter 2 outlines the study setting, design, method or theoretical framework, the population under study, the sampling procedure, and the method that was used to collect, analyse, and interoperate data. The measures to ensure trustworthiness, reliability, and validity of the study are addressed. Lastly, ethical considerations pertaining to the study are also discussed.

2.2 Study Design

According to Terre Blanche, Durkheim and Painter (2006:34), “study design is a strategic framework for action that serves as a bridge between the research questions and the execution or implementation of the research”. The study design that is employed for this study is qualitative, exploratory, and descriptive in nature (Creswell 1996). The reason for using this method was to obtain thick descriptions that helped to interpret and describe the nature of the problem story. This design allowed participants a platform of expressing themselves about the factors that contributed to the perceptions and attitudes of families towards crises, illness, and professional help or counselling, and the implications thereof (Leedy & Ormrod 2010). This design incorporated an interpretation approach which acknowledges that human life is complex and carries associated meanings and understandings of lived phenomena as social constructs (Rubin & Rubin 1995; cf. Charmaz 2006).

2.3 Study Setting

The study was conducted at the Shigalo Tabernacle Worship Centre Full Gospel Church of God in Southern Africa, located in Shigalo Village, which is situated in the Vhembe District of the Limpopo Province in South Africa. This community falls under the Thulamela Local Municipality, which falls under the Shigalo local authority, and is 15km away from Malamulele. The village inhabitants consist mostly of middle-class Tsonga-speaking people. The weather gets very hot in summer and cold in winter.

The types of houses found at Shigalo differ per person's financial means – some are mud-thatched houses, while others are brick-walled houses. The number of people per house varies from five to ten. The population size of the church from which the participants are found, is approximately 450 – consisting mostly of adults, followed by youth, then children, and lastly, elderly people [(Shigalo Tabernacle Worship Centre (FGC) Statistics, 2013)].

There is one clinic which has five catchment areas, including the Shigalo Head Kraal. The source of income is old-age grants, child support grants, domestic workers, and private business and government employees. The most prevalent diseases in the villages are diabetes, mellitus, diarrhea, mental illness, asthma, vomiting, skin infections, sexually-transmitted infections, malaria, hypertension, HIV and AIDS [Shigalo Clinic Monthly Statics, 2012]. Cultural practices are characterised by Christianity and ancestral worship.

2.4 Study Methods and Theoretical Framework

Methodologically, the qualitative research journey, which incorporated the analyzing of narratives drawn from a specific sample of narrators and the interpretations thereof, was used in this study (Berg 2007) to give an account of the narrative metaphor and social constructionism of a postmodern world view as a metaphorical framework, informing the overall academic reflection process (Freedman & Combs 1996).

Lieblich, Tuval-Mashiach and Zilber (1998) suggest that the narrative materials can be analysed and interpreted along two dimensions:

- The holistic form (one whole story).
- A categorical content that includes one or more dissected stories with defined categories of meaning and structure.

The research was planned as exploratory to seek comprehension and insight (Babbie & Mouton 2001) within units of analyses (Henning, Van Rensburg & Smith 2004) of how participants could describe and explain what the crises and illness represented, and how it was perceived. This incorporates an interpretive approach,

which acknowledges that human life is complex and carries associated meanings and understandings of lived phenomena as social constructs (Rubin & Rubin 1995; Charmaz 2006).

According to Freedman & Combs (1996:1), “using the narrative metaphor leads to think about people’s lives as stories and to work with them to experience their life stories in ways that are meaningful and fulfilling”. Therefore, this clarified the dominant stories that are used in the constructions of perceptions and attitudes with regard to crises, illness, and professional help as it relates to their faith and culture in telling their preferred stories(Morgan 2000:2,9)

Freedman & Combs (1996:20) argue that “social constructions lead to consider ways in which every person’s social, interpersonal reality has been constructed through interaction with other human beings and human institutions, and focus on the influence of social realities on the meanings of people’s lives”.

Morgan (2000:v) speaks of narrative therapy as “the ideas and ways of working with people in therapeutic process”, citing the central principle of narrative ways of working in that “the knowledge and skills of those who consult therapists shape the practice of the therapy in significant ways”. These can be understood through a descriptive condition, and not a definition.

The descriptive condition of narrative therapy: Narrative therapy seeks to be a respectful, non-blaming approach to counselling and community work, which centres people as the experts in their own lives. It views problems as separate from people and assumes that people have many skills, competencies, beliefs, values, commitments, and abilities that assist them to change their view on problems in their lives.

Curiosity and willingness to ask questions to which therapists do not know the answers are important principles of this work. There are many possible directions that any conversation can take. The person consulting the therapist plays a significant part in determining the direction that is taken with the therapy.

Narrative therapy is sometimes known to involve re-authored or recreated conversation. It considers unique outcomes and is interested in discovering more about it. White and Epston (1990:61) attest to that by indicating the role of unique outcomes and imagination: “Imagination plays a very significant part in the practices of externalizing the problem – both for the therapist and for those who have sought therapy. This is particularly important in the facilitation of conditions for the identification of unique outcomes and for the performance of meaning in relation to them”.

Freedman & Combs (1996:20) add that narrative therapy is based in Pare’s third world view that states that knowledge arises within the communities of knowers – the realities we inhabit are those we negotiate with one another. They see a rough correlation between Pare’s three views and the first order cybernetic, second order cybernetic, and narrative/social constructionist.

Pare’s description of the first world view on evolution is referred to as “modernism”, “positivism”, “structuralism”, or old-fashioned common sense. It is a world view where people believe in possibilities of finding essential objectives, facts that can be connected into overarching and generally applicable theories that bring someone closer to a more accurate understanding of the real universe. This kind seeks to develop a sweeping meta-narrative about the human condition and how to perfect it in science. It leads to the belief that these ideas are representations of general truths about a basic underlying reality about people’s perception of crises and illness, and seeking professional help.

According to Freedman & Combs, (1996:20), “the postmodern argument is not against the various schools of therapy, but only against their posture of authoritative truth”. Moreover, “postmodernists believe that there are limits on the human ability to measure and desire the universe in any precise, absolute, and universally applicable way” (Freedman & Combs 1996:21). This simply means that people, who experienced crises and illness, reach limits of not knowing how to deal and cope with it anymore. These limitations suggest that they seek help from elsewhere, rather than to look within themselves.

Postmodernists differ from modernists in the sense that exceptions interest them more than rules. Hence, they choose to look at a specific contextualization of details, rather than looking at the grand generalization of difference in contest to similarity. Therefore, these two therapists describe how, within a community of therapists, they go about applying the two metaphors – narrative and social construction – in organizing their clinical work. These metaphors help:

- to think about people’s lives as stories;
- to work with them to experience their life stories in ways that are meaningful and fulfilling;
- consider the ways in which every person’s social, interpersonal reality has been constructed through the interaction of other human beings and human institutions;
- to focus on the influence of social realities on the meaning of people’s lives;

In modernism, these metaphors are discussed as “family as entity” and “family as systems”, for example, in using a structure as a guiding metaphor, we think of families as rather rigid, geometric arrangements of people (Freedman & Combs 1996:3-5). This kind of thinking can lead to the development of ideas such as triangulation and boundaries.

The work of Freedman & Combs (1996:3) – prior to shifting the paradigm from systems to stories – was solidly within the strategic therapy. Their thinking, like strategic cybernetic system therapists, focused on how families could become stuck in repetitive loops of unfulfilling behaviour, on hierarchical structures that are improperly balanced, and on what therapists could do to interrupt those patterns and guide families into healthy stability.

The modern view makes the therapists focus their attention on whether therapy is “on target” or not. In other words, they tend to think of the help they offer as being guidance in controlling things so that a specific goal is reached (Freedman & Combs 1996).

The first order cybernetic theory invites therapists to view families as machines (like thermostats, guided missiles, or computers). Hence, this view suggests that therapists are separated from, and able to control families. Therapists can detach and deliver an objective assessment of what is wrong, fixing problems in a way machines fix a malfunctioning.

The second order attempts to point the way to a less control-oriented model, a model that does not place the therapist outside of, or above the family (Freedman & Combs 1996:5-6). This one defines a family as a co-evolutionary, and such a paradigm is called an ecological system. Instead of looking for patterns of behaviour in families, therapists look for patterns of meaning. Their interview focuses on the myth or a promise that shapes the meaning of the family members' actions. They are there to give information, rather than getting information. When these ideas of co-evolution guide therapists, they place more emphasis on collaboration than they had with the first (cybernetic) system.

However, the narrative approach, when compared to other approaches of counselling with regard to pastoral care and counselling, differs when seen through the eyes of a postmodern world view. A postmodern world view of reality, of narrative and social construction, gives useful ideas of how power, knowledge, and truth are negotiated in families and larger cultural aggregations. There is no truth, for truth is relative in a postmodern world view. It is about an attitude and ethics that is drawn in from the relationships it supports. This world view of postmodernism can be classified in four ideas, according to Freedman & Combs (1996:23):

- Realities are social constructs.
- Realities are constituted through language.
- Realities are organized and maintained through narrative.
- There is no essential truth.

The next chapter will discuss all the above-mentioned realities thoroughly, as well as the role of the social construction of reality. Lastly, the researcher will list the tenets of modernity and postmodernity to highlight the difference between the two world views. The researcher will also place his position within one specific world view. The

listing will be in accordance with the list of Meylahn (2010:55-58). The purpose is to further elaborate on the differences.

The researcher clearly positions himself within a postmodern world view. This will help relate with an African way of doing therapy. Africans are good story tellers. It will help the researcher to shift from systems to stories, which postmodernism advocates regarding a change in thinking in the family therapy. Moving from systems to stories implicates a social construct where realities are organized and maintained through the narrative.

2.5 Study Population and Sampling

This study was conducted on the Shigalo Tabernacle Worship Centre members as the focus group. The population size of this church is approximately 450 people, consisting mostly of adults, then youth, followed by young children and the elderly [Shigalo Tabernacle Worship Centre (FGC) Statics 2013.

These members predominantly live in the Shigalo Village, and have been victims of crime in the village. The following professionals have also been identified and interviewed for this study:

- Thulamela Health.
- Social and Education Department personnel, as they are responsible for supplying care and counselling in the village.

Their voices were interwoven with the voices of the faith community to offer another perspective on the problem story.

2.5.1 Sample Size

A minimum of 5 Focus Group Discussions (FGDs), each consisting of 8 to 10 people, were conducted with the adult community members of Shigalo TWC. Another FGD was held to reach data saturation. Two professional nurses, two social workers, two teachers, a medical doctor, and a psychologist were included in the study during in-depth semi-structured interviews. The FGDs only consisted of community members of faith who volunteered to participate in this study.

2.5.2 Sampling Method

Stratified purposive sampling was used to select the participants. In purposive sampling, judgement on who can provide the best information to achieve the objectives of the study was used (Leedy & Ormrod 2010). Individuals who can provide the needed information were selected. All the professional personnel were purposively selected to participate in this study. Members of the Shigalo Tabernacle Worship Centre who met the inclusion criteria were purposively selected for this study as well.

2.5.3 Inclusion Criteria

Community members older than twelve years of age, and who are members of the church for more than one year, were included in this study. Some of the Shigalo clinic professional nurses, Malamulele-Bosasa psychologists, pastors, and the Thulamela Department of Education and Social Welfare Development personnel, who are responsible for counselling at the village schools, were also included.

2.5.4 Exclusion Criteria

Individuals with mental illnesses were excluded from this study, as their responses could be influenced by their mental illness. Individuals who are working for the Departments of Education and Social Welfare Development, whom are staying in the Shigalo Village and form part of the church, were excluded, as their responses could be influenced by the knowledge they had acquired in their careers. Children under the age of twelve, and all members who were less than a year in the church, were excluded as well.

2.5.5 Data Collection Tool

An interview guide was used to conduct both the focus group discussions and in-depth interviews with the participants from the community, and professionals from the Department of Education and Social Welfare Development. The interview guide consisted of open-ended structured questions (Appendices 1 and 2).

A semi-structured open-ended questionnaire with biographical information was used to collect data from the clinic nurses, social workers, psychologists, teachers and pastors – just to give an opportunity for narrative potential to emerge (Henning *et al.*

2004:122). The interview guide was translated into Shangaan/Xitsonga, as it is the native language spoken in the village. It was then translated back into English to make sure that it produced the same original English meaning (Appendix 1).

2.6 Data Collection

An interview guide was used and the designed questions were based on the objectives of the study and the type of participants (Appendices 1 and 2). Steps that were followed when collecting data through in-depth interviews were as follows: Tape recordings were used to record all the interviews on the focus group discussions as well as the other professionals' interviews. Permission to do the study was obtained from the Executive Council of the Full Gospel Church. The Local Council was requested to call a church community meeting (an *imbhizo*), where the study was explained in detail (Appendix 5).

Then followed the recruitment phase. Those who agreed to participate were grouped into small groups of 6 to 10 people consisting of all age groups. Men and women were grouped differently, because in Shangaan/Xitsonga culture, women feel it is disrespectful to talk or express their views in front of men.

The groups were given different dates on which to attend the focus group discussions. Focus group discussions were conducted at the church in one of the office rooms which was not in regular use. Data were collected on Saturday afternoons as the church was not too busy and many people had already done their household chores and attended social functions. Yet, some took place during the course of the week, depending on the availability of the groups.

Field notes on the non-verbal communication were noted down as well. Information was later captured and stored in a computer. The tape recorders were used to record FGDs and professional personnel interviews. Data was collected from nurses, social workers, pastors, psychologists, and teachers using a semi-structured questionnaire (Appendix 2).

A semi-structured interview was conducted for the Department of Education and Social Welfare Development's personnel (Appendix 2). Two representatives from

each department, who were working around the Shigalo Village and Malamulele, were requested to participate in this study on a voluntary basis. Appointments were made with them for interviews. Interviews were conducted at the place of their choice, on the condition that it was safe and the area had privacy. One interview was conducted with each representative, unless there was agreement between the researcher and the participant to conduct a follow-on interview for completion of an incomplete interview, or any other reason.

2.7 Data Analysis and Interpretation

Data was analysed in qualitative ways, thematically for the content of the interviews, using narrative metaphors and social constructionism (post-structuralism) (Creswell 1996). The steps that were involved, are the following: All the transcripts were perused carefully and the tape-recorded information was listened to carefully to get a sense of the whole. Some ideas that were coming into mind, were jotted down. Documents were picked up and read through thoroughly, and the thoughts that emerged from those documents were noted down. A list of all the topics from the interview documents was made and compiled. Similar topics were grouped together and arranged into major, unique topics and leftovers (cf. Creswell 1996).

Topics were abbreviated as codes and written next to the appropriate segment of the text. The most descriptive wording for the topics was sought and turned into themes and sub-themes. Related themes and sub-themes were grouped together to reduce the list of categories. Lines were drawn between the categories to show the interrelationships (Creswell 1996).

A final decision was made on the abbreviation for each category and codes, and these were done alphabetically. Data falling within the same themes and sub-themes were assembled together and analysed (Creswell 1996).

Since the current research was aimed at looking at the dominant stories of the participants, their own interpretations and meanings were used in order to work on the retelling of their stories (Elliot 2005; cf. Naidu & Adonis 2007:4, 6).

The researcher preferred to look for imagery, narrative tones and themes usually found in personal narratives to aid him with the analytical exploration of this study (Crossley 2007:140).

According to Crossley (2007:140), “narrative tones are described as features found within the content of stories and the manner in which they are told, yet imagery is culturally constructed through language use of images, metaphors, and symbols”. These are culturally embedded as well, forming a linkage to dominant stories of belief systems, values, and morals (Crossley 2007:140). Themes are narratively bound, and indicate or reflect events, incidents, and occurrences to pattern or structure the story.

In the preliminary phase of analysis, the researcher read the verbatim transcripts to check the multiple stories shared by the participants in each interview. The researcher was cautious not to fragment these stories, but tried to identify the boundaries of the narrative segments within the interviews (Grbich 2007:130). Working with narrative segments, the researcher took cognisance of the narrative origins which were culturally and socially bound and did not attempt to change the language expression, grammar, or imagery in the details of the shared stories. Overlaps within and between stories and textual bodies were themed around descriptions and explanations, as mentioned earlier, and explained the impact of crises, illness, and professional help by means of a content-oriented story approach (Lieblich *et al.* 1998).

2.8 Limitation of the Study

The participants may exaggerate the truth as they may think that the study will bring solutions to the crises, illness, and professional help problem. Another limitation may be time and access, as the sample comprises of some illiterate people who might take time to understand the purpose of the study. This study had a limited time frame as well.

2.9 Measures to Ensure Trustworthiness

Trustworthiness refers to the extent to which a research is worth giving attention to and worth taking notes of. It also refers to the issue of whether the reader is convinced that the findings are to be trusted or not (Babbie & Mouton 2001).

2.9.1 Dependability

Dependability involves appropriateness of inquiry, decision, and methodological changes. The processes must be reviewed constantly to ensure that the inquirer's bias does not influence the inquiry (Creswell 1996). Dependability is achieved by describing the research method fully and by describing the research protocol with the team and independent encoders. A tape recorder was used to maintain reliability when doing all the interviews.

2.9.2 Credibility

Leinenger (1991) stresses the "significance of identifying and documenting recurrent features like patterns, themes and values in qualitative research". The emphasis on recurrence suggests the importance of spending time with participants to identify reappearing patterns. The researcher ensured the credibility by remaining in the field for a prolonged time. A variety of sources was also used in data collection to maintain credibility. This includes the use of a tape recorder, notes from the field, and observations.

2.9.3 Transferability

According to Trochim (2006), "transferability can be ensured through describing the research context and assumptions that are central to the research". Transferability was maintained through dense descriptions of data. The responses from the participants were documented and analysed as well. Purposive sampling was used to ensure that only those who qualified for the study, were recruited.

2.9.4 Conformability

This happens when literature studies are being sought after from other publications in different academic disciplines to form the foundation in which findings can be compared, confirmed, contrasted or rejected. Inputs from the supervisor's regular

contact with the researcher provided a different interpretation of data, which might interfere with biases, assumptions, stereotypes, and beliefs held by the researcher.

2.10 Ethical Notes

The proposal was submitted to the Higher Degree Committee of the University of Pretoria (TUKS), and then submitted to the Ethics Committee to obtain ethical clearance to conduct the study. Permission from the Head Office of the Full Gospel Church of God in Southern Africa was obtained for the study to be conducted in the church. A presentation to the Shigalo Tabernacle Worship Centre was done in order to obtain permission from the Local Executive Church Council.

The permission to do focus group discussions was obtained from the church. Written consent from the participants was obtained before conducting the study – they were told that participation was voluntary and that they had the right to terminate their participation at any stage of the project, despite their initial consent. During the focus group discussions, the participants' anonymity was maintained by not calling them by names, but by labelling the participants A or B when writing the reports.

Participants were protected from physical and psychological harm at all times. They were guaranteed freedom to withdraw from the study at any time if they felt emotionally or physically exhausted while they participate in the study. To maintain professional honesty, findings of the study were reported in a complete and honest manner, without misrepresenting what was actually found in the study.

CHAPTER 3

FINDINGS AND DISCUSSION

3.1 Introduction

This study used the qualitative research design – incorporating analyses of the narratives and their interpretation drawn from a specific narrator. This design incorporates an interpretative approach, acknowledging that human life is complex, as it carries associated meanings and understandings of lived phenomena as social constructs (Charmaz 2006; Rubin & Rubin 1995). The narrative of this study originates from the interviews.

The research is planned as an exploratory study to seek insight and comprehension within units of analyses of how participants could describe and explain the understanding of professional help, and how they experienced it. The researcher presents the results of the study thematically with links to the relevant literature, as well as the researcher's own observation of these experiences amongst the community of faith. Some of the themes that emerged, could not be brought into conversation with the literature, as the experiences shared, refer to oral traditions transmitted from one generation to another within the community in which the research is conducted.

The participants' age ranges from 16 to 78 years old. All of them have been part of the members of the community of faith and the church for more than a year.

3.2 Participants' Views on Perceptions towards Crises, Illness and Seeking Professional Help

This study is about crises, illness and seeking professional help. It is done from a pastoral perspective. For one to fully grasp this concept, a full understanding of what is meant by crises and illness from both literature and the respondents are needed.

3.2.1 Meaning of Crises and Illness

Under this sub-heading a few interpretations of the meaning of crises and illness by some of the respondents are given. One participant said, “When some of your loved ones pass away, especially one who was the breadwinner, it’s a crisis”. Knight and Cavaglieri (2010) wrote a report called *Surviving the death of a breadwinner*. Their central research question was, “How can you keep your family finances alive?” They arrive at the following conclusion:

These may be modern times, but millions of families are still relying on a sole breadwinner to keep their finances afloat. Too few, it seems, think about what would happen if the family breadwinner dies, according to a new study from insurer Friends Provident. Twenty-four million people in Britain have no life cover in place. What’s more, the study shows that even those who have considered getting cover would underestimate their family’s income needs by an average of 14,500 Euros a year. And even if a loved one has died, there are still financial obligations to be met.

This report gives a notion to the idea of the participant’s definition of a crisis when there is a loss in the family. The loss of a loved one is a crisis, and even more so when the person was the breadwinner of an extended family. Therefore, death is considered as a loss to the family, which in turn can be viewed as a crisis when related to the financial sustainability of the house. Another participant added to it by saying, “Not only when you are a breadwinner, but death itself puts someone off by nature”.

3.2.1.1 Crises

De Jongh van Arkel (2000:247) defines a crisis as a “temporary state of emergency when a person or people perceive certain things or events as so threatening that their coping skills are not really equal to the threat. Their coping skills may furthermore be inadequate to dealing with the negative meaning attached to the stressor”. The lack of skill in coping with threats becomes a challenge to the one facing these threats. The emergency of having to deal with death in someone’s life, and the loss of sustainability, may financially be an offset to the people who truly depend on that person for continuity of financial viability. This becomes a sudden

shift that suggests new means where the family might not be in a position of knowing how to deal with it. This is the case of the previous participants.

This view is supported by one participant who said, “When you fail at school, it becomes a problem where you have to repeat a grade, while your friends progress to the next level”. To this respondent, the stressor attached to failing, becomes the crisis. Chapman maintains that crises arise when changes in people’s life space necessitate adaptations or adjustment in their relations with others, or in their self-perception (Chapman 1964). Again, a male participant highlighted something along the line of responsibility, shedding more light onto what a crisis might be, or the meaning it carries for him: “As a father, if you are not working, it becomes a huge challenge, because your family looks up to you for provision”. To this man, who has lost his job, it is a real crisis – not only for him, but also for the extended family. De Jongh van Arkel concurs with this by saying, “When people’s lives are involved in the various developmental stages and transitions, it refers to starting a new job, being fired, retirement, births, and children leaving home. In cases of death, suicide, grave illness, and dismissal from work, would often invoke a crisis” (De Jongh van Arkel 2000:247).

Furthermore, a young female spoke of the crisis in the form of chaos in the family: “There was once a chaos that took place in the house, caused by my father that required the entire family to see a psychologist”. Another male participant said, “We can use counselling to re-establish someone’s self-esteem whose right had been violated through rape”. “Counselling can be used to salvage married couples that are going through a rough path of separation or divorce”, another participant alluded. To this young female participant, chaos is a crisis. The transition that took place in her family, which moved them from a peaceful home to a house full of violence, was interpreted as a crisis.

Deducing from the above-mentioned responses, one tends to understand that they define a crisis as chaos that might happen in the house – this includes rape, separation or divorce, failure at school, loss of a job, and death in the family. For this study, crisis is defined as a temporary state of emergency when a person or people perceive certain things or events as so threatening that their coping skills are not

equal to the threat. Their coping skills may furthermore be inadequate in dealing with the negative meaning attached to the stressor (De Jongh van Arkel 2000:247). Therefore, the narrative interpretation of a crisis to the respondents is when the story of their lives no longer flow in a linear line. In other words, the narrative resources of the past and the present cannot shape the happenings in the present, thereby bringing about a clouded or darkened view of the future.

3.2.1.2 Illness

Illness is defined as an unusual human condition which disrupts a person's life, poses danger to a normal course of life, and isolates the patient from his or her familiar environment and social contacts (De Jongh van Arkel 2000:81). This can be clearly understood by looking at what some participants said about the dangers that illness poses to individuals. The dangers are picked up in the moment of reaction when illness strikes. One participant said: "I will go to the pastor, to lay hands on me". The other interjected and said, "Let us be honest, we usually go to clinics and hospitals and think of calling the pastor later when we feel it cannot be medically treated". Another participant also quipped in and said, "Truly speaking, if it is a minor case, like headaches, I might come to the pastor, but if it's nausea or vomiting and headaches, my preference is an injection at the hospital first, then I can call the pastor after that". One participant, who is a psychologist, spoke of illness as a mental disturbance. She said: "To me...when you are ill or sick, you could be mentally ill or sick. Not in the form of witchcraft, but to our people, when one is sick, this could be attested to witchcraft or punishment from God".

Bary's (1982) description of illness attests to that: "Illness can be experienced as more or less an external event that has intruded upon an ongoing life process. At first, illness may seem to lack all connection with earlier events, and thus ruptures our sense of temporal continuity, and if the rupture is not mended, the fabric of our lives may be ripped to shreds". The experiences of illness to these participants seem to lack connections, hence they differ when it comes to the preferred place of help. Each one is trying to connect to the meaning of their illness.

A medical doctor spoke of sickness as a physical and psychological condition which can affect a person both physically and psychologically if the prognosis is not known.

He said: “A person has a physical body that can be ill, he/she also has a soul whereby there can be sickness as well – the sickness in the soul part is psychological, medically speaking. It includes the mind, feelings, and emotions. You can be hurt on that level. When people are physically ill, it sometimes affects them psychologically. And these two places – the physical and psychological aspects of a person – are not treated in the same manner. If you are physically ill, with no clear understanding of the illness, then you can be psychologically ill, but if you do have a prognosis of your illness, then it does not jump into your psyche to cause psychological illness”.

The medical doctor participant also indicates two types of illness and the effects thereof. When talking about illness, Hyden (1997:48-69) uses two types of illness to show its difference and the impact thereof:

Acute illness, in the best cases, has only a temporary significance in our lives; it constitutes a transitory and limited disruption; an acute illness may cause us to re-examine our lives in the light of our own frailty. Chronic illness, on the other hand, usually changes the very foundation of our lives, because illness creates new and qualitatively different life conditions. Our range of options no longer seems so wide and varied; we may be forced to look at the future from a totally different angle (Hyden 1997:52).

Hyden elaborates on this by stating that chronic illness alters the relationship between the patient’s body, self, and surrounding world. Thus, for the chronically ill, the reconstruction of one’s own life story is of central importance (Williams 1984). In this case, the patient should be conceived as a text that can be read, which actualises the narrative perspective (Daniels 1986; Gogel & Terry 1987).

For this study, illness will be defined as an unusual human condition which disrupts a person’s life, poses danger to a normal course of life, and isolates the patient from his or her familiar environment and social contacts (De Jongh van Arkel 2000:81).

3.2.2 Causes of Crises and Illness

In everyday life, one often hears about a “crisis”, but many of these are not crises in the sense implied by the crisis theory (De Jongh van Arkel 2000:243). Therefore, it is important to be very clear about what constitutes as a crisis. De Jongh van Arkel (2000:247) defines a crisis as a “temporary state of emergency when a person or people perceive certain things or events as so threatening that their coping skills are not equal to the threat. Their coping skills may furthermore be inadequate to dealing with the negative meaning attached to the stressor”.

People perceive causes of illness and crises differently. Therefore, they seek different interventions. Some seek spiritual intervention, because they believe that they have been bewitched or punished for their sins against God. This is supported by one respondent who said that “nothing just happens in this life. When you are not well, it’s either God punishing you for the sins committed or you are bewitched” (*I swilo swa vanhu*). The African belief system clearly echoes this. Africans hold certain beliefs, stating that nothing just happens without a supernatural force, which can be godly or satanic – good or bad, negative or positive. Whether it is crises or illness, they believe that there is a force behind it, responsible for such happenings (Oral Tradition).

This participant is of the view that a crisis, whether it is in the form of illness or other factors, has a cause to it. This is in line with what Khoza (2000:56) refers to, when he speaks of the myth of what happens after death, whether it be sickness or being fired and demoted at work, that could be associated with having failed to attend the funeral of a relative back at home. Therefore, what happens after such a failure can constitute into a bad thing to take place, serving as a punishment (Khoza 2000:56). To them, the causes might be directly linked to some ritual brought together by the Christian convictions with African traditional beliefs and practices (Lartey 1997:129).

The story of yet another participant speaks volumes when it comes to how people perceive various causes of crises in life. This participant did not experience a bereavement moment, but due to some abusive family issues, it eventually bred a crisis in her life, as the researcher paraphrases: “Due to something that happened back then at home, that was so abusive from my father who really got me

traumatized, I saw a psychologist who helped me to deal with these issues. Later, I went to a social worker and the results were positive”. Another male participant indicated that the reason why he was looking for professional help, was financially related. He said: “Yes, I did go to counselling and it was due to a financial crisis where I needed to pay the school fees of my children, and I was under immense pressure”. Again, the other male participants quipped in and said, “I did receive counselling from the pastor after experiencing a car hijacking where I was so traumatized and afraid to own a car because of this experience”. Both these male participants’ causes of crises were financial predicaments.

Illness and crises can therefore be socially defined (De Jongh van Arkel 2000). For example, to the academics and non-academics, the causes of both crises and illness are perceived differently. The academics perceive illness as something caused by germs or stress, yet the non-academics are of the view that illness is caused by witchcraft or a sort of punishment from a deity [Robert Mabasa]

One participant, who is a psychologist, spoke of illness as a mental disturbance. She said: “To me, when you are ill or sick, you could be mentally ill or sick, but to our people, when one is sick, this could be attributed to witchcraft or punishment from God”. Again, another participant, who is a medical doctor, also spoke of illness as a physical and psychological condition which can affect a person both physically and psychologically if the prognosis is not known. He said: “A person has a physical body that can be ill. He/she also has a soul where there can be illness – the sickness in the soul part is psychological, medically speaking. It includes the mind, feelings, and emotions. You can be hurt on that level. When a person is sick physically, it sometimes affects them psychologically. And these two places, the physical and psychological aspects of a person, are not treated the same. If you are physically ill with no clear understanding of the illness, then you can be ill psychologically, but if you do have the prognosis of your illness, then it does not jump into your psyche to cause psychological illness.”

Both professionals allude to the fact that illness, or its origin, can be attested to various things such as witchcraft, emotional or physical weakness. The definition that

a person (or family) assigns an experienced stressor(s), plays a crucial role in determining whether it will lead to a crisis (McCubbin & Patterson 1983:915).

Therefore, death could not be the only thing that constitutes a crisis in one's life. There can be many factors that contribute to crises. This study reveals that there are many factors that constitute to the cause of a crisis in a person's or family's life, such as the death of loved ones, retrenchment, car hijacking that caused the fear of driving again, financial constraints, chaotic or abusive environments, rapes, and chronic illnesses.

3.2.3 Meaning of Professional Help

In the quest to understand the meaning of the term "professional help" from the respondents' point of view, a question was asked to the participants across the spectrum: "Would you please share your understanding of the terms 'professional help' or 'counselling'?" The term "counselling" has been used to simplify the question particularly to those who do not belong to the professional class and are not equally privileged on an educational level.

According to Ngonidzashe & Douglas (2014:156),

[c]ounselling may also be described as a process that enables a person to calmly address their psychosocial problems and issues in a supportive environment so that a greater understanding can be achieved. This can assist a person to make positive changes, or it may help someone accept a difficult situation and become more resilient.

This is supported by a participant who responded as follows: "To me, professional help or counselling is when a person comes to a solution to the problem that another person comes across, and having a solution to the difficulties the other person is facing".

Another participant, code-named MK, said: "Counselling is support to those hurting and showing the person that life does not end there. There is life after problems". "It is getting help when facing tough times", code-name RM puts it. To code-name SC,

“It comes when a person has certain problems that are beyond control. Then, you go to those who will help you calm down”. Furthermore, participant code-named TB, said, “Counselling has many elements: 1. Correcting someone; 2. Building a person back up to continue with life; 3. Excommunication”. To participant code-named G, it is “when you go to others for help”. Lastly, code-name MT sums it up in relation to abuse of any form: “When you are abused by relatives or others from the community, such a person seeks people to help them”.

In his address of pastoral care, Lartey (1997:1) sheds some light on what help might be according to the participants’ views. Lartey (1997:1) is of the view that pastoral care consists of helping acts done by representatives of Christian people, directed towards the healing, sustaining, guiding, and reconciling of troubled people whose trouble arise in the context of ultimate meaning and concerns, which has become more or less a standard definition of pastoral care.

He further elaborates to indicate the iteration of pastoral care and counselling, stating: “It involves the utilization by a person in ministry of one-on-one, or small group relationships, to enable healing, empowerment, and growth to take place within individuals and their relationships. Pastoral care is the broad, inclusive ministry of mutual healing and growth within a congregation and its community through the life cycle (Lartey 1997:2).

These explanations are in line with the way in which participant code-named X defines counselling from a health perspective, showing a broad inclusion of healing and growth within individuals and their relationship to the stressor: “Counselling health-wise – before you get tested, you must first receive counselling. Therefore, counselling is explaining to a person and makes that person understand that they are not alone. It is taken in by the mind of that person and brings them back to a good place, so that they must not feel like they’re dying. You counsel a person to come to an understanding that HIV is there and it does not kill. Encouraging a person to take treatment is done in counselling – it’s giving understanding where people lack understanding”.

Counselling, therefore, is a process designed to help married couples to solve their problems and to assist them in planning for the future (Zindi & Makotore 2000). Participant code-named RL said, “Counselling is to show a way to a person who seems lost, or getting lost. A person facing challenges can be counselled in a comforting way, or as a way of comforting them, showing that person that there is still a future ahead”.

Marriage counselling is a conjoint effort where both partners are seen together from the beginning to assist them in resolving marital conflicts. Some have described marriage and family counselling as marital counselling, relationship counselling or couples counselling and therefore these terms will be used interchangeably (Ngonidzashe & Douglas 2014:156).

Wembley (1979), an African-American pastoral theologian, explores pastoral care in the African-American church. In his book, he defines pastoral care as bringing the total caring resources of the church to people and families in crises – using his four functions of pastoral care for liberation which are worship, care, nature, and witness. One participant said, “We also get counselling at the church services when the pastor is preaching or when we are worshiping God through singing. We get healed and encouraged to go on with our lives in the midst of its challenges”.

Counselling, according to Wembley (1979), is a “western practice, and not an African practice. Under the influence of a discernible social, political, ideological and cultural trend, post-enlightenment western society seemed to have developed an approach related to illness which beset individuals”. Participant code-named T agrees with this notion: “Counselling is like calling the elder to come and help settle a dispute”. It is different from seeking professional help. Second, participant code-named H said, “Counselling is encouragement – encouraging one to go on with life. It is showing one how to live when two are in a dispute”. Participant code-named S validates this by saying, “Counselling is a manner of showing each other of how we solve problems and avoid things before they happen”. Participant code-named K further elaborates on this: “Counselling is when things are heavy and you do not know how to handle it, then someone shows you how to handle such a heavy load”.

The values and ideals held by the counselling profession seem to be well-suited for a post-Christian, post-political society. They provide a way of being loving, helpful, and kind without being religious (Lartey 1997:55). These values, when properly employed, may bring individuals, small groups, and families to the next actualisation: “Is found in the aims; the aims endeavours in skilled... are clients being able to express their thoughts, feelings and behaviour, to reach clearer knowledge and understanding of themselves and results find the strength and resources to cope more effectively with life” (Lartey 1997:56).

Patton says that counselling is help given to the person who took the initiative to seek help, where it may include support, guidance, and a variety of other means through which care may be expressed (Patton 1983:16). The following inputs from the participants shed light on this statement. One of them argued that “professional help is a thing that can be used to take something away that is stuck in someone’s mind, affecting that person negatively”. Another one agreed: “Professional help is when a person or people get to be helped through the difficulties of life – so that their problem(s) cannot stop them to go ahead”. Participant code-named L quipped in and said that counselling goes together with problems: “If you pass certain stages in life, then you get help from someone who will help you clear your mind”. To participant MC’s understanding, “counselling is when you have problems and you are failing to deal with them, and then you ask help from others”. Participant MP summed it by saying: “It is going to someone for help with the problem that you couldn’t handle”.

One professional nurse describes counselling as follows: “Counselling, to me, is trying to bring a perception of a person into the reality by also finding out what this person knows regarding that part, particularly the discussion that is being tackled at that time. It is trying to understand what they understand with that particular element, and then starting to bring in a positive site of that element that you comprehend, which is realistic, as discussed at that particular time.”

The majority of the participants seem to understand counselling/help from the point of healing, sustaining, guiding, and reconciling people. The help does not have to be professional. This will be discussed in detail later, under auspices of getting help. The question is: Do they really understand the meaning of counselling or

professional help? The researcher is of the view that they really do, but some cannot define it up to the level of academia – this means that they cannot define it scholastically. They have an idea of what counselling might be, or is.

The question may then be asked: What turns regular help into professional help? According to Lynch (2002:82-94), what makes help become professional help, is the professional ethics that are adhered to by those who are trained in these professions. What makes pastoral care and counselling a unique profession, is the professional ethics that this field have. Some of the participants seem to agree with these ideas when saying, “Counselling is a professional help that a person gets from therapy or pastors when there are challenges.” “It is a way of getting help”, said participant K. Participant B interjected and said, “In my view, counselling is trying to solve a dilemma by going to the trained ones”. Participant MT said that “it is a professional way of dealing with problems that could affect a person mentally”.

According to Lartey (1997:55), counselling is based on the skilled and careful use of relationships within which conditions are created to facilitate the expression of thoughts and feelings, and the exploration of behavioural patterns which may be causing concerns. Participant B understood counselling to be the thing that “goes together with being traumatised, and there are those who can help the person – people such as social workers – to deal with the current challenges”. Counselling is the skilled and principled use of relationships to facilitate self-knowledge, emotional acceptance and growth, and the optional development of personal resources (Lartey 1997:56).

McCully (1962) discusses professionalism, and refers to an established criterion for professionalism, arguing that a person is primarily service-oriented, and the service it provides is of great social value. Performance of the specified social service rests primarily upon intellectual techniques. Members of a profession possess a strong commitment or calling to the profession. They view it as a life-long career and are engaged in the profession on a full-time basis. A profession is based upon a common body of knowledge, theory, and skills that is not generally known to the public, is based on scientific research, and is unique to the profession.

The service provided to society is unique, and society has professions delegated to qualified members of the profession-exclusive authority to provide specified social services (McCully 1962:18; Ritchie 1990). Entry into the profession requires an extensive period of specialised training and higher education. There are explicit and uniform standards for training. Admission into training is highly selective. The profession controls the training standards.

Members must exhibit minimum competency by examination and supervised apprenticeship or internship prior to an entry into the profession. The profession is legally recognised by certification, licensure laws, or both. Members of the profession are bound by an ethical code that defines both ethical and unethical conduct and services, and provides for strict enforcement of its rules and regulations. Individual members of the profession possess broad authority over the practice of their service, and the profession as a whole possesses broad autonomy over internal operations.

Counselling does not meet these criteria up to date, while Ritchie (1990) acknowledged that counselling does not have, in a broad sense, autonomy. He therefore suggests that counsellors should work together with insurance companies and other regulatory bodies to maintain professional autonomy. Therefore, the areas of research, training, and legal recognition are the central issues that need to be considered, according to the criteria of McCully (1962:18-24). According to some of the female participants, they agree with McCully that professionalism in counselling is brought by training, and legal recognition considered according to the criteria: "Counselling is fixing problems or mistakes that take place in families, and fixing these mistakes are done by the people who are trained (professional helpers)", said a female participant. Another participant described a professional helper as a person coming with a solution to certain problems. She said: "To me, a professional helper is someone who is trained in giving a solution to certain problems".

Professional help, to the participants, may simply mean that it is help given by the professionals in their field of expertise, such as medical practitioners, professional nurses, psychologists, pastors, and educators who are qualified to do counselling of some sort in life. Yet, help to them can also mean someone from the family who is more senior or experienced in a certain area of life, e.g. marriage conflict.

3.2.4 When Do They Seek Help?

The current study shows that people do seek help. Yet, it is also revealed that some prefer to deal with problems on their own without seeking help of some kind. The question prompted by their reactions, is: What type of help do they go for? Is it professional help or non-professional help?

Reflecting on this, the researcher remembers an argument that broke out between the participants about illness and seeking professional help. The argument was about when and where they seek help when illness strikes. One participant said: “I will go to the pastor to lay hands on me”. The other interjected and said, “Let us be honest, we usually go to clinics and hospitals and think of calling the pastor later when we feel it cannot be medically treated”. A third participant quipped in and said, “Truly speaking, if it is a minor case like headaches, I might come to the pastor, but if it’s nausea or vomiting and headache, my preference is an injection at the hospital first, then later I can call the pastor”.

Here we find a mixed reaction as to when they seek help. Pain seems to be the factor that influences them seeking help or not. Its aggravation becomes the determining factor. This means that the amount of pain determines their choice, influenced by their perspective of illness in relation to their beliefs and culture. This brings us to what a medical doctor said: “People only come for a consultation when the situation of their illness has reached a chronic point, finding that if they have attended to the situation earlier, it would have been a different scenario altogether”.

One participant, who is a professional social worker, described the kind of work that she does daily: “I see different people from various walks of life. Some are referred from the clinics by nurses, some come from churches where they were referred by the pastors, and others come from the tribunal authorities”. One participant agreed: “One can also go to counselling when you are referred by someone who has been there before”.

Another participant, who is a psychologist, indicated that most of her clients came to see her through referrals from other professions and self-referrals. In addressing the challenges that is associated to these referrals, she said: “When I observed those

who came to me through self-referral – by self-referral I mean someone who feels that they have problems and need consultation – it is not a challenge, because it means that they already have the belief that therapy helps. But the challenge is with those that have been referred by the doctor. This is where a medical doctor sees a client complaining about insomnia. The doctor thinks the client is depressed and refers the client to me. It is tough and challenging for those people, so you must help them understand that therapy helps. These people are of the view that medicine removes pain, so talking without any medication given cannot solve the problem for them! They would ask how this is going to help”.

A medical doctor attested to the attitude of clients and patients, stating: “It differs depending on who sought help. The one brought to a hospital or clinic comes with a higher resistance and a bad attitude. He/she does not want counselling, but the one who came on her/his own, seems to do better”. He also asked: “When do they go or not? The common cause for people to consult, is pain. Many people wouldn’t come because they need help, but only for the treatment (removal) of their pain. Some people would come because of the heavy pain that they do not know how to deal with. At the end of the day, they would visit the doctor. And the doctor is in the distribution policy of saying, ‘I would refer you to someone else’. Most men do not come because they are afraid of pain; they would be dragged to the consulting room when it gets beyond the norm. Moreover, the majority of people would visit traditional healers first. Experience has taught us that even Christians go to consult traditional healers more than you can imagine or think. For example, when you come to lay hands on them, you would not ask to see the waist, but as medical practitioners, we do see things when we meet them at labour wards and so forth. In an attempt to justify themselves – because they know that we know them as Christians – they would say, ‘They have tied me in this robe to prevent miscarriage’. Our people believe in traditional things. As a result, they often follow the traditional route of dealing with current problems. You would hear someone who is pregnant saying, ‘I went to the pastor and he/she told me through the spirit that the child inside the womb is not well-positioned’. Then you wonder how on earth would they believe such things. Yet, this person is working and has a medical aid. They could have gone for a scan to check the position of the baby and it would be the medical aid that

covers the cost, but still they walk around and entertain the idea that the child is not well”.

A female social worker brought to light how some family members position themselves towards getting professional help, stating: “When a family comes to report a certain problem to us, they believe that the problem should have been reported to the elders of the house prior to taking it to the professionals, because these are the people (elders of the family) who will understand you better. They believe that, for a family matter to be taken to the professionals, it must have failed to be resolved at home first”.

The psychologist participant also indicated another reason why people decide to stay at home with their challenges without seeking any form of help. She said: “I think they have other means of dealing with their issues, which is entrenched in their belief system”. One female participant added: “When I was depressed from an in-house challenge, I used an empty chair technique to deal with depression without consulting anyone for help”. Another professional nurse related why people do not seek help: “It is because we nurses are known as people who cannot keep secrets, so people will not come for help. For example, let’s take a person who is on ARVs. They would prefer to go somewhere else where they are not known to collect their medication or do some tests, because no one knows them there. According to them, their secrets are safe. People are secretive about their lives”. Another participant agreed: “Lack of confidentiality amongst the people who are supposed to offer you help, is what convinces people not to seek counselling. How do you feel after sharing your secrets with a person, only to realise later that your matter is the talk of the town?” Another participant quipped in and said: “These people cannot be trusted, who knows that, after they have spoken to you, they would not tell their best friends about my matters?”

This is what some participants said about going for help:

- “I went for counselling when I had personal problems and I received it from my aunt and granny”.
- “I saw a doctor and nurse when I lost my parents”.

- “Mine was given by a psychologist and a social worker when my father did something at home that was very traumatic”.
- “I got mine from a friend and a sister during my failure at school”.

This study revealed that help is obtained from various places such as hospitals, elders of the family (grannies, uncles, and aunties), community leaders (pastors), psychologists, social workers, trained educators, and medical practitioners. These examples of counsel can be accessible by the poor and the rich of this environment, given the setting where this study was done, which has an element of an Afro-centric cultural-societal setting. The researcher does not have to be biased about the fact that counsel has always been provided by the elders in the societies, and still is the case today. Hence, in African communities, only a senior person can help to deal with the problems (Ngonidzashe & Douglas 2014:156).

3.2.5 The Difference Between Men and Women when it comes to Help, and Why

3.2.5.1 Gender Inequality

This study reveals that people differ when it comes to help and counselling, and there is a good reason for that: The difference between men and women is more apparent and evident. Researchers have shown that men seeking psychological services, are less common than women (Vogel 2011:368-9). One female participant attested to that by pointing out that “the gender issue contributes to when it comes to seeking help – men usually say ‘I will not be counselled by a female counterpart’”. This is also concurring with what a professional nurse participant said in relation to gender issues when it comes to help and counsel: “According to my profession, when a new client comes in – let’s suppose the condition they have, is to go through required HIV testing and counselling – we would encounter gender problems when it comes to this. Females mostly do not have any problem – their attitude is positive. For males, they will say ‘I will see to it some other day, but today I did not come for that’. It looks like, gender-wise, it has an affection on attitudes towards counselling”. He further elaborated on this by saying, “You can take ten women and ten men and tell the twenty to go to the Shigalo Clinic for testing. It may be that one out of the ten

men will come back having been tested, but the rest without being tested. For women, all will be tested, you can tell". Kessler, Brown and Broman (1981) agree that men are less likely to seek treatment than women, even when experiencing the same levels of distress. Vogel, Wester, Wei and Boisen (2011:368) cited one reason why men are under-utilising counselling services: It is because they have less favourable attitudes regarding seeking professional help than women.

When compared to women, men seem to be reluctant when it comes to seeking help, which is influenced by inequality between the two genders. Their attitudes towards seeking help is based on, what one participant said, "the view of oneself as belittling themselves by taking their problems to a counsellor and exposing their matters to strangers, or those who might be viewed as unequal to them. Therefore, it is a status issue".

A female participant, who is a psychologist, also expounded to this fact by saying: "In this scenario, men feel like exposing themselves to strangers and degrading themselves to the level of no significance in a society. This is due to cultural orientation that says men or boys do not easily cry. Men should be strong in handling their matters and not become weak like women who always vent their frustration easily to anyone, including strangers".

Traditional masculine norms, dictated by a dominant gender inequality society, state that men should be stoic, controlled, and self-sufficient (Mahalik *et al.* 2003). From an early age, boys are exposed to messages like "boys do not cry" (Newberger 1999) within a dominant culture of masculinity. This has no big margin in its variation to the group under study.

Another male participant cited a story that is culturally related: "As a young boy who went to 'initiation school', we were taught about manhood. We were told that men should not show weakness in front of women. A man's tears should not be witnessed publicly. From an early age we were told that 'boys don't cry' (*Mihloti ya ngwenya i mati*), meaning that a man's tears should be inwardly shed and not outwardly. When you cry, do not let people see that you are crying. Out of the many things that we have been taught from 'Man School', it boils down to one thing: Men should be

strong and tough, not weak. Therefore, African tradition simply indicates that men are not equal to women, so their status must be maintained by simply projecting a strong socio-cultural position in dealing with their inner issues and problems” (Oral Tradition).

Vogel *et al.* (2011:369) show that “these messages, such as boys don’t cry, have an impact of decreasing the likelihood of boys and men showing mental health symptoms to others, as they quickly learn that others will not respond in a positive manner. In fact, boys are always teased if they show weaknesses by crying”.

According to Vogel *et al.* (2011:369), there are four aspects of a dominant male gender role, and conflicts associated with “attitudes towards seeking help”, which are:

- Success.
- Power.
- Competition: restricted emotionality.
- Restricted affectionate behaviour between men: conflict between work and family.

These aspects have consistently shown their importance, resulting in negative consequences for self or others, and being non-help-seeking attitudes. This seems to be informed by men’s orientation of their socio-cultural setting, that tends to influence or formulate a certain belief system, robbing them of the opportunity to seek help.

The maleness issue seems to play a very integral role when it comes to help, and it still needs an answer to the reason behind it. In this study, men and women are not the same and are not treated equally. Patriotically, men are above women. Therefore, help is expected to come from a stronger person. The researcher would like to cite an anecdote that speaks volumes about why men have a higher resistance when it comes to help that involves women or strangers: “A certain widower became very sick. The family surrounded him and took care of him. He later called the family together with the pastor, asking them to release him to join his wife

in peace. When they tried to talk him out of that, and suggested to take him to the hospital, he simply smiled and told them that it is not because he is not taken good care of at home. Furthermore, he told them their service is much better than what he might receive in the hospital. Afterwards, he asked to see the pastor alone and stated his reason to the pastor – being touched and bathed by women makes him feels uncomfortable, so exiting this world would be better to him than accepting help from others who are not in a position of helping (bathing and caring for) him. As a highly-respected man, he said he would rather prefer to die with dignity, than in shame of being touched in places they are not supposed to be touching him”.

Speaking on a degree to which men adhere to masculine norms, dictated by a dominant culture in society, that varies on the basis of cultural factors across racial and ethnic groups, the emphasis on specific aspects of the male gender role differs in the sense that certain gender role expectations would take more importance than others (Vogel *et al.* 2011:370). This underpins the fact that, although many traditional values of how a man “should be” overlap across ethnic groups, they may vary in intensity and prominence (Vogel *et al.* 2011:370). For example, the one participant who is a professional nurse already showed this difference by referring to the problem of testing and counselling a gender-related issue that contributes to the way clients perceive and behave towards professional help.

To some men, this is culturally or traditionally embedded in an Afro-centric belief system of manhood. One male participant argued as follows: “Going to counselling, I feel like a failure. I dislike counselling. As you know, Africans have a fear when it comes to revealing their secrets. I have my pride in life – I do not want to look like a failure by going to counselling. You know that the government adopted the western way of doing things after we received our democracy (referring to counselling). As Africans, it is difficult to adapt to this (professional help) – Africans view counselling as a Western thing”.

The following pages will be focusing on culture and other related factors that contribute to the difference between men and women when regarding counselling. Gender inequality serves as a stumbling block for most men to seek and receive

help from those they consider unequal to them, when it relates to socio-cultural beliefs.

3.2.5.2 Socio-cultural Beliefs

Adding to a previous participant's statement, another participant elaborated by saying, "I perceive this (professional help) as an adopted thing from the Western culture, but spiritually, it is needed. And yet, culturally, it's difficult, because our culture does oppress this". This participant, according to his culture, feels restricted to open up to new ways of dealing with life's issues which are Western oriented to him.

3.3 Social Standing and Culture

Men, in general, are far less likely to seek professional help for marriage problems and other mental problems than women. Some men are more resistant than women when it comes to marriage counselling, with the main reason identified as masculine norms. Ideally, these are norms for success, power, emotional control, and self-reliance (Ngonidzashe & Douglas 2005:157).

A psychologist respondent shed some light on the social orientation of a client when talking about the challenges facing them. She said: "Men and women are different in our socio-cultural environment, which makes them to believe in a certain way that ends up influencing their perception on seeking help. For example, let's take the issue of dealing with a client's marital problems: I saw a lady, after which I asked the husband to join us. When he came, the first question he asked was, 'Are you married?' He believes that an unmarried person, who is also young and a female, will not be able to help them".

This is a gender issue that breeds a certain perception in relation to seeking help. It also prevents people from getting help based on their social status and age. Participant G highlighted the following: "Contempt based on age is apparent in seeking professional help amongst the people of colour. People say 'this pastor or person, who is going to help me, is such a child! What help would they give me?' This defeats the purpose of seeking help, according to me".

In traditional Africa, family rules dictate that if married couples experience marital conflicts, they should consult their elders to resolve the problems (Ngonidzashe & Douglas 2005:156).

Speaking on the gender-salient issue, a psychologist participant said: “Gender-wise, men will always be men. Men perceive themselves as higher than us (women) – it’s an upbringing that, as they grow up, they see themselves as higher than us women. They were told, when growing up, that ‘you are a tiger, you (*wena*)’ and you are a man, *wena*. So, power and age play a great role in self-perception, which affects how they view help and who offers it. They would undermine you and you would feel powerless. To me, I see it as a defence mechanism, putting himself in a safe position. Women are socialised. You are told that men are above you and you must respect them. So, when he says ‘Jump!’, you ask, ‘How high, sir?’ (*baba*). You do not ask why you should jump, because you are a woman – you have to do what he says. This is how women are socialised. Moreover, there are unhappy wives at home, but when you see them in the streets, you cannot tell, because they are trained not to reveal matters of their households. That is the way things are in our society. Even an upbringing plays a role. For example, if a girl grows up in a house where there is abuse, she will grow up thinking this is how things are supposed to be. It is a social setting for that girl, that will influence her view of life, including getting help if she finds herself in a similar situation like her mother. It is what we are exposed to that shapes us in life. You would not even know that a woman can say no to *baba*, or suggest that things are not done this way, because of the way you are socialised. It is a matter of a socio-cultural belief. Even though you have the groups where women sit and talk, you would still find women like this in this fast and ever-changing society. You find people like that in our societies”.

According to Ngonidzashe & Douglas (2014:155), some women, often of the working class, may resent counselling, because they perceive that they can live alone, or in singlehood. They may think that they no longer need a man in their life, so they may not seek counselling. Women who used to be oppressed, have been empowered educationally and psychologically. The media have campaigned for equal rights, and with the technological advancement in the form of Internet, women have been made to be aware of their rights. The enactment of laws which protect women, like the

Zimbabwe Domestic Violence Act (Chapter 5:16 1997), have been put in place, though it would appear that women do not understand the Act. Being educated, and becoming a breadwinner, women can choose to live with or without a man in their life. It seems that elite women no longer have the pressure to seek recourse through counselling, because they are now able to take care of themselves (Ngonidzashe & Douglas 2014:155).

Participant K mentioned the issues of *Kutivelana*, suggesting that when one knows the person's social standing, it makes them not to seek help from that person. The participant elaborated: "Knowing what is going on in the life of a person who has to counsel you, knowing that they have got similar problems like mine, I may not want to go and be helped by that person". Participant B took it further by saying, "The Influence of other people can make you not wanting to go for professional help. For example, when helpers are doing referrals, they even have some negative input about the person they're referring you to". Participant MK indicated an issue of one's perspective in social life: "Viewing problems as a personal thing, brings a negative attitude and view towards seeking help. It also makes one not to feel comfortable to discuss personal issues".

Lack of knowledge could contribute significantly to a person's self-esteem in society. Participant L attested to that when he said, "Self-esteem can cause one to go to counselling when one is confronted with problems. Let us take, for example, a rape issue, which has the power to develop a low self-esteem in one's life. Counselling can be used to boost low self-esteem, but your confidence is teared down. You might go because of what you went through". When considering this, one can tell that various things make up the build in one's social standing, that could end up having a significant impact in whether one is going to seek help or not. The researcher remembers one participant mentioning pride as an influential tool in determining the help-seeking search. He said: "The pride of a person, based on his or her social standing, has a bigger influence in seeking help or not seeking it at all". To Africans, it's the elders that give guidance to the young, not the other way around. "Age plays a big role regarding this issue", said participant G. Lastly, people are secretive, as another participant explained, saying, "People are secretive about their

issues in life. They do not want other people to know what is going on in their lives, so they are not open about it”.

According to another participant, revealing one’s secrets to strangers (meaning professional helpers), would be a sign of weakness. The other participants pointed to that issue as well by saying, “It might be considered a weakness by other men, and it would seem that you are failing to handle your own affairs and run your family properly. That, on its own, would render one to be seen as useless, and a weak person in society”.

To others, this secretive mindset is caused by several things that will be discussed later in the following pages – things like fear, trust, faith, and belief. Referring to religious beliefs, another participant pointed out something very interesting when she said, “Going for counselling, or seeking help from the pastor and others, would seem that one is weak in faith – you are not strong enough in your prayers”. The social standing of a believer in a community of faith stands to be questioned when one consults the professionals about their life’s challenges. Because of these and other varied reasons, many do not understand the efficacy of seeking professional counselling in their marriages or lives.

Accordingly, this study sought to find the perceptions of the Shigalo Tabernacle Worship Centre community on crises, illness, and seeking professional help. Therefore, a person’s social standing becomes the dominant narrative, and is used in the construction of the reality of this community.

One of the participants, in relation to seeking counsel as an African man, argued: “Culturally, it does not go hand-in-hand with my beliefs as an African man”. Yet another objected by saying, “Looking at culture, compared to the olden days, it hampers not with our tradition, because I believe that the elders used to help people with problems”. Again, speaking on the issue of seeking professional help regarding socio-cultural beliefs, and as to whether it goes against faith and culture or not, it was said that, “According to our faith, it’s okay, but culturally, it is not. The African culture encourages a person to keep his own secrets to himself, in order to make one strong. Telling your secrets to others is a weakness – it takes your manhood

away”. Moreover, another participant quipped in and objected, “Counselling, or seeking help, was there even in our African culture. In English, or Western, it is called counselling. Even in an African cultural way, it’s there. It’s called *Ku khalima* – trying to show us a way forward. Therefore, counselling does not fight against our culture or faith”. That shows that not all participants agree with the view that our culture and faith contradict each other. But does that say that culture has no influence at all on how one views the issue of professional help? The researcher would like to say that culture has an impact on that.

Another participant said: “Culturally and spiritually, it is okay. It isn’t going against it. Even on a cultural level, it’s okay – in the olden days, elders used to help (or correct) others who were in the wrong by doing counselling, yet it was not formal”. As participants voiced their views from both genders, they quipped in and said, “Culturally, it was there, but nowadays there are those qualified to do it. The difference is in the way we do it now. In the olden days, family members were used to correct or help a child”. The other participants concurred. One said: “It would appear that married couples do not always seek counselling when in need. In collectivist communities, some married partners may be exposed to the belief that the intervention by professional counsellors, pastors or VFU officers are tantamount to interference. This could be because some married couples may lack trust and may view counsellors as strangers” (Ngonidzashe & Douglas 2014:155). Men seem to be in support of this view in the community in which the study is undertaken. Yet, women don’t seem to be experiencing difficulties whatsoever when coming to faith and culture about seeking professional help, but have indicated that their failure to seek professional help is not aligned with culturally-embedded issues. This could be influenced by other factors, which will be focused on later in this chapter.

The entire focus group of men concurred that counselling does not clash with their faith and culture, but people’s views can influence men not to seek help when help is needed. Therefore, an understanding of men’s perceptions serve as a critical role for men seeking professional help. Vogel *et al.* (2011:368) claim that the number of men experiencing psychological concerns, but not seeking counsel, represent a mandate for counsellors to better understand the help-seeking process for men in order to target interventions that encourage men’s help-seeking behaviour.

People have a culture and a tendency of doing things because of seeing others do them. Other people's actions influence them to do certain things in a certain manner. One participant indicated this point by saying, "Having seen others in our society who have been to the professionals and received help, others get motivated (i.e. influenced) to go seek professional help".

In Africa, long before colonisation, the "round table" used to be quite effective as a way of resolving marital conflicts. However, some researchers have proved that modern styles of living have affected it, including the disintegration of the extended family, education, and media. In the old way of counselling, the aunt or uncle played a pivotal role (Ngonidzashe & Douglas 2014: 156).

This is what culture means to the society in which the study is conducted: Culture is an acquired trait of habit, skill, art, music, institution, food, etc., done within a society to a certain people in each segment of civilization (Gurley 1995:51). Zimmermann (2015), a live science contributor, who wrote his findings on culture, says "culture is the characteristic and knowledge of a particular group of people, defined by everything from language, religion, cuisine, social habits, music, and arts". The Centre for Advanced Research on Language Acquisition goes a step further, defining culture as shared patterns of behaviour and interaction, cognitive constructs, and understanding what's learned by socialisation. Thus, it can be seen as the growth of a group identity, fostered by social patterns, unique to the group.

Culture is a people's way of doing things, created (constructed) by the group (Khoza 2000:50). We, as Africans, have our ways of living and doing things. When that gets interrupted, it brings a lot of problems, bringing people to a standstill and making them seek help/therapy. Our cultures produce our religion. That is our way of feeling, thinking, believing, and the knowledge that makes up our spirituality. Hence, STWC has a culture of her own, which is informed by her belief systems as a community of faith. This is undertaken in religious beliefs.

3.3.1 African View

Culture makes one to uphold certain values. By values, the researcher means that which is perceived to be true, and that which is beautiful. All people are raised and

socialized within a cultural context, which formulates their world view regarding truth and beauty. The culture which a person upholds, will make them formulate a world view, which could be an African, Asian, or Western world view.

The researcher prefers to explore an African world view, because it would best suit this study. In this African view, the researcher also wants to indicate where the emphasis lies. In an African view, it is the community which defines a person. The emphasis placed on community is its most central and all-pervasive characteristic, universally embodied in its customs and institution. An African society puts more stress on the group than individuals, more on the communion of people than on their autonomy. But it does not mean that it ignores the individual or solidarity. It means that it bases itself on the general activity of the group. The African society is famous for its notion of the extended family – capable of extension to include anyone, not only those related by blood, kinship or marriage (Oral tradition). This must be understood from the philosophy of *Ubuntu* – inclusive African humanism. It is an integrated, multifaceted, cultural practice where a human being is understood to be sacred, and is treated as such, to the extent of loving one's neighbour as oneself.

Khosa (2000:88-89) further elaborates on African humanism by discussing the three pillars of *Ubuntu*:

- The pillars of *Ubuntu* are interwoven and communicated through a usage, sharing of edibles, and respect.
- The second pillar of *Ubuntu* is sharing of food.
- Respect of the elderly people in the community.

Respect is directly linked to *Ubuntu* and the culture, interwoven with the gestures and norms of the community. Yet, the researcher also understands that respect can be misunderstood as fear, where, in some cases, people in these settings actually mean “you must fear me”, when they demand respect.

Mazrui (1980:13-29) highlights several functions of culture that are critical in the understanding of an African epistemological perspective world view:

- a) Culture provides lenses of perception and cognition.

- b) Culture provides motives for human behaviour.
- c) Culture provides criteria of evaluation.
- d) Culture provides a basis of planning.
- e) Culture provides the system of production and consumption.

Here, the community of faith under study looks at help through the lenses that their culture provides. To them, counselling is a Western-adopted practice that do not fit in their African context (Lartey 1997:51), as this study pointed out earlier with a couple of participants' views surrounding professional help and counselling.

Concisely, their views are influenced by African customs, values, traditions, and unison that African people uphold. However, the researcher knows that cultures differ from one tribe to another. One would have to consider cross-cultural communication in exploring the dominant narrative of this research to see if one can learn from other cultures when it comes to seeking help and counsel.

3.4 Religiosity

The question of how people perceive professional help as it relates to their faith and culture was presented to the participants in the following way: How do you perceive (see) counselling in relation to your culture and faith? In order to fully comprehend that, a bit of clarity was needed regarding the cultural setting of the STWC community of faith. This could not have been achieved if the study did not look at culture in an African context and related it to what it means to have faith. This explanation was done to encompass and check the influence of an African world view with the views of the participants, to avoid bias.

Belief systems are the determining factor when it comes to seeking help. Khoza (2000:51) defines beliefs as “something that would include myths and superstitions, beliefs about God, about reality, or an ultimate meaning”. A participant elaborated on this by saying, “Belief systems are the one thing that will determine whether you seek professional help (counselling) or not. When you are a Christian, there is a feeling of saying, ‘I should be able to solve my problems or sort out my own challenges, because God is there’. And I believe in God. To show that I cannot deal

with my issues, it looks like I am saying God is not there to help, and it also suggests that I am weak in my faith”.

Another respondent said, “Help, in relation to faith, is something that shows weakness to my faith”. Another quipped in and said, “Going to seek help from other institutions would mean that I am not strong enough in my faith. As a result, it would indicate, or serve as a sign that, I am not praying enough and my prayers are not strong enough”.

Another respondent also supported this: “Telling others about your problems, as a believer, looks like you are not praying enough, or are strong enough in your prayers”. A lack of faith in a counsellor, or the person helping you, can put a hold on counselling and change your view on the outcome. Another participant said: “Belief systems can make me not to go for professional help. For example, if they are a witch doctor, who also holds a profession of counselling, and I am a Christian, then I would not feel comfortable around that person, so I would not go or continue with that help”.

The entire focus group of men concurred that counselling does not clash with their faith. Taylor (2000:74) conducted a study on mental health services in faith communities, focusing on the role of clergy in African churches. These are some of the things that the research came up with: African adults display high levels of religiosity across a variety of religious indicators, including membership rates and frequency of public behaviour such as church attendance, as well as private devotional practice (example, prayer and reading religious materials). He furthermore states that there is an equally long tradition of faith-based initiatives, and work in African communities has been concerned with the well-being and health of individuals and families (Gilkes 1980; Levin 1984; Olson, Reis Murphy & Gean 1988).

A growing literature shows that religious factors are linked with specific behaviours affecting health, such as drug, alcohol, and tobacco abuse (Brown & Gary 1994; Cochran, Beeghley & Boch 1988; Gottlieb & Green 1984). In addition, studies indicate that religious involvement is associated positively with life satisfaction, self-

esteem, and other aspects of well-being and self-related health, and is related inversely to depression and distress, long-term physical disability, and mortality. Collectively, these works show that the study of religious involvement may provide a unique insight into the health-related status, behaviours, and attitudes of defined groups within the population (Taylor 2000:74).

Therefore, religious faith influences behavioural issues. These behaviours may suggest that there is weakness in one's faith and prayers if one consults a professional counsellor. Yet, other participants differ from this view – one can concur that the majority of female participants are of the view that seeking help can be impeded by the concepts they hold. One needs to listen to the voices of others.

Here are some of these “voices” regarding faith and seeking professional help: “In my opinion, professional help and counselling goes together with my faith. It does not fight against my faith. It does not negatively affect my religion. It's about getting help. We are not going there to worship or serve anything, but purely for help. You can go and come back to continue with whatever things you were doing”, said one participant. Another one elaborated by saying, “Some counsellors or professional helpers go to church. Others even add some scripture during the session, so counselling does not clash with my faith”. One participant commented on the question of belief systems, saying, “Yes, according to our faith, it is okay”. Another respondent said: “Spiritually, it is needed. It does not disturb one's faith at all, but breeds peace and new perspectives, which would eventually enhance your spirituality”.

Enlightenment was brought forth when a participant quipped in and said, “Even though you might have a different religion, when it comes to counselling/professional help, we ignore the religious belief or cultural things, and get the help we want”. The belief system has a way of influencing one's perception towards crises, illness, and seeking professional help. Looking at it from the pastoral perspective, which includes religious beliefs, one would ask a question as to why community members of faith do not use the pastoral service at their disposal in dealing with illness and crises as a helping system.

Some light was shed on the subject by the psychologist respondent when saying, “Now I am picking it up – even at the church, you find people looking at the pastor as a preacher, and not a therapist, because of the lack of exposure in this area. This is a challenge. They look at the pastor preaching in front of them, opening Job 5:2; then they have to come for counselling. Are they able to switch from seeing you as a pastor to seeing you as a counsellor? On Sunday, you are a preacher, but on Monday, they tell you about their marital problems. To them, when you preach about marital problems, there is a conflict of interest, or a dual relationship. In dual relationships, there are conflicts of interest where you find yourself playing different roles. And the people find it difficult to relate with you when comparing both roles, yet they would choose that you become their pastor, not their therapist. It becomes difficult to shift roles, and see you as a system of help and where they would be comfortable with talking about their problems and still not hear them anywhere”.

In rounding up, the ways in which people deal with the issues of life can be a means to measure their strength in faith and their relationship with God. This can be detrimental in regard to getting help. Looking at the above information brings one to a conclusion that it all boils down to one’s own religious beliefs. Some of these perceptions are the determining factors in getting help or not.

3.5 Stigma and Fear

While the focus of this study was on the perception of helping people, stigmas and fear became prevalent reasons for many to avoid help. One gender-salient variable, that has recently been identified as a barrier to seeking help, and is more proximal to attitudes toward counselling, is stigma. Vogel *et al.* define self-stigma as the internalization of negative views of a society towards mental illness and seeking help (to believe oneself as inferior or weak for needing counselling) (Vogel *et al.* 2011:369).

One participant attested to this by stating: “As a man, others might think of me as a weak man who allows the matters of his house to be dealt with by strangers, and they might begin to say all sorts of things about me and call me names”. Another participant added, “People feel like they are shaming themselves when going for counselling or seeking help”. Many of the participants are in accord with this line of

thinking that one of the major impediments in seeking help, whether it is professional or not, is stigma, and the fear attached to it (being afraid of the attachments of stigmatization).

According to Vogel *et al.* dominant male gender, based on self-reliance, avoidance of weakness, and stoicism, may lead to a greater self-stigmatizing perception, and subsequently be linked with less positive attitudes towards counselling (Vogel *et al.* 2011:370). They further urge that, although this pattern may be true for many men, the strength of the relationships between these factors may depend on cultural and demographics factors (Vogel *et al.* 2011:370).

This view is supported by most men that were interviewed in this study. Most of the ladies do not share these concerns when it comes to seeking help, even though some have shown great concern. Men, in general, seem to be more concerned when talking about their issues with “strangers”.

The importance of independence, social harmony, and saving face for one’s family may all serve to magnify the influence of self-stigma around seeking help (Vogel *et al.* 2011:370). One risks bringing not only shame on oneself, but also disgrace on one’s whole family (Shea & Yeh 2008), as a participant indicated when saying, “Another reason is that people are afraid to be laughed at by others when they go for counselling. This is a thing caused by slandering – people will call you names and say you are weak in your faith to deal with your matter as a leader of house”.

Vogel *et al.* (2011:371) speak of cross-cultural studies that support the idea that stigma, in particular self-stigma, is a relevant factor, and that self-stigma can vary between cultural groups, as it does across demographic groups. Thus, the role of stigma in the help-seeking process, for men in different racial and ethnic groups, needs to be explored further.

The assessment of the relationship amongst masculine norms, self-stigma, and attitudes of men across different racial and ethnic backgrounds should help clarify how these factors operate for men (Vogel *et al.* 2011:371). They have hypothesised, from the beginning of their research, that conformity to dominant masculine gender

roles will be positively linked with attitudes towards counselling. The results showed that men with a higher endorsement of dominant masculine belief, have less favourable attitudes towards seeking psychological help. It also showed that this is partially mediated by the degree to which men experience self-stigmatization (Vogel *et al.* 2011:375).

Eisenberg, Downs, Golberstein and Zivin (2009:2) say that mental health problems at a young age are associated with adverse academic, occupational, health, and social outcomes, suggesting that timely and effective treatment may offer substantial long-term benefits. The stigma associated with mental illness has been identified as a key attitudinal factor that may impede mental health service use. Therefore, stigma serves as an impediment in seeking professional help.

According to Eisenberg *et al.* (2009:2), public stigma is defined as a negative stereotype, and prejudice about mental illness held collectively by the people in a society or community (Corrigan 2004).

The perceived public stigma is commonly referred to as an individual's perception of public stigma, while self-stigma occurs when an individual identifies oneself with the stigmatized group (people with mental illness), and applies the corresponding stereotypes and prejudice to themselves (Eisenberg *et al.* 2009). The interplay of the two could be blamed for the hindrance to seeking professional help.

It suggests that stigma could be a formidable barrier to seeking help. Personal stigma and self-stigma may deter individuals from seeking help if it implies acknowledgment of their own mental health problems, and if the individual's negative attitude about people with mental health problems would harm their own self-esteem (Eisenberg *et al.* 2009:3; cf. Corrigan 2004). This is in line with Participant G's conviction that he does not want any help, because of public stigmatization: "...stigmatization and fear of your secrets to be known by the public".

A higher personal stigma prevents people from seeking professional help. Studies examining people's own stigmatising attitude have generally found that a higher personal stigma is associated with people less likely to seek help amongst both

adults and adolescents (Cooper, Corrigan and Watson 2003). It further elaborates on another study done by Mojtabai, Olfson and Mechanic (2002) that found out those participants who reported embarrassment associated with mental health treatment, were less likely to perceive a need for help or use of mental health services, although this study did not distinguish between personal stigma or a perceived public stigma.

In a community-based study, Kessler *et al.* found that one in four people who perceived a need for help, did not seek it because of concerns about what others might think (Kessler *et al.* 2001). The researcher in this study measured seeking help by asking whether they have undergone any form of counselling during their challenging moments. It also asked whether they would seek counselling if the need arises in their lives. Eisenberg *et al.* (2009:9) state: “Most people would think less of someone who has received mental health treatment when compared with responses to the analogous personal stigma item”.

There is an estimated association between stigma and the three measures of help-seeking – perceived need for help, use of psychotropic medication, and use of therapy or counselling – in that personal stigma is associated with a lower likelihood of each measure of seeking help. In contrast, a perceived stigma was associated with a significantly higher likelihood of using medication or therapy. Personal stigmas of students who used medication was associated with a lower likelihood of medicines being prescribed by a psychiatrist, where the perceived stigma was not significantly associated. Students with a higher stigma were less likely to report that they decided to seek help, compared with students with a low personal stigma (Eisenberg *et al.* 2009:10-12).

Eisenberg *et al.* (2009:13) refer to other reasons for not seeking help: being encouraged, pressured, or forced by a friend, family, or other person receiving more information about treatment options. There was no significant difference between low and high stigma groups. The conclusion is that personal stigma is significantly associated with a lower likelihood of receiving non-clinical support, where the perceived stigma was not. On the other hand, students reported a willingness to talk to academic personnel about mental health problems. This was negatively

associated with both perceived and personal stigmas, though neither estimates were significant at conventional levels (Eisenberg *et al.* 2009:13). To have a higher personal stigma, one must have a high perceived stigma. It seems to support the idea that personal attitudes are significantly shaped by prevailing public attitudes; the awareness is a precursor to agreement with stereotypes. It goes on to explain that people with a high personal stigma do not want to face cognitive dissonance associated with admitting to intolerant views that others do not hold, so they choose to assume that others share their views (Eisenberg *et al.* 2009:14).

Other studies have found that African-Americans report less stigmatizing views about mental illness and mental health service, though they are less likely to use these services (Align, Albert, Link, and Phelan 2008; Mojtabai 2007). Asians and Latin-Americans generally report more negative attitudes toward mental health treatment than other groups (Ojeda & McGuire 2006; Shea & Yeh 2008; Zang & Dixon 2003). As for age, while recent trends suggest that young adults hold more favourable attitudes than previous cohorts, young adults also endorse more stigmatizing views and use fewer services compared to the older adults (Mojtabai 2007; Ojeda & Bergstresser 2008).

Colberstein, Eisenberg and Epllust (2008) indicated the reasons for not seeking or using mental health services:

Perceived stigma was higher among males, older students, Asians, Pacific Islanders, international students, students with a lower socio-economic status background, and students with current mental health problems. Perceived stigma was also higher among those without any family members or friends who had to use mental health services and among those who believed that therapy or medication is not very helpful. Perceived stigma was negatively associated with the likelihood of perceiving a need for mental health services, but only among younger students. Among those with probable depression or anxiety disorder, there was no evidence that perceived stigma was associated with service use. In conclusion, these results suggest that, at least in this population, perceived stigma may not be an important barrier to

mental health care as the mental policy discourse currently assumes.

Yet, one must notice the fear which is attached to stigma. This fear does not mean that it is only stigma-related, but it is more a fear of sharing one's secrets. In this study, fear has been revealed as one of the reasons why the community of faith avoided help at some points in their lives. Here are some of the things they had to say:

- “Fear to be laughed at, and not feeling comfortable to discuss personal issues”.
- “Fear stands as a stumbling block to people who must seek help”.
- “Stigmatisation and fear of your secrets to be known by the public”.
- “Fear of your secrets to be made known to the public. We are concerned about confidentiality issues”.

Participant MK elaborated: “To me, my problems are personal matters. Therefore, when I go and tell someone about them, I fear that they would laugh at me, thinking that I am too weak to handle it. I am not feeling comfortable about discussing my personal issues with others”. Another participant added: “Fear contributes a lot, for we are afraid that others will come to know our personal matters; fear, confidentiality, or the issue of trust. Fear and lack of trust are the reasons why we are avoiding help from other people, and deciding to keep our matter to ourselves”. One male participant said, “I fear that the matters of my house will be shared to strangers”. Another female participant reiterated the point and said, “This is fear to reveal the things that trouble them, for they think that sharing their issues, exposes them. They are trying to hide things that cannot be hidden”. Another one interjected with a strong facial expression and said, “Bad-mouthing in counselling makes people afraid. For example, going to trauma therapy – people say the questions that are asked, would provoke or scratch the wounds”. One participant drove the point home when she said, “It is the fear to face my reality and the refusal to admit that it ever happened (denial)”. This was also articulated by the professionals that were interviewed. They are of the view that people are afraid to face the reality of their lives. The fear of what might happen to their status is exactly what they do not want to hear.

Treatment, fear, and not being comfortable with self-disclosure (Vogel *et al.* 2005:461) are some of the determinants that make people avoid seeking professional help. Some of the factors that influence the decision to seek professional help, are social stigma, self-concealment, anticipated risk, anticipated utility, distress, social support, previous social support, and gender. The intention to seek help for inter-personal, academic, and drug/alcohol issues seem to be a great influence in seeking help. These are mostly found in places where help is offered professionally, as it encompasses those areas.

Treatment fear is all about the fear of how they will be judged negatively for seeking treatment. The fear of being pushed to think or do things they do not want to, serves as another concern, as well as self-disclosure (Vogel *et al.* 2005:459-470). The participant who was involved in the car hijacking, narrated his story by indicating: “After I experienced a car hijacking, I became so afraid to drive. I hated driving the wife. To help with the problem, she then called the pastor”. His fear was due to a car hijacking, which needed treatment of some kind for him to drive again.

3.6 Socio-economic standing

Boisen (1936), a pioneer in the field of pastoral care and pastoral counselling, is of the view that “crises are not simply fraught with danger: they also offer opportunities for spiritual and emotional growth, since crisis management heightens emotional and intellectual activity”.

One participant, code-named MP, spoke of professionalism as a thing that is costly and can influence people negatively in seeking professional help, stating: “Professionalism involves money. Seeking professional help might be costly”. Therefore, if one is not financially stable, then such help might be difficult to access. Participant BB interjected and said, “No, you do not need money, for one can come to the pastor – he would not need money. The clinic for HIV counselling, social workers, and even psychologists, do not need money. It’s a mind system (meaning a mindset)”. This has to do with the thinking pattern of people based on the knowledge they have. According to the participant code-named NT, it is a lack of information.

Other people in this study happened to avoid help, not as a result of help being costly from a professional point of view, but because of the fear that they might lose the very system of financial support. The following anecdotes might shine more light on the picture. The one participant with the financial challenges said, “From the experience of seeing the pastor, I was given the mechanism and skills to cope with my financial predicament”. Earlier, the researcher cited an observation which led into a crisis. Should the financial predicament of this household be dealt with differently, maybe the story of this family could be different.

- **Anecdote 1 (the statutory rape case)**

The observatory story goes like this:

A father slept with his daughter for more than ten years. This went to the extent of fathering a child with her. When the matter came out of the closet, the father was arrested, and then released on a bail charge of R10,000. Later, the case got cancelled, because the mother and the daughter decided to withdraw the case in the interest of financial sustainability of the family, since the father was the breadwinner. The family said that if they are to send him to jail, this would result in financial hardship for the family.

This incident affected the mother of the house psychologically. However, she never sought to get professional help. This became the talk of the town. She later went for help to one of the leaders in the church, who asked if the matter was reported to the pastor. In the process, the mother of the house was advised to seek professional help in counselling, but it was all in vain.

- **Anecdote 2**

The researcher had an unplanned discussion with a lady who oversees one of the clinics in the Vhembe district area, which was not included in this study. She told a story of a lady who came to the clinic, bringing her child. She had a big scar on her right hand which looked fresh and recent, but never received medical attention. The nurse asked the lady about the wound. Her response was simple – she told the nurse that it was nothing to worry about. Her narrative was that she had a small fight with her husband because he did not bring home any money.

The financial crisis of this house led to an injury that never received medical attention. Seeking help did not occur, because the wife took the fight lightly. According to the lady, the man spent all the money on other women, so the right of fighting with her husband does not need medical attention, because going to the clinic may cause the police to get involved.

The circumstances of the above-mentioned anecdotes might have been different if the socio-economic standing was different. Choosing to seek help would perhaps have been influenced differently. According to Ngonidzashe and Douglas (2014:155), some women, often of the working class, may resent counselling, because they perceive that they can live alone or in singlehood. They may think that they no longer need a man in their life, so they may not seek counselling.

There can be many factors that contribute to crises. One's economic standing in a society could contribute a lot. This is seen in the bargaining people are willing to do when it comes to help. Gazi-Moghadan (2009:47) wrote about Iranian clients, especially the older ones who have lived the majority of their adult lives in Iran. They would follow a social tradition of bartering for fees in the United States. In this case, they would like to bargain the therapy fee and bring it down to a more suitable level for them, rather than accepting the standard fee for service.

3.7 Conclusion

The participants describe crises and illness as something that, when attached to stressors, constitutes weakness to deal with whatever threat is attached to it from their side. To them, there are different factors that contribute to what constitutes a crisis. For example, the death of a breadwinner, or loved ones in a household; failure at school; chaos in the family, resulting in abuse or rape; and separation or divorce amongst married couples.

Therefore, the negative interpretation of a crisis is when the story of their lives no longer flow in a linear manner. In other words, the narrative resources from the past and the present cannot explain the events of the present, thereby bringing a clouded and darkened view of the future. This also includes illness that serves as an unusual human condition, which disrupts a person's life – posing danger to a normal course

of life, and isolating the patient from his or her familiar environment and social contact (De Jongh van Arkel 2000:81).

Causes of crises and illness are perceived differently by the respondents. This is seen by seeking different interventions when crises and illness strike. The places where they go to for help, is echoed by personal belief. Such belief systems differ as per individual. This is due to traditional or religious beliefs. Therefore, crises and illness are socially defined.

The definition of professional help by the respondents may simply refer to help given by the professionals in their field of expertise – medical practitioners, professional nurses, social workers, psychologists, pastors, and educators. Yet, help to them can be given by someone in the family, who is older or experienced in certain areas of life.

This study discovered that most people who went for help, did not go for professional help, but leaned towards help from a round-table exercise, falling within African tradition. It was also revealed that there are differences between men and women when it comes to seeking help, and why it is the case. The factors influencing those differences, just to mention a few, are:

- Gender inequalities.
- Socio-cultural beliefs, which include their social standing in a society and the influence of culture.
- Religion.
- Socio-economic standing.

CHAPTER 4

Synthesis of research report and information integration

4.1 Introduction

The focus of this chapter is to seek and understand the perceptions and attitudes of the people of the STWC community within the context of their faith and culture, trying to determine what narratives are informing these perceptions and attitudes toward seeking professional help.

To come to an understanding of people's perceptions and attitudes, one needs to explore three vital research questions:

- What are the dominant narratives that are used in the construction of these perceptions and attitudes towards professional help?
- What kind of realities do these constructions within their world view create, and do they offer stories of hope for the future?
- How can these constructions be deconstructed to open the possibility for re-imagined stories of the future?

This chapter will be argued using the literature and the researcher's own observations of these realities. Most of these are orally transmitted from one generation to another, which end up forming the cultural belief systems of the community in which the research is conducted.

4.2 The Dominant Narratives that are used in the Construction of these Realities

The question we are exploring is, "What are the dominant narratives that are used in the construction of people's perceptions and attitudes towards professional help?" This question seeks to explore the dominant stories that are used in the construction of these realities. The dominant stories relate to gender inequality, socio-cultural beliefs including social standings and religiosity, socio-economic standings of families and individuals, stigma and fear, and the educational level of individuals

within the community of faith and their family support systems revealed, as discussed in this study.

These dominant narratives are the determining factors for the people seeking help, whether it is professional or in a round-table format – help given by the elders in a family or community, eventually shaping their lives. The researcher agrees with Morgan when she says, “All stories are constitutive of life and shape our lives” (Morgan 2000:8). Therefore, these are the stories that shape the community of faith under study and constitute to their perceptions and attitudes towards seeking help.

These dominant realities are considered methodologically within the narrative metaphor and social constructionism of a postmodern world view as a metaphorical framework, informing the overall academic reflection process (Freedman & Combs 1996:1). This helped the study to map the narrative practice processes of the community under study (White 1996), which eventually led to people’s perceptions and attitudes towards crises, illness, and professional help.

An individual interpretation of crises, illness, and professional help was sought from the four ideas of a postmodernist world view, classified by Freedman and Combs (1996:23):

- Realities are socially constructed.
- Realities are constituted through language.
- Realities are organised and maintained through narrative.
- There is no essential truth.

A postmodern world view of reality, narrative, and social construction gives useful ideas of how power, knowledge, and truth are negotiated in families and larger cultural aggregations. There is no truth, for truth is relative in a postmodern world view. It is about an attitude, ethics that is drawn in from it, and the relationships it supports (Freedman & Combs 1996:33).

Yet, Graham (1996:1) urges that “the philosophical mood of a postmodern world view is one of scepticism towards any notion of an eternal, metaphysical human

nature. The individual is always a cultural subject, inscribed in linguistic, historical, and social contexts”. To Graham, postmodernism also emphasizes the indeterminacy and fluidity of identity and knowledge, and the rootedness of selfhood in a social context.

Returning to the idea of no essential truth in a postmodernist world view, Meylahn (2010:16) gives a proper explanation of this statement:

This truth is a narrative truth. It is not an analytic truth that can be proven through scientific theories, but it is a truth that is known in the experience of liberation. In other words, it is a metaphoric (narrative) truth that gives truthful or appropriate meaning (interpretation) to an experience, and this is known as truth.

He further states that one can test the truthfulness of a narrative by the necessary interrelation between narrative and character (Meylahn 2010:16). Therefore, the researcher tested the truthfulness of these dominant narratives, and found that “all stories are constitutive of life, and shape our lives” (Morgan 2000:8). To this community of faith, perceptions and attitudes in life towards professional help are shaped within the context of their dominant narratives of social realities. For example, one participant articulated the reason he should not go for help. He said, “Going for counselling as a man makes you look like a failure, because one is failing to manage the affairs of his household”. The stigma attached to failing makes people to avoid help. Therefore, the environment, where there is stigmatisation, has an influence towards people seeking help.

The researcher agrees with Morgan’s argument: “There is always a context in which the stories of our lives are formed. The context contributes to the interpretations and meanings that we give to the events” (Morgan 2000:9). She further explains that the context of gender, class, race, culture, and sexual preference are powerful contributors to the plot of the stories by which we live (Morgan 2000:9). Therefore, the context of the community under study is no different from that which Morgan had articulated, where gender inequality, socio-cultural beliefs, socio-economic standings, stigma, and fear are the powerful contributors to the plot of the stories by

which the community of the STWC live by. It also shapes their perceptions and attitudes towards seeking help.

This takes us back to an anecdote of a male participant, who requested to be allowed to join his beloved one, as he could not take the issue of being cared by a female counterpart after the death of his wife. The context in which he found himself was a bit embarrassing to him, so he stopped them from caring and helping. According to this man, not a single female had the right to nurse him other than his wife. This is espoused by the values that he upholds in life, derived from a particular religious institution that is culturally embedded within the value system of the community. Values are concepts and beliefs pertaining to describe end-states or behaviours, which transcend specific situations, guide the selection or evaluation of behaviours and events, and are ordered by the relatives' importance within each individual (Francis, Kay & Campel 1996:424). What was important to this man, was his dignity as a masculine human. He was prepared to die, for he valued his manhood more than his life. The values that guided his life created a certain perception and attitude towards crises, illness, and seeking professional help. Speaking of values, one needs to understand that they are the standards by which people measure themselves. Without these values, individuals may pursue behaviours that are not in line with their own value systems, which may lead to behaviours that the institution does not encourage.

The questions regarding values for this study are: What are the values that the STWC promote? Are the community members adhering to these values? Due to the scope of this research, we are not going to elaborate into these values.

4.2.1 Gender Inequality

Gender inequality becomes one of the dominant narratives in informing the decision taken when faced with a crisis or illness. When this is compared to the metaphorical element of realities that are socially constructed, one can understand the society in which this community found itself in a socio-cultural environment, which shows the imbalance of homeostasis towards gender equality. This simply means that gender is not treated equally in this setting. In this context, males seem to enjoy certain privileges compared to females.

The researcher observed that to be a male in this context of gender, inequality gives one certain privileges compared to female counterparts. In the socio-cultural environment, males are not permitted to do house chores. They cannot cook or clean the house. These are chores relegated to females. Even when it comes to the church setting, there is a site that males would occupy where females are not supposed to sit. Preaching is considered a man's work. A woman can only be a programme director at the most.

As a feminist, Graham advocates a strong view of this syndrome. Her voice echoes the following: "Women's unequal position in a society has gone unchallenged by the churches, because pastoral theology has been caught in a paradigm of 'sexism and clericalism', which implicitly disavows the expertise of lay people and especially women" (Graham 1996:48). She continues: "Clearly, there are complex ethical and political dimensions to the caring relationship, and it cannot be assumed that counselling or helping is immune from the values and power structures of society at large" (Graham 1996:49). The emphasis is on the mutuality of care in contrast to the formality and hierarchy. For this setting, the researcher focused on the societal formality and its hierarchy that causes the dynamics of power and difference of gender, class sexuality, and professionalism.

The patriotic language of this community is that women are not regarded in the same manner as men. There are things expected of women that are not expected to be done by men, and *vice versa* (Freedman & Combs 1996:12). When articulating another idea that they first encountered through Erickson, which continues to inform their practice, they state that "experiential realities are constituted through language". For them, language has a constitutive power. This means that language can lead to a particular altered state of consciousness.

Within this community, there is a saying that is impartial to males, stating: "Boys do not cry". This breeds a certain state of consciousness to these "boys" that end up having an impact on them, and influencing their perceptions and attitudes towards help centres. These perceptions and attitudes have their origins from the larger cultural context of the divisions of males and females and their roles in society. How is this perpetrated through language?

Traditional masculine norms, dictated by the dominant gender in an unequal society, state that men should be stoic, controlling, and self-sufficient (Mahailik *et al.* 2003), because from an early age, boys are exposed to these kind of messages (Newberger 1999). In this way, African tradition indicates that men are not equal to women. Their status must be maintained by projecting a strong socio-cultural position in dealing with their inner issues and problems (Oral Tradition).

Vogel *et al.* (2011:369) show that these messages, such as “boys don’t cry”, have an impact of decreasing the likelihood of boys and men showing mental health symptoms to others, as they quickly learn that others will not respond to it in a positive manner. In fact, boys are always teased if they show “weakness” by crying. Comparing the ratio between male and female participants, the researcher found that most male participants have less contact experience with help centres compared to their female counterparts, because the so-called cultural setting, bred by the language, is used in the construction of a man’s role within this society.

According to Vogel *et al.* (2011:369), there are four aspects of the dominant male gender role and conflicts associated with attitudes towards seeking help: success, power, competition, and restricted affectionate behaviour between men, referring to conflict between work and family. These aspects have been consistently shown to be important, resulting in negative consequences regarding help-seeking attitudes. This seems to be informed by the men’s orientation towards their socio-cultural setting, turning into influence or formulating a certain belief system that robs men of the opportunity to seek help.

The male issue seems to play a very integral role when it comes to help. In this study, contextually, men and women are not the same and are not treated equally. Within a patriarchal system, men are viewed to be above women. In such a system, help comes from the stronger person – males do not ask for help, they give help. The researcher would like to cite an anecdote that speaks volumes to why men have higher resistances when it comes to asking for help from women or strangers in particular: The degree to which men adhere to masculine norms dictated by a dominant culture in society varies, based on cultural factors across racial and ethnic

groups. The emphasis on specific aspects of the male gender role differs, i.e. certain gender role expectations take more, or less, importance (Vogel *et al.* 2011:370).

This simply says that, although many traditional values of how a man “should be”, are overlapping across ethnic groups, they may vary in intensity and prominence (Vogel *et al.* 2011:370). For example, as stated earlier by one participant who is a professional nurse, this became clear by citing the problem of testing and counselling a gender-related issue that contributes to the way clients perceive and behave towards professional help.

Researchers have also shown that men seeking psychological services are less common than women (Vogel 2011:368-382). Kessler *et al.* (1981) found that men are less likely to seek treatment than women, even when experiencing the same levels of distress.

Vogel *et al.* (2011:368) stated that men underutilise counselling services: “They have less favourable attitudes regarding seeking professional help than women”. This explains how these people perceive help – to them, realities are socially constructed (Berger & Luckman 1996:58). Luckman attests to this by saying, “Realities are constituted through the passing down of certain generational family traits” (Luckman 1996:60). This became the linguistic turn of the STWC community.

4.2.2 Socio-cultural Beliefs

As has already been stated, men in general are far less likely to seek professional help for marital and other mental problems than women. Men are more resistant than women when it comes to marriage counselling, with the main reason identified as masculine norms. Ideally, these are norms referring to success, power, emotional control, and self-reliance (Ngonidzashe & Douglas 2005:157).

In traditional Africa, family rules dictate that if married couples experience marital conflicts, they should consult their elders to resolve the problems (Ngonidzashe & Douglas 2005:156). This fits well within the group under study, as mentioned earlier that round tables have been the practice of the community.

Wembley (1979) explored pastoral care in the black church. He defines pastoral care as “the bringing of, upon people and families in crises, the total caring resources of the church – using its four functions of pastoral care for liberation, which are worship, care, nature, and witness”

Lartey discussed this practice in relation to counselling, and said the following about Wembley: “Counselling, to him, is a western practice, not an African practice. It is a western practice developed under the influence of a discernible social, political, ideological, and cultural trend” (Lartey 1997:55).

In Africa, long before colonisation, the round table, as a way of resolving marital conflicts, used to be quite effective. However, some researchers have argued that modern styles of living have affected it, including the disintegration of the extended family, education, and media. Some people of the community under study are of the opinion that help existed prior to colonisation: it was provided by the elder members of the family. However, help which is done in a professional manner in this regard, could be associated with counselling, and is not considered to have been part of the African tradition, but would be seen as part of western modern culture.

One needs to understand that the values and ideals espoused by the counselling profession seem to be well-suited for a post-Christian, post-political society. They provide a way of being loving, helpful, and kind without being religious (Lartey 1997:55). This suggests that, even though counselling might not be considered to be of an African descent, the values and ideas espoused by counselling cover all people without considering where they are from, culturally or religiously, in a society. Here, the issue and the matter at hand are being dealt with. These values and ideas go beyond a post-Christian, post-political society.

When referring to an Afro-centric belief system, the researcher is specifically referring to the beliefs that emanate from an African culture, which ends up influencing the meaning (interpretation) of help and how the community perceives it. Therefore, it would be best to indicate what is meant by culture. Culture is an acquired trait of habit, skills, arts, music, institutions, and food, done within a society to a certain people in a given segment of civilization (Gurley 1995:51). Zimmermann

(2015:19), a life science contributor, wrote a finding on culture: “Culture is the characteristics and knowledge of a particular group of people, defined by everything from language, religion, cuisine, social habits, music, and arts”. The Centre for Advance Research on Language Acquisition goes a step further, defining culture as shared patterns of behaviours and interactions, cognitive constructs, and understandings that are learned by socialization. It can be seen as the growth of a group identity, fostered by social patterns unique to the group.

Culture is a people’s way of doing things, created (constructed) by that group (Khoza 2000:50). Khoza argues: “We, as Africans, have our ways of living and doing things. When interrupted, it brings a lot of problems that brings people to a standstill, making them to seek help/therapy. Our cultures produce our religion. That is our way of feeling, thinking, believing, and knowledge that makes up our spirituality” (Khoza 2000:51). The STWC has a culture of its own, which is informed by its belief systems as a community of faith.

In an institutionalization of practices, it is understood that “realities are constructed through the passing down of generational family traits – an institutional world is experienced as an objective reality, and the threat we go through makes us to defend it” (Berger & Luckman 1996:60). This passing down becomes the culture in which a particular group of people tends to measure themselves. It is within this Afro-centric view that the STWC is measured.

4.2.2.1 African View

Culture makes one uphold certain values. By values, the researcher is referring to that which is perceived to be true and valuable, and that which is beautiful. All people are raised and socialized within a cultural context, which formulates their world view regarding truth and beauty. The culture which a person upholds, will make them formulate a world view, which could be African, Asian, or Western in nature.

The researcher prefers to explore an African world view, because he is of the view that it would be best-suited to this study. By an African view, the researcher also refers to the emphasis it holds:

In an African view, it is a community which defines a person. The emphasis placed on community, is its most central and all-pervasive characteristic, and universally embodied in its customs and institution. An African society puts more stress on the group than individual, and more on the communion of people than on their autonomy. But it doesn't mean that it ignores the individual, or solidarity, but it means that it bases itself on the general activity of the group. Lastly, the African society is famous for its notion of the extended family, and is capable of extension to include anyone, not only those related by blood, kinship, or marriage (Menkiti 1984:1-13).

However, this must be understood from the philosophy of *Ubuntu*: “*Ubuntu* is an all-inclusive African humanism. It is an integrated, multifaceted cultural practice where a human being is understood to be sacred, and is treated as such, to the extent of loving one's neighbour as one loves oneself” (Lartey 1997:51). Koka argues along the following line: “*Ubuntu* is the ‘common denominator’ of all brands of African anthropology (as well as African religion and philosophy), and can be shared among people” (Koka 1998:34).

Khoza (2000:88-89) further elaborates on African humanism by discussing the three pillars of *Ubuntu*:

- The pillars of *Ubuntu* are interwoven and communicated through a usage and sharing of edibles and respect.
- The second pillar of *Ubuntu* is the sharing of food.
- The third pillar is the respect of the elderly people in the community.

The researcher also understands that respect can be misunderstood as fear, of which in some cases, people in these setting might be meaning “you have got to fear me”, when they demand respect.

Mazrui (1980:13-29) highlighted several functions of culture that are critical in the understanding of an African epistemological perspective world view:

- 1) Culture provides lenses of perception and cognition.
- 2) Culture provides motives for human behaviour.
- 3) Culture provides criteria of evaluation.
- 4) Culture provides a basis of planning.
- 5) Culture provides the system of production and consumption.

Here, the community under study looks at help mostly through the lenses that their culture provides. To them, counselling is a western-adopted practice that doesn't fit well in their African context.

Concisely, with the term "African world view" the researcher refers to the customs, values, traditions, and unity that African people uphold. However, the researcher knows that cultures differ from one tribe to another. If time and space were given, one would have to consider cross-cultural communication in exploring this dominant narrative of the research to see what one can learn from other cultures when it comes to help and counselling.

Since we understand that reality is socially constructed and constituted through language, it should be organised and maintained through stories. There are no essential truths. We need to understand that the socio-cultural narratives of the STWC construct the contextual realms of possibilities from which individuals and families can select the politics of story-making and mythmaking (Freedman & Combs 1996:26).

Social realities may not be essentially true, but that does not stop them from having real affects on the people when faced with challenges that influence them to seek help professionally (Freedman & Combs 1996:36). In this community, men are more highly regarded than women. They are not encouraged to seek help from those who are perceived to be weaker than they are. If it is help from the hospital, some choose not to be touched by women until a male nurse or doctor comes.

How power is negotiated, is influenced by the preferred knowledge the community is given by those who want to enjoy these privileges. Language is an instrument of

power, and people have power in a society in direct proportion to their ability to participate in the various discourses that shape that society (Freedman & Combs 1996:37-38). This study has discovered that because men are considered superior to women in the society under study, they enjoy preferential treatment when compared to their female counterparts. The males, in this regard, has the power over the females, who are weak and inferior to men. Due to this diabolic system of power, and the privileges that are enjoyed by men, help cannot be perceived as something that could be received from those that are considered weak and inferior.

The society in which the research is done, has a saying when it comes to relationships: “*Tava Mbirhi ta vambhiri ntsena wa vunharhu i ma onha mhaka*”, meaning that interference in the matter of two lovers is dangerous and disruptive in the flow of such a relationship. Nobody should interfere, even if there are some differences or conflict for that matter. According to Ngonidzashe and Douglas (2014:155),

[i]t would appear that married couples do not always seek counselling when in need. In collectivist communities, some married partners may be exposed to the belief that the intervention by professional counsellors and pastors are tantamount to interference. This could be because some married couples may lack trust and may view counsellors as strangers.

Men seem to support this view in the community. Women do not seem to be experiencing difficulties with their faith and culture regarding seeking professional help, but have indicated that their failure to seek professional help is not aligned with culturally-embedded issues. This could be influenced by other factors, which will be focused on in the next sections. According to Ngonidzashe and Douglas (2014:155), some women, often of the working class, may resent counselling, because they perceive that they can live alone or in singlehood. They may think that they no longer need a man in their life, so they may not seek counselling.

4.2.3 Religiosity

Belief systems are the determining factor when it comes to seeking help. Khoza (2000:51) defines beliefs as “something that would include myths and superstitions,

beliefs about God, reality, or an ultimate meaning”. The entire focus group of men concur that counselling does not clash with their faith, but they have indicated that consulting during illness or crises might suggest one’s weakness in faith, lack of trust in God, or prayerlessness on one’s side.

Taylor (2000:74) conducted a study on mental health services in faith communities, focusing on the role of clergy in African churches: African adults display high levels of religiosity across a variety of religious indicators, including membership rates and frequency of public behaviour, such as church attendance, as well as private devotional practice. There is an equally long tradition of faith-based initiatives, and work in African communities has been concerned with the well-being and health of individuals and families.

A growing literature shows that religious factors are linked with specific behaviours affecting health, such as drug, alcohol, and tobacco abuse (Brown & Gary 1994; Cochran, Beeghley & Boch 1988; Gottlieb & Green 1984). In addition, studies indicate that religious involvement is associated positively with life satisfaction, self-esteem, and other aspects of well-being and self-related health. It is related inversely to depression and distress, long-term physical disability, and mortality. Collectively, these works show that the study of religious involvement may provide a unique insight into health status, behaviours, and attitudes of defined groups within the population (Taylor 2000:74). One can see that religion has an effect on behavioural issues. These issues may seem to suggest that there is weakness in people of faith, or that they may not be strong enough in their faith and prayers. If they happen to consult someone else than their Creator, who is all-powerful, to help and deal with their challenges, believers may be enquiring as to why they do it. Other participants differ from this view. One can agree that the majority of female participants are of the view that seeking help can be impeded by their ideas of being a true and strong believer.

It is true that the ways in which people respond to the various issues of life, can be a means to measure their strength in faith and relationship with God. This can be detrimental in regard to getting help, because if prayer and the Holy Spirit are the only means in dealing with problems, ignoring those that have the skills to help us

deal with our present-day realities would suggest that the very religion which was meant to be of a great help, now serves as an impediment to seeking help. This brings one to the conclusion that it all boils down to one's own religious beliefs. Some of these perceptions are brought in by their religious belief systems, and they become the determining factor in seeking help.

4.2.4 Fear of stigmatization

When the study was looking at the perception of people towards help, stigma and fear became prevalent reasons for many people to avoid help. Vogel *et al.* (2011:369) pinpointed one gender-salient variable that has recently been identified as a barrier to seeking help, which is more proximal to attitudes towards counselling – stigma. He defines self-stigma as the internalization of negative views of society towards mental illness and seeking help (e.g. to believe oneself as inferior or weak for needing to seek counselling).

A dominant male gender – based on self-reliance, avoidance of weakness, and stoicism – may lead to a greater self-stigmatizing perception, and subsequently be linked with less positive attitudes towards counselling (Vogel *et al.* 2011:370). Vogel *et al.* (2011:370) further urge that, although this pattern may be true for many men, the strength of the relationships between these factors may depend on cultural and demographics factors.

Most of the women do not seem to have much of these concerns when it comes to seeking help, even though some have shown some great concerns. Men in general seemed to be concerned when talking about their issues with “strangers” and have a fear of being labelled as weak or not capable to deal with their household matters.

The importance of independence, social harmony, and saving face for one's family may all serve to magnify the influence of self-stigma regarding seeking help (Vogel *et al.* 2011:370). One risks not only bringing shame on oneself, but also disgrace on one's whole family (Shea & Yeh 2008).

The study revealed that most of the participants have not been to counselling or sought out help of any kind. Many kept their problems to themselves, deciding to

deal with whatever challenges they are facing – the influencers being fear and stigmatisation. They were afraid to share their personal matters with strangers.

To others, it was a fear of being stigmatized by the public. These participants thought it would be better to keep the matters to themselves without seeking any help, whether it is professional or not, for the avoidance of being seen as failures or weak people who cannot handle their family matters.

Vogel *et al.* (2011:371) speak of cross-cultural studies that support the idea that stigma, in particular self-stigma, is a relevant factor – self-stigma can vary between cultural groups, as it does across demographic groups. For men in different racial and ethnic groups, the role of stigma in seeking help needs to be explored further (Wester 2008).

The assessment of the relationships between masculine norms, self-stigma, and attitudes of men across different racial/ethnic backgrounds should help clarify how these factors operate for them (Vogel *et al.* 2011:371). From the beginning of their research, Vogel *et al.* have hypothesized that conformity to dominant masculine gender roles will be positively linked with attitudes towards counselling. The results showed that men with a higher endorsement of dominant masculine belief, have less favourable attitudes towards seeking psychological help. It also showed that this is partially mediated by the degree to which men experience self-stigmatisation (Vogel *et al.* 2011:375).

According to Eisenberg *et al.* (2009:2), public stigma is defined as negative stereotypes and prejudice about mental illness (“people with a mental illness are dangerous and unreliable”). It is held collectively by the people in a society or community.

The perceived public stigma is commonly referred to as an individual’s perception of public stigma, where self-stigma occurs when an individual identifies oneself with the stigmatized group (Eisenberg *et al.* 2009). The interplay of these two normally are the ones that cause a hindrance to seeking professional help. The community of the STWC finds themselves in this dilemma. People keep their problems to themselves,

because of a fear to be laughed at when seen at the doors of help by the public and those around them. It suggests that stigma could be a formidable barrier to seeking help. The perceived public stigma may prevent people from using mental health services to avoid possible criticism or discrimination from others. Personal stigma and self-stigma may deter individuals from seeking help if the service implies acknowledgment of one's own mental health problems, and if the individual's negative attitude about people with mental problems would harm their own self-esteem (Eisenberg et al. 2009:3)

A higher personal stigma prevents one from seeking professional help. Studies examining people's own stigmatizing attitude have generally found that a higher personal stigma is associated with a lower rate of seeking help amongst both adults and adolescents (Cooper *et al.* 2003). Cooper *et al.* further elaborate on another study done by Mojtabai *et al.* (2002) that found that participants who reported embarrassment associated with mental health treatment, were less likely to perceive a need for help or use mental health services, although this study did not distinguish between personal stigma or perceived public stigma. Kessler *et al.* (2001) found that one in four people who perceived a need for help, did not seek services, because of concerns about what others might think.

In this study, the researcher measured seeking help by asking whether the participants have undergone any form of counselling during their challenging moments. One should notice the fear attached to stigma. This fear is not only stigma-related, but also a fear of sharing one's secrets. In this study, fear was revealed as one of the reasons why the community avoids help at some point in their lives.

For the people with distressing emotions and self-concealment, treatment fear is being not comfortable with self-disclosure (Vogel *et al.* 2005:461). Vogel *et al.* continue by highlighting some of the factors that are influencing the decision to seek professional help: Social stigma, self-concealment, anticipated risk, anticipated utility, distress, social support, and the gender of the participants. The intention to seek help for interpersonal, academic, and drug/alcohol issues seems to be a great influence in seeking help.

Treatment fear is all about the fear of being judged negatively for seeking treatment (image concern), and about being pushed to think or do things they do not want to (coercion concern) (Vogel *et al.* 2005:459-470).

The fear of labelling and how one is viewed in society, play an integral role for men and women. The weight and pain of a situation being bad-mouthed, or unnecessarily spread around, have a great impact on seeking help as well. Living in a world of stigmatizing people can cause others to have a negative attitude and a blurred perception towards seeking professional help. Being seen leaving a consulting room might bring labelling and shame from others. This has been identified as one of the dominant narratives to not seeking help.

4.2.5 Socio-economic standing

Boisen, a pioneer in the field of pastoral care and pastoral counselling, is of the view that “crises are not simply fraught with danger – they also offer opportunities for spiritual and emotional growth, since crisis management heightens emotional and intellectual activity” (Boisen 1936)

The circumstances of the anecdotes mentioned in Chapter Three might have been different, should the socio-economic standing be different. Choosing to go for help, would perhaps have been influenced in a different way. These types of abuse simply suggest that their socio-economic standing influenced them not to seek help from relevant people. The woman with her wound never reported the case or went to the clinic for the treatment of the wound that was caused by the abusive husband. The financial status of these women kept them from seeking help.

Death could not be the only thing that constitutes a crisis in one’s life. There can be many factors contributing to crises. One’s economic standing in a society could contribute a lot. This is seen in the bargaining people will do when it comes to help. The population under study mention that some of the causes of failure to access professional help, is because help is expensive, since it involves money to see the medical doctor or psychologist. Given the fact that the entire Malamulele has one government psychologist situated at the hospital, makes things difficult for the people

to seek this professional kind of help. Those who are financially stable, can go to a private psychologist for help, and it feels more private and safe there.

The dominant narratives that are used in the constructions of perceptions and attitudes towards seeking help, are: gender inequality, socio-cultural beliefs, social standings, religiosity, socio-economic standings, stigma, and fear. These constructions, within their world view, create the kind of realities that the community tend to live in. The realities are that men are superior to women, boys “do not cry”, and only an experienced elder can be in a position of helping during a crisis. Culturally, the weak (women) cannot be able to help the strong (men), even though “weak” people have the ability and skill to help a client during crises or illnesses.

This has created the so-called weakness in faith, as a believer will be considered being less prayerful when seen in the consulting rooms. It creates an environment that is full of fear of stigmatisation. These realities are socially constructed, and are constituted through power and superiority – they are organised and maintained through cultural narratives.

Meylahn (2010:16) says: “This truth is a narrative truth, it is not an analytic truth that can be proven through scientific theories, but it is a truth that is known in the experience of liberation. In other words, it is a metaphoric truth that gives a truthful or appropriate meaning to an experience, and this is known as truth”.

4.3 The Unique Outcomes

The one question that should be asked, is: How can the above-mentioned constructions be deconstructed to open the possibility for re-imagined stories of the future? When the dominant ideas and beliefs that support the problem are exposed and discussed, the times when a person has challenged them may also become visible. If this is significant to that person, it is a unique outcome that will open possibilities for the discovery of an alternative story (Morgan 2000:50).

A unique outcome can be anything that the problem would not like – anything that does not fit into the dominant story. These are instances or events that would be difficult to achieve in the light of the problem. These events stand over against the

problem's influence (Morgan 2000:51-52). Here are two stories that might support this:

- **A man with a car phobia**

During the men's focus group, a man told a story about a car hijacking encounter that left him in a position of fear to drive again. Prior to the hijacking, he said that driving was easy and something that he enjoyed, but after the incident of being hijacked, he became afraid to drive again. This fear got to an extent where his wife noticed the problem and took him to the pastor for help, who worked with him until he regained confidence in driving again.

The pastor helped him to look at driving in a new way, where he used those moments of easy and enjoyable driving to thrive against the fear of being hijacked. This became a unique outcome to the problem, which changed into a different story from that of a dominant narrative of having a car phobia. During the explorations of the problem, he was taken back to the times of driving before the hijacking occurred. Driving was a very enjoyable thing in his life. That moment of enjoyment was used to open the possibility for a re-imagined story of future driving and owning a car again. This occurred when a deconstructive conversation was implemented by the pastor through relative influence questioning (White & Epton 1990:42), to help the client to map the influence of the problem in his life, and also to map his own influence in the problem.

- **Mr X's fear of buying a car**

Mr X was a principal of a high school. He used to commute by buses and taxis for years before he could own his first car. The reason for him to go years without buying a vehicle, even though he had the ability to do so, was the fear of driving cars. This was due to the conception he had about people dying in road accidents: he thought that many people die in car accidents on a daily basis. As a result, he did not want to own a car.

The story became the talk of the town, until his family decided to do something about it. They called a meeting. In that meeting, they tried to change his mind about buying

a car. They talked him into seeking help about this situation. In the process, the following questions were asked to help him break from the sense of guilt or blame:

- How does he get to town?
- Under which category do buses and taxis fall for him?
- How many accidents did he encounter during his travel with public transport?

He answered that he got to his destination using public transport. During these trips, he never experienced any accidents. This was a unique outcome that spoke against the fear of death through accidents. Space for a new story was made through questions (Freedman & Combs 1996:42). This deconstructive conversation helped him to unpack the dominant story about his fear of death through car accidents, and changed his view to a different perspective (Morgan 2000:50). Mr X now owns three cars.

4.4 Other Stories that do not Fit the Dominant Narratives

4.4.1 Lack of Information

Lack of information is a factor that could influence people not to seek help of any kind. One participant said: “The reason some of us do not go to these professionals, is because we do not know where to find them and how much it will cost”. Another concurred by saying: “We do not have any information about them, so how can we go to them if we do not know?” Another participant said: “I think the lack of information is the problem. Moreover, I think information is the key to people using these professions, therefore I suggest that information about them be made available to the people, to make informed decisions”.

4.4.2 Family Support Systems

One participant said, “If you have a good family support system, it becomes easy for you to go out there and look for help. When you know that your family stands by you and they will not criticise you, it is easy to face whatever challenge, even to support you during the process of counselling”. The family’s support seems to be of great importance when it comes to seeking help.

4.4.3 Personality

So many factors are involved in one's personality. One can acquire something, but it is difficult to change a personality. Everyone has certain personality disorders, for example, dependent personality disorder. Here, one would like people to observe them in a favourable way – the person becomes a people pleaser. These people need to be empowered to become interdependent.

4.4.4 Scapegoat

One medical doctor argued: “Many people come for counselling, but most are not actually looking for help/counselling, but only use it as a scapegoat”. He elaborated by giving an example: “When you are counselling a couple, mostly when men have blundered, they would suggest to get help for their wives. When you are talking to them, you can detect whether they want help or not, and we normally see that the one who blundered, is the one doing much of the talking – using that as a cover-up to appease himself and manipulate his wife by saying that they got help concerning the issue – so they won't talk about it anymore”.

4.4.5 Pain as a Common Factor to Seeking Help

Pain is the most common factor that brings people to a place of help. Men would actually go for help when pain is involved, because they cannot handle the pain anymore. When pain becomes too heavy to deal with, they consult doctors. Doctors are in the distribution policy of saying, “I would refer you to someone”. They then will find themselves sitting in the offices of psychologists, social workers, counsellors, or pastors.

4.4.6 Traditional Healers

Most people, including people who know God, would visit traditional healers first. Experience has taught the researcher that even Christians go to consult traditional healers. When a pastor comes to lay hands on people, they would not ask to see the waist, but medical practitioners would see things when they meet these people at the labour wards, and so forth. Then the clients would justify it by saying, “They have tied this robe around me to prevent miscarriage”.

The African people believe in traditional things. They often follow the traditional route to deal with their current problems. One would hear someone say, “I went to the pastor and he told me, through the spirit, that the child is not well-positioned in the womb”. And one would wonder how they believed that.

4.4.7 Age Difference and the Cultural Understanding of the Elderly

In a community where the elderly is perceived as the wise people, it will be difficult for an elder person to seek advice and help from a young person. Age influences the elders not to be able to receive help from the young ones and those who are less experienced in the issues of marital life. This is because they live in a patriotic environment where people are socialised in a certain preferred manner by those who seek to benefit from it.

4.4.8 More Factors that do not fit the Dominant Stories found in this Study

Some participants have openly said that bad-mouthing of a counsellor causes people to avoid the idea of seeking professional help. People’s pride would influence their mindset. The view of problems as a personal thing may cause a person to keep the problem to themselves – they end up feeling uncomfortable to discuss personal issues, keeping it to themselves to protect their territory, and from anyone who might be trying to invade such places to help that person. Participants see that as an invasion of privacy. There is also the fear of facing the realities of life. The participants fear that the counsellor might worsen the situation by unearthing the hidden elements; the counsellor might ask things that would open old wounds.

All these stories have an impact and influenced people’s perceptions and attitude towards seeking professional help.

CHAPTER FIVE

RECOMMENDATIONS

The recommendations in this study are based on the research findings about the participants' perceptions and attitudes towards crises, illness and seeking professional help. This could be improved in the following manners.

5.1 Education and Exposure

One has to educate people about counselling, inform them about it, and tell them how counselling works. One has to expose it through education, awareness campaigns, and community *imbhizos*, because people have problems without knowing that there is help out there, which could be a crisis in its own.

These people have to be exposed and educated, for it is better to engage with something one knows. For example, people who commit suicide are mostly stuck with their problems – they cannot move or think, and therefore they kill themselves. They are overwhelmed by their problems, because they only think about their problems. However, the solution lies in sitting down calmly and communicating one's problems to someone else, asking that person what they can do about it. The individual might not see the solution, but others can come up with one. That will only happen when people are exposed and educated along the line of seeking professional help – understanding that these professions are meant for their well-being.

This can also be achieved by using media tools to promote professional help or counselling, and how to access it. Many members of the community have access to radio or television. Lastly, exposures and educational information can be wrought through strategic workshops – the use of a yearly conference – to decimate this information.

5.2 Develop Strategic Workshops between Clients and Professional Help Providing Bodies

A client-counsellor summit must be called where the clients, counsellors, and providers of professional help would meet to talk about counselling and its challenges. In this summit, partnerships between relevant stakeholders on crises and illness could be strengthened. Community awareness about illness, crises, and professional help training programmes can be established and strengthened as well.

5.3 Developing and Strengthening Confidentiality between Clients and Professional Help Provides for a Good Working Environment

Counsellors should be encouraged to attend training and refresher courses, which will serve as a reminder of how a therapist or counsellor should behave in dealing with clients. Counsellors should also assure people about confidentiality during these sessions. Counsellors should be trained in keeping secrets to restore the confidence of the clients towards them. People should be encouraged to report those who cannot keep confidentiality to the governing bodies of these professions.

Online counselling is a solution to the problem of the lack of trust, because the majority feels that their secrets are not safe in the hands of a counsellor. Therefore, online counselling should be encouraged, as it is ideal for anonymity. Lastly, those who feel uncomfortable sharing their challenges of life with counsellors, due to lack of trust, can do so by writing to the magazines anonymously since no-one would have to know who wrote the letter.

5.4 The Church's Role and Dual Relationships

The church must co-operate with social workers, clinics, and professional help providers to herald the news about places of help and the importance of getting help. People should not be allowed to suffer by themselves, because they do not know where to get help, and the significance thereof. Since the church plays a very integral role in the life of the stakeholders of the community, it needs to be hands-on when addressing these matters.

Churches need to communicate this from the pulpit to assist in eliminating the wrong perceptions and attitudes influencing people not to seek professional help when

faced with challenges. The church needs to establish a counselling department and provide training to the workers and volunteers in that department.

Pastors in churches should study and understand the issues of dual relationships in a congregational setting. They should study dual relationships to help people shift from seeing them as pastors to seeing them as counsellors or therapists. Dual relationships would help the pastor to understand the conflict of interest between the clergy and the congregant.

The clergy find themselves playing different roles in a congregation, and people find it difficult to relate to the pastor when comparing the roles of pastor and therapist. They would rather choose to talk to their pastor, and not their therapist. This is because of the conflict of interest due to dual relationships between the client and counselling pastor. The reason is that people are looking at pastors as preachers, not as therapists. This is because of the lack of exposure in this area. They look at the pastor, reading and preaching to them from Job 5:2, but later they have to go to the pastor for help and counselling. On a Sunday, he or she is a preacher, but on a Monday, they must tell the pastor of their marital problems. To them, there is a conflict of interest, or dual relationships. They would not go, because when the pastor preaches about a subject that came up during a previous private session, it will not feel right to them. This is the reason a study on dual relationships was commended.

5.5 Conclusion

The study found that people went for help, but the help that they obtained, was not mainly professional help. Most of the participants interviewed, have consulted a member of the family in the form of aunts, uncles, or elders. Others preferred to deal with their challenges on their own. Only a few have ever been to social workers, psychologists, medical doctors, or pastoral counsellors for help.

The reason for this is because of the dominant stories that influence their actions. These stories need to be deconstructed to find unique outcomes to help the members of the community to start seeking professional help when facing challenges. Pastors and churches need to work with other stakeholders in educating

the community about professional help. A further study in this area of crises, illness and seeking professional help is required, with a pastoral perspective. The study on dual relationships in a congregational setting towards providing help is also needed.

APPENDICES

Appendix 1: Interview Guide for Community Members

1. What do you understand about counselling?
2. What types of counselling do you know?
3. When do you think people seek professional help?
4. Have you ever undergone some form of counselling in your life?
5. If yes, “which one”? and how helpful was it?
6. If no, will you go if a need arise?
7. How do you perceive (see) counselling in relation to your culture and faith?
8. How do you feel about counselling?
9. What are the reasons for the perceptions and attitudes you hold towards counselling?
10. How could these perceptions and attitudes towards counselling be improved?

Appendix 2: Semi-Structured Interview Guide for the Educators, Nurses, Social Workers, Medical Doctor and Psychologist

1. Section A: Biographic Information

Age		
Gender	M	F
Occupation		
Area of work		
No of years on the current position		

2. Section B: Semi-structured Interview Guide

1. What do you understand about counselling?
2. What types of counselling do you know?
3. Have you ever undergone some form of counselling in your life?
4. If yes, "which one"? and how helpful was it?
5. If no, will you go if a need arise?
6. How do people (clients) perceive (see) counselling in relation to your culture and faith?
7. What are the clients' attitudes towards counselling?
8. What are the reasons for the perceptions and attitudes they hold towards counselling?
9. How could these perceptions and attitudes towards counselling be improved?

Appendix 3: Letter to the Full Gospel Church of God in Southern Africa

University of Pretoria School of Theology
Department of Practical Theology
Private Bag x 20
Hatfield
0028
Date

The Secretary General
Full Gospel Church of God in Southern Africa
Private Bag X40
Irene
0060

Dear Sir/Madam

REQUEST FOR PERMISSION TO CONDUCT RESEARCH

I am a Master of Theology student in the School of Practical Theology at the University of Pretoria. Based on the curriculum of my programme, I am expected to conduct a study which could be of value to a community and to enhance my knowledge and skills in research; I envisage conducting a study entitled, “Crises and illness and seeking professional help: A pastoral perspective” at Shigalo Village. The purpose of the study is to explore the factors that contribute to perceptions and attitudes of families towards professional help, and describe how families of Shigalo Tabernacle Worship Centre perceive (view) professional help (counselling). The research will seek to understand this perception within the context of their faith and their culture, trying to determine what narratives inform this perception. The objective of the research is first to understand this practice and second to seek ways in which these attitudes and perceptions can be overcome; and also to determine the health implications of negative perceptions to the community members and to document the prevalence of perceptions and the extent to which it affects the daily living of the community members. I therefore request your permission to conduct the study.

Hoping that my request will be granted.

Kind regards

.....

R. B. Mabasa

Cell number: 083 342 4863

Appendix 4: Consent Form

I am Robert Bumani Mabasa, a post-graduate student at the University of Pretoria, School of Theology. I am conducting a research entitled, “Crises and illness and professional help: A pastoral perspective” at Shigalo Tabernacle Worship Centre.

The purpose of the study will be to explore the factors that contribute to perceptions and attitudes of families towards professional help and describe how families of Shigalo Tabernacle Worship Centre perceive (view) professional help (counselling). The research will seek to understand this perception within the context of their faith and their culture, trying to determine what narratives inform this perception.

I would like to invite you to participate in the study. All your particulars shall not be revealed in public. Data collected during the study will be kept confidential and will not be disseminated to other parties without your permission. Your participation in this study is voluntary. If at any time you want to withdraw from the study, you are free to terminate the interview. Your decision to take part or not take part in the study will have no adverse impact on your life or right to access basic services.

.....
Researcher’s signature

.....
Date

Participant

I _____ have read the content of this form and give consent to voluntarily participate in this study.

.....
Participant’s signature

.....
Date

.....
Witness

For more information, please contact R. B. Mabasa (the researcher), cell number: 083 342 4863.

Appendix 5: Letter to the Shigalo Tabernacle Worship Centre (Full Gospel Church of God in Southern Africa)

University of Pretoria School of Theology
Department of Practical Theology
Private Bag x 20
Hatfield
0028
Date

The Secretary General
Shigalo Tabernacle Worship Centre
P.O. Box 356
Malamulele
0982

Dear Sir/ Madam

REQUEST FOR PERMISSION TO CONDUCT RESEARCH

I am a Master of Theology student in the School of Practical Theology at the University of Pretoria. Based on the curriculum of my programme, I am expected to conduct a study which could be of value to a community and to enhance my knowledge and skills in research; I envisage conducting a study entitled, “Crises and illness and seeking professional help: A pastoral perspective” at Shigalo Village. The purpose of the study is to explore the factors that contribute to perceptions and attitudes of families towards professional help, and describe how families of Shigalo Tabernacle Worship Centre perceive (view) professional help (counselling). The research will seek to understand this perception within the context of their faith and their culture, trying to determine what narratives inform this perception. The objective of the research is first to understand this practice and second to seek ways in which these attitudes and perceptions can be overcome; and also to determine the health implications of negative perceptions to the community members and to document the prevalence of perceptions and the extent to which it affects the daily living of the community members. I therefore request your permission to conduct the study.

Hoping that my request will be granted.

Kind regards

.....

R. B. Mabasa

Cell number: 083 342 4863

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