UNIVERSITY OF EDUCATION, WINNEBA

THE RELATIONSHIP AMONG PERCEIVED SOCIAL SUPPORT, COMPASSION SATISFACTION, SECONDARY TRAUMATIC STRESS AND BURNOUT AMONG CLERGY IN THE CENTRAL REGION OF GHANA

AUGUSTINE EKUBAN

(202144193)

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DECLARATION

STUDENT'S DECLARATION

I, AUGUSTINE EKUBAN declare that this thesis, with the exception of quotations and references contained in published works, which have all been identified and duly acknowledged, is entirely my own original work, and it has not been submitted, either in part or whole, for another degree elsewhere.

SIGNATURE: ……..……

DATE: ……..

SUPERVISORS' DECLARATION

I hereby declare that the preparation and presentation of this work was supervised in accordance with the guidelines for supervision of thesis as laid down by the University of Education, Winneba.

Hannah E. Acquaye, PhD (Principal Supervisor)

Signature:……

Date:……

Mr. Joshua Luther Ndoye Upoalkpajor (Co-Supervisor)

Signature:……

Date:……

DEDICATION

I dedicate this work to my dear wife Asafomaame Janet Ekuban. Her love and great support made my study journey a smooth one and this dream a reality.

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Abstract

Clergy are individuals ordained for religious duties in the Christian church. They are generally the first point of call for church members who encounter both suffering and joy. Because they experience the gamut of happenings in people's lives, they face both the pain and joys of stories they hear. This study was undertaken to understand the relationship among perceived social support, compassion satisfaction, burnout, and secondary traumatic stress among clergy in the central region of Ghana. Grounded on the realism ontological position and objectivist epistemological underpinning, this study used the quantitative research approach and correlational design to understand the relationship among the variables. The Interpersonal Support Evaluation List (shortened version), the Professional Quality of Life Scale, and a demographic questionnaire were the three instruments used in gaining information from the participating clergy (n = 103; mean age = 44.64 years, SD = 8.45). Most participants (n = 88) were married, classified as Pentecostals (n = 69), and had some level of post-secondary education (n = 94). Majority of the clergy reported high perceived social support (85.4%), compassion satisfaction (90.3%), low burnout (68.9%) and a little over half with high secondary traumatic stress (50.5%). Compassion satisfaction had a strong negative relationship with burnout, a little positive relationship with secondary traumatic stress and some positive relationship with perceived social support. While the sample size was small, the study indicated that counselling psychologists could provide strategies that enhance increased social support among clergy as it could reduce burnout.

CHAPTER ONE

INTRODUCTION

1.0 Introduction to the Chapter

This chapter being the introductory part of the research lays out the background and the problem statement of the study. The chapter also states and explains the theoretical and conceptual framework underpinning this research. The purpose, research questions and significance of the study are also highlighted in this chapter. Finally, the chapter explains the delimitations of the study.

1.1 Background to the Study

There are a lot of stressors that originate in the occupational context that make helping professionals develop several debilitating symptoms that affect their physical and emotional well-being (Duarte & Pinto-Gouveia, 2017). These symptoms make a helper feel so exhausted that they begin lacking the ability to empathize (Stamm, 2009). Some authors refer to this emotional and physical exhaustion as "burnout" (Fallon et al., 2013; Lubbadeh, 2020; Maslach & Jackson, 1981, 1982;). This phenomenon is normally associated with professionals who are constantly in contact with people who experience pain or distress (Sinclair, et al., 2017; Sorenson et al., 2017).

According to Dostoyevsky (2001), no individual can live without suffering and pain. If church members have their pastors as their first point of contact in emergencies, then pastors generally bear the brunt of pain-related stories of congregants. The effect of constantly listening to these stories culminates in what psychologists refer to as "secondary traumatic stress" (Maslach & Leiter, 2016; Parker

& Martin, 2011; Stamm, 2009). Some researchers have revealed that this term can be used interchangeably with compassion fatigue (Fallon et al., 2013).

In as much as the work of the clergy is exhausting, there are instances where they experience the joys of helping others. The phenomenon is referred to as 'compassion satisfaction' (Stamm, 2009). Compassion satisfaction may be defined as the feeling of satisfaction that the helping professional gains from helping others by taking care of them, this satisfaction motivates them to keep helping others (Hansen et al., 2018). Compassion satisfaction is noted to be an essential protective factor that brings about a positive professional quality of life (PRoQOL; Sacco et al., 2015; Stamm, 2009).

Professional Quality of Life is a three-dimensional idea that may be described as the perception of well-being that individuals go through when their personal needs in their occupational settings are met (Roney & Acri, 2018). Compassion fatigue, burnout, and compassion satisfaction are the components of Stamm's conceptualisation of Professional Quality of Life (Stamm, 2010). Contrary to Compassion satisfaction that has a positive effect on Professional Quality of Life, Burnout and compassion fatigue have direct negative effect on Professional Quality of Life (Al-Majid et al., 2018).

Professionals that are classified as "helpers" (Young, 2013, p. 45) include counsellors, psychologists, nurses, teachers, social workers, and clergy. Clergy is defined as Christian men and women ordained as religious ministers like Pastors, Reverend Ministers, Apostles, Prophets, and Moderators (Novieto, 2013). Some of the roles they perform that are similar to what counsellors do include helping people to cope with: the loss of loved ones, life crises, and other general life stressors (McCain & Morgan, 2016). Thus, by way of illustration, the clergy do not only

officiate worship services, preach weekly sermons and teach members at church, but also help in counselling church members and help in emergency circumstances (McCain & Morgan, 2016).

There is adequate research concerning the counselling-related duties that the clergy performs. The clergy are identified in many spheres as caregivers. The clergy are the first point of call when individuals go through distress before they consult their health professionals (Asamoah & Osafo, 2014). In Ghana for example, study report shows that in Kumasi (the second largest city in Ghana), about 20% of people attending to mental health services for the first time had either seen a clergy and or a traditional healing practitioner (Appiah-Poku et al., 2004). Being the first point of call, the clergy are an essential source of primary care in mental health practice. These counselling-related duties, coupled with other ministerial roles, make the work of the clergy burdensome and emotionally draining (Parker & Martin, 2011).

The clergymen and clergywomen that do not belong to the Catholic faith generally get married in Ghana. Spouses of these clergy are expected to provide some level of social support to alleviate the stressors that come with their work. Social support has been studied across multiple fields. A lot of research - past and current - has indicated that where social support level is high, there is a correlated high level of compassion satisfaction (Barr, 2017; Cohen et al., 2000; George et al., 1989; Lee & Kim, 2016; Moak & Agrawal, 2010; Seeman, 1996). In both popular and academic circles, lack of social support is frequently cited as a key factor contributing to poor mental health among the clergy (Eagle et al., 2019; Edwards et al., 2020). Social support is a mediating mechanism between work stressors and the presence of compassion fatigue in helping professionals (Liu & Aungsuroch, 2019). Research indicates that where there is the adequacy of constant social support system the level

of burnout is low, in the same vein, where there is no social support the level of burnout is high (Hall, 1997).

Researchers differentiate between two main forms of social support: 'perceived social support' and 'received social support' (Barrera, 1986; Eagle et al., 2019; Vangelisti, 2009). Perceived social support is said to be the perception of available and adequate social networks; received social support emphasizes the amount and value of the support given.

Craig Barnes, president of Princeton Seminary and a former pastor, calls the condition faced by the clergy as one of "crowded loneliness" thus, pastors are all the time surrounded by people, but have few if any, supportive relationships (Barnes, 2013). The class of religious leaders and clergy are in many ways high-risk professionals, yet they are ignored (Birk et al., 2001). In their quests to ensure their congregations are secured spiritually, clergy often abandon their own welfare, ensuing in stress, compassion fatigue, and other health-related issues (Halbesleben & Buckley, 2004). This abandonment usually spreads to the families and congregations of the clergy. It has been noted by Gersten et al. (2018) that when the clergy are strained as a result of extra demands on them, their helpfulness in caregiving cannot be achieved. They always experience different types of stressors that come from exhaustion, emotional labour, stress, and compassion fatigue and its resultant pressure on them (Staley et al., 2013). A clergy member who is not able to cope with these same encounters in their own life may not be effective in assisting church members to cope with their stress. Cunningham (2014) therefore stated that issues of stress and well-being of the clergy do not affect only the clergy. It is also a psychological health and well-being issues for their congregants as well as their community.

1.2 Statement of the Problem

Multiple research study findings indicate that higher levels of social support are closely related to better mental health results (Cohen et al., 2000; Edwards et al., 2020; Moak & Agrawal, 2010; Seeman, 1996). Other studies also suggest that there is a strong and positive correlation between poor mental health and low levels of perceived social support (Lakey & Cronin, 2008; Liang et al., 2001). Also, there had been a long custom of studies within observed theology and psychology of religion from mostly advanced regions of the world, in Africa and a few in Ghana. These studies were about clergy work-related psychological health, stress, and compassion satisfaction issues. Such works have centered within different individual religious denominations. For example, Francis et al., (2019) examined the effects of satisfaction in ministry and emotional exhaustion in ministry on the wellbeing of Anglican clergy in the Church of England. The results of the study indicated that high satisfaction in ministry reduced the negative effects of high emotional exhaustion in ministry. Crea and Francis (2021) also explored the relationship between psychological type and personal wellbeing among Catholic priests pastoring in Italy. Their study confirmed the Francis and colleagues' 2019 study on Anglican clergy. For the Crea and Francis study on Italian Catholic priests, the results indicated a significant interaction between the effects of emotional exhaustion in ministry and satisfaction in ministry. These two studies appeared to agree on the fact that when clergy felt their purpose in life was served in ministry, there was a reduction in emotional exhaustion in ministry-related work. In another sample and with a different denomination of clergy, Francis, Haley, and McKenna (2022) examined the connection between conservative Christian beliefs and work-related psychological wellbeing among Methodist ministers pastoring in Great Britain. This study on

Methodist ministers sought to build on an earlier study by clarifying psychological type profile between male and female clergy. The results indicated that while both genders were similar in their typologies (e.g., introversion, sensing, feeling, judging), females more than males were high on feeling (59% male; 72% female). Thus, psychological typology did not appear to be a dividing line in determining who became clergy.

In Africa, Shikanda, Kiptiony and Ndiso (2022) investigated the effect of emotional exhaustion on mental health of clergy serving in the Christ Is the Answer Ministries in Kenya. The authors wanted to understand if psychosocial resources and interventions could be used to reduce burnout among the clergy in Kenya. Results of the census indicated that the effect of burnout on the clergy mental health was eliminated with the increase of psychosocial support. The authors identified psychosocial support to good human resource management practices in their organizations (e.g., retreats, days off, recreational facilities) as well as counselling, fellowships, and care groups.

The situation in Ghana is not very different as most studies done on clergy addressing stress and psychological health are conducted within different individual religious denominations. Fia, Fosu-Ayarkwah and Kusi (2022) conducted research on the impact of stress and burnout on the clergy quality of life. This study focused on the clergy in the Assemblies of God Church in the Ashanti Region, Ghana. Bonsu (2016) with his study explored the lived experiences of Ghanaian Pentecostal clergy. Findings of this study showed that the relationship between the clergy and their congregation as well as clergy self-care has great effect on the clergy life. Nortey (2019) investigated psychosocial correlates of psychological wellbeing among clergy of the Presbyterian Church and the Church of Pentecost in Accra. Anyetey (2018),

who sought to find sources of stress and coping strategies of the clergy in the various Christian denominations limited his study to the clergy within the Cape Coast Metropolis only.

These studies, did not specifically delve into perceived social support and its amalgamation with the helping roles played by the clergy in a combined group of clergies from both traditional churches and Pentecostal-Charismatic ones. Looking at the combined group could provide an understanding on shared experiences to inform the Christian community about pastoral / clergy care. Again, there seem to be little studies in Ghana addressing stress and psychological health of the clergy covering the various Christian denominations in Ghana. To fill this empirical gap (Miles, 2017), I want to undertake a study to investigate the relationship among perceived social support, compassion satisfaction, burnout, and secondary traumatic stress within the clergy in Ghana, specifically the Central Region of Ghana. I chose the Central region because it was the first seat of Christianity in Ghana with the arrival of the Europeans in the 1880 (Opoku-Dapaa, 1992).

1.3 Theoretical Framework

In this study, the Job-Demand-Control-Support model (Theorell et al., 1990) provided the theoretical framework. The Job-Demand-Control-Support model was used to determine the effect of social support on the Professional quality of life of the clergy in the Central Region of Ghana. The Job-Demand-Control-Support model is a theory that describes how job attributes affect employees' psychological well-being (Theorell et al., 1990). The theory explains how job demands serve as stressors for employees. Some of the stressors can be heavy workload, role ambiguity, and job-related strain. However, the theory postulates that employees can manage these stressors by making use of job skills that enables them have autonomy and control

over their work. The theory works with the illustration that when individuals have high levels of job demands, they are stressed. Nevertheless, these individuals can reduce this stress by having greater job control and develop good relations with their coworkers as well as supervisors.

In the case of the clergy, research has frequently discovered that their job is psychologically demanding (Berry et al., 2012). The high job demand on the clergy work leads to high levels of clergy stress (Bledsoe et al., 2013). However, the clergy can decrease this stress by gaining greater job control. The clergy can gain job control by being able to take decisions on their own. Some of the decisions that can be taken by the clergy include following their self-care plan. The clergy can set and maintain a moderate and realistic goals for themselves. (e.g., Take vacation at least once in a year; reduce working hours). The clergy can also decide to say no to some of the unnecessary demands from their congregants.

Again, the clergy can also form good relationship with their supervisors as well as their colleagues. Forming good relationships with supervisors and co-workers is essential because helpful social interactions can cushion the effect of stress. Job support is defined as the "overall levels of helpful social interaction available on the job from both co-workers and supervisors" (Theorell et al., 1990, p. 69).

1.4 Conceptual Framework

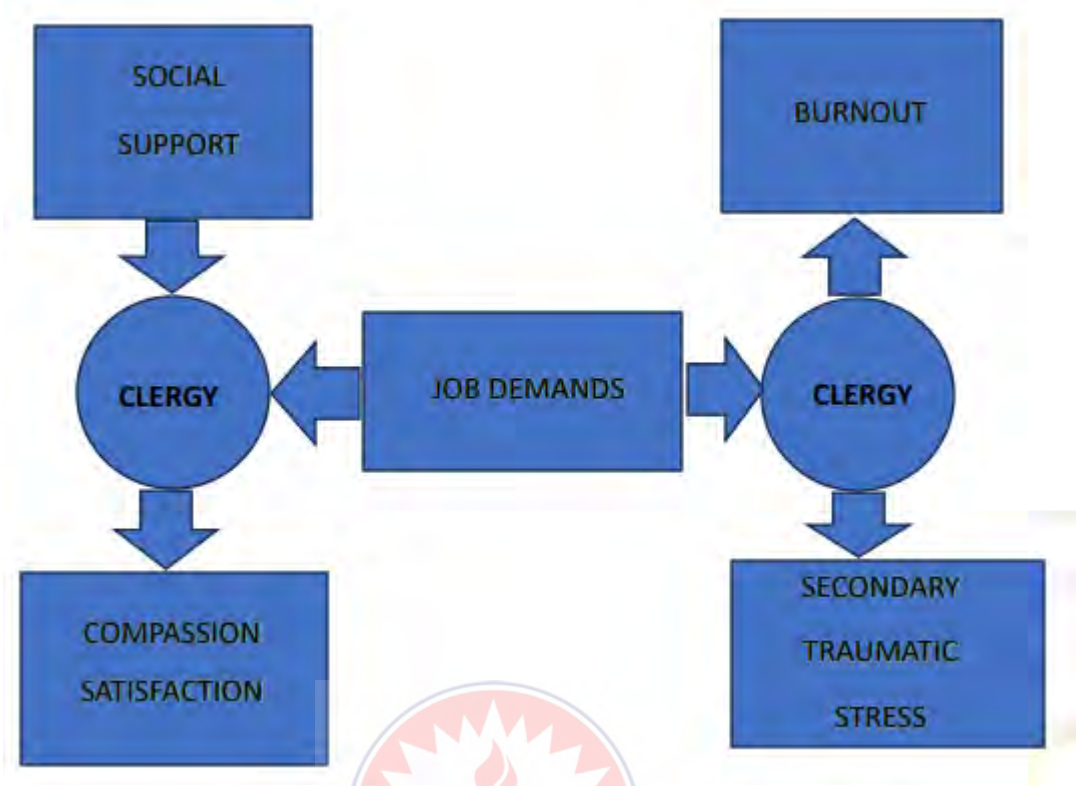


Figure 1. Conceptual framework of variables

The experiences the clergy go through when discharging their clerical duties impact their psychological well-being either negatively or positively (Lee & Iverson-Gilbert, 2003). Skovholt and Trotter-Matthison (2014) reported that the clergy like other category of professionals, experience life in different ways. These religious ministers engage in a myriad of duties, including spiritual nourishment of their members, psychological engagements, pastoral care, and their family responsibilities (Lewis et al., 2007). For example, the clergy do not only conduct worship services, prepare weekly sermons and teachings, but as well aid in counselling church members and assist in emergency situations (McCain, 2016). They are also required to officiate special services such as confirmations, baptisms, weddings, funerals and cater for their homes (Kinman et al., 2011). The irregular, unplanned and the high-demand nature of the clergy vocation predispose them to a number of psychological challenges

such as battling with anxiety, burnout, stress and emotional labour (Hyde et al., 2016). However, if the clergy are able to receive social support these negative constructs of compassion fatigue are mitigated (Lewis et al., 2007).

There is a plethora of research regarding social support and its cushioning factor on burnout (Cohen et al., 2000; George et al., 1989; Moak & Agrawal, 2010; Seeman, 1996). According to Stetzer (2020) the clergy need three kinds of relationships in the form of social support to help them deal with compassion fatigue in their pastoral work:

i. Friends who know them well as pastors
ii. Mentors who will hold them responsible and guide them in their ministerial lives,
iii. Decision-making body to help them lead their congregation.

By these Stetzer (2020) is suggesting that if the clergy enjoy social support their compassion fatigue and compassion satisfaction levels reduces and increases respectively, thereby enhancing their professional quality of life.

Using the above diagram, the clergy have a high job demand in the form of preaching, officiating worship services, teaching members, helping people cope with grief and loss, helping members get over life crisis and counselling church and non-church members. The high job demand serves as a source of stress for the clergy. If the clergy receive social support from their clergy colleagues (who can give them morale support and encourage them when they are down), their superiors in the ministry (who can mentor and guide them when necessary) and boards (who will serve as decision bodies to help them lead their members) then the clergy can enjoy compassion satisfaction.

However, if the clergy do not receive social support to cushion against these constructs of stress, then the clergy experience either burnout or secondary traumatic stress or both.

1.5 Purpose of the Study

The purpose of the study was to investigate the relationship among perceived social support, compassion satisfaction, burnout, and secondary traumatic stress within the clergy in the Central Region of Ghana.

1.6 Research Objectives

The broad aim of this study was to examine the relationship among perceived social support, compassion satisfaction, burnout, and secondary traumatic stress within the clergy in the Central Region of Ghana. To achieve this, the study was guided by the following objectives:

1. To examine the level of compassion satisfaction among clergy in the Central Region of Ghana.
2. To assess the level of burnout among clergy in the Central Region of Ghana.
3. To examine the level of secondary traumatic stress among clergy in the Central Region of Ghana.
4. To evaluate the level of perceived social support among clergy in the Central Region of Ghana.

1.7 Research Hypotheses

H01: There is no statistically significant relationship among compassion satisfaction, perceived social support, secondary traumatic stress, and burnout among the clergy in the Central Region of Ghana.

H02: There are no gender differences based on:

- Compassion satisfaction

- Perceived social support
- Secondary traumatic stress, and
- burnout

1.8 Significance of the Study

The study is pertinent, in that it will increase awareness for clergy to gain a better understanding of the factors influencing their well-being, such as perceived social support, compassion satisfaction, burnout, and secondary traumatic stress. This awareness can help them recognize signs of stress and develop strategies to manage it effectively. The findings of the study can also inform the development of supportive policies within religious organizations aimed at addressing burnout and secondary traumatic stress among clergy members. This may include providing access to resources such as counseling services, peer support groups, or stress management programs. Again, clergy members may use the insights from the study to inform their professional development efforts. This could involve seeking out training opportunities related to self-care, boundary setting, and resilience-building techniques to better cope with the demands of their role. The study will also help religious organizations to provide support services to their communities, including counseling and pastoral care. The findings of this study can help these organizations better understand the factors that contribute to the well-being of their clergy and other staff members, enabling them to develop support systems and policies to address burnout and secondary traumatic stress.

Human resource managers in various institutions can use the insights from this study to develop policies and programs aimed at supporting employees in helping professions. By understanding the factors that contribute to compassion satisfaction and decrease burnout, HR managers can create a supportive work environment that

promotes employee well-being and retention. Again, researchers and academicians will benefit from the study's findings as it contributes to the existing body of knowledge on social support, compassion satisfaction, burnout, and secondary traumatic stress. The study can serve as a reference point for future research endeavors in this area, guiding researchers in designing studies and interventions aimed at improving the well-being of helping professionals. Finally, professionals in helping roles such as therapists, counselors, and social workers can benefit from the findings of this study. Understanding factors such as perceived social support, compassion satisfaction, burnout, and secondary traumatic stress can inform their practice and help them develop strategies to improve their well-being and effectiveness in their roles.

1.9 Delimitations of the Study

Delimitations are concerned with the classifications that the researchers decide to use as boundaries or parameters of their work to enable them to achieve the aims and objectives of their study. The researcher did not include all the other helping professions in the population because research shows there have been some studies on the clergy work-related psychological health, stress, and well-being issues. Again, the researcher chose to collect data from the clergy in only the Central Region of Ghana. The scope of the study is in two forms: the contextual scope and the geographical scope. The contextual scope of this study was restricted to how perceived social supported amalgamate with compassion satisfaction, burnout and secondary traumatic stress to impact the professional quality of life of the clergy. In terms of the geographical scope, the study covered the Central Region of Ghana.

1.10 Definition of Terms

Burnout	Physical and emotional exhaustion that make a helping professional lack the ability to empathize (Stamm, 2009).
Clergy	Christian men and women ordained as religious ministers like Pastors, Reverend Ministers, Apostles, Prophets and Moderators (Novieto, 2013).
Compassion satisfaction	The feeling of satisfaction that the helping professional receives from helping others by taking care of them.
Orthodox Churches	Christian churches which form the Christian Council of Ghana
Pentecostal Churches	Christian churches that form the Ghana Pentecostal and Charismatic Churches (GPCC)
Pentecostal clergy	A trained and an ordained minister who is in charge of a Pentecostal church
Perceived social support	Perception of availability and adequacy of social networking.
Professional Quality of Life	This a is a three-dimensional idea that may be described as the perception of well-being that individuals go through when their personal needs in their occupational settings are met (Roney & Acri, 2018). Compassion fatigue, burnout, and compassion satisfaction are the components of Stamm's conceptualisation of Professional Quality of Life (ProQOL; Stamm, 2010).
Received Social Support	The quantity and quality of social networking received

Secondary traumatic stress	The effect of constantly listening to these stories culminate in what psychologists refer to as "secondary traumatic stress" (Maslach & Leiter, 2016; Parker & Martin, 2011; Stamm, 2009).

1.11 Organization of the Chapters

The study will be organized into five chapters. Chapter one will provide the background study with specific emphasis on the statement of the problem, research objectives, research questions, hypothesis, significance of the study scope and the organization of the study. Chapter two will provide a comprehensive review of literature pertinent to issues pertaining to perceived social support, compassion satisfaction, burnout, and secondary traumatic stress. The review will also cover the physical and psychological impact of fatigue, and how it impacts the clergy. The review will also cover the theoretical and empirical side of issues. Chapter three will provide a detailed methodology with specific emphasis on the research design, study area, sample and sampling technique, data collection instruments, data collection procedure, as well as data management and analysis. Chapter four will present data collection from the field, as well as key findings in relation to literature or past findings. Chapter five will present the summary, conclusions, and some pertinent recommendations.

CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction to the Chapter

This chapter presents literature on burnout, its similarity to, yet difference from stress and other similar constructs. The chapter also explores the different categories of burnout, and how burnout affects people in the helping professions. In addition, the chapter will talk about people classified as "helpers" (Young, 2013, p. 45). The chapter also describes actual and perceived social support in how it interacts with burnout. Finally, the chapter takes a look at the unique position of the clergy in their role as 'helpers' and how this role intersects with burnout, social support, and their daily help to congregants. Each of these sub-topics are categorized under "theoretical" or "empirical" review.

2.1 Theoretical Review

2.1.1 Maslow's Theory of Needs

Abraham Maslow in his seminal work explaining the hierarchy of needs theory of motivation, posited that towards the journey of life satisfaction, individuals meet five sets of needs set up like a hierarchy (Maslow, 1943). To be complete, satisfied and happy, people have to meet each of these needs from the bottom of the pyramid to the top – physiological, safety, social, esteem, and self-actualization. Hotchkiss and Lesher (2018) set out to examine the relationship between self-care practices and the professional quality of life of chaplains. They synthesized Maslow's hierarchy of needs (Benson & Dundis, 2003), mindful self-care by Cook-Cottone and Guyker (2018), compassion fatigue by Figley (1995), and compassion satisfaction by Stamm

(2010) to provide the theoretical framework that explained needs and motivations pertinent to people in the helping profession such as chaplains.

The idea of Maslow's model is that lower-level needs (deficiency motivations) must be fulfilled before higher level needs (higher motivations) are addressed (Maslow, 1968). Maslow's hierarchy of needs is often represented in a pyramidal structure with lower-level needs at the base (physiological, safety, belonging, esteem), ending in a growth motivation (self-actualization). Based on the resource depletion perspective which suggests that helping professionals experience physical and mental exhaustion when they help distressing people by taking care of them, burnout was conceptually used to represent the resource depletion framework.

Again, secondary traumatic stress was used to represent the emotional contagion perspective framework which refers to the secondary effect of trauma on the helping professional when they help people who go through traumatize situations (Hatfield, Cacioppo, & Rapson, 1993). Conceptually, Hotchkiss and Lesher referred to compassion satisfaction and mindful self-care as contributing factors of well-being whiles burnout and secondary traumatic stress, were described as detractors of well-being in the study. The six domains of Mindful Self Care Scale (MSCS) were conceptualized to represent Maslow's hierarchy of needs as follows: physical care and mindful relaxation (physiological needs), supportive structure (safety needs), supportive relationships (belonging needs), mindful awareness (cognitive needs), and self-compassion and purpose (esteem needs; Maslow, 1968).

According to the study, chaplains who enjoyed compassion satisfaction and frequently practiced various self-care strategies had lower burnout risk. Mindful self-care practices and secondary traumatic stress served as mediators between the association of compassion satisfaction and risk for burnout. Self-compassion and

purpose, and mindful self-awareness were seen as the strongest mediators between compassion satisfaction and burnout. This finding establishes the importance of calling in the chaplain's life and self-awareness for general well-being.

Each of these findings confirm the theoretical grounding, based on Maslow's model, that lower-level needs (deficiency motivations) must be fulfilled before higher level needs (higher motivations) are addressed. Also, compassion satisfaction expresses chaplain self-actualization. When chaplains experience a sense of joy and purpose, and have their needs fulfilled as theorized in the Maslow hierarchy, they can cushion the effect of both secondary traumatic stress and burnout. This supports the findings of earlier studies which suggested that being satisfied and finding meaning in one's vocation can serve as a protective factor against stress and burnout (Pereira, Fonseca, & Carvalho, 2011; Pinikahana & Happell, 2004) The findings also support the existing studies that show a positive relationship between professional well-being and work meaningfulness (Leiter, Harvie, & Frizzell, 1998; Tzeng, Ketefian, & Redman, 2002).

2.1.2 Job Demands Resource Theory

Benton and Girdley, (2023) in their study, sought to examine the occupational demands and resources that predicted burnout, secondary traumatic stress and compassion satisfaction as well as the factors of wellbeing for the clergy. This study was conducted in the period of the COVID-19 pandemic. The authors adopted the Job Demands and Resources theory as their theoretical framework for the study. Four hundred and ten clergy out of the 444 responses provided complete data for the study.

From the result of their study the following were observed: Average scores for the clergy in their sample were: Burnout (M=25.98, SD=6.50); Secondary Traumatic

Stress (M=24.69, SD=6.43); and Compassion Satisfaction (M=37.23, SD=6.47). These scores were based on the raw data without the use of the t-conversion. These results were compared to some studies which did not utilize the earlier versions of Stamm's work in a meta-analysis as a benchmark to burnout, secondary traumatic stress and compassion satisfaction. Helping professionals (N=5,612) were examined in De La Rosa (2018) which was conducted before the COVID-19 pandemic. The following average level results were obtained BO (M=22.8, SD=5.4); STS (M=16.7, SD=5.7); CS (37.7, SD=6.5

According to Benton and Girdley, (2023), age had been a steady predictor of BO, STS, and/or CF in earlier studies (Francis et al., 2008), age was therefore entered as a control variable in the first step. The second step involved clergy COVID-specific organizational and care tasks. The job demands of Role Ambiguity (RA) and Role Conflict (RC) were entered in the third step.

According to JD-R theory, Self-care (SC) can be classified as a personal resource and therefore was entered in the fourth step. The variables for social support were entered in the fifth step. The following results were observed from the three five-step hierarchical regressions. Age was a significant predictor for all the outcomes or the components of Professional Quality of Life (PROQOL). The first hypothesis stated that COVID-related job tasks were a predictor of Burnout, Secondary Traumatic Stress, and Compassion Satisfaction. The second step for all models showed a significant R^2 change over the control of age. Organizational tasks had a positive significant association with BO and STS, and a significant negative association to CS. Care tasks were a significant positive predictor for STS, but not for BO or CS. When perceived congregational emotional support and anticipated congregational support were added as variables to the final model, only the analysis

for compassion satisfaction showed a significant increase in variability, and only emotional support was significant. The fourth hypothesis was only partially confirmed.

In the last model, the combined job demand variables produced 35% of the unique predictive ability for burnout, 28% of the unique predictive ability for secondary traumatic stress, and 31% of the exceptional predictive ability for compassion satisfaction. Combined Job resource variables produced 15% of the exceptional predictive ability for burnout, 8% of the exceptional predictive ability for secondary traumatic stress, and 10% of the exceptional predictive ability for compassion satisfaction. Self-care was the variable with much influence for burnout in the final model, pr2 (409) =.14, p <.001.

2.1.3 Social Support Theory (Cullen, 1994)

Lisa Kort-Butler (2018) in her study on the Social Support Theory tried to establish the relationship among social support, crime, and delinquency. Kort-Butler credited the origin of social support theory to Cullen (1994). Kort-Butler pointed out the distinction Cullen made between macro-level (societal) and interpersonal-level (relationship) impacts of social support. These distinctions were made to emphasize on how macro- level support and interpersonal support can reduce societal and individual crime rates. He also argued that social support is a predictor of effective social control and rehabilitation. Kort-Butler (2018) argued that unlike other theories of crime and delinquency which have their focus centered on negative aspects of life like: lack of social relationships, low self-control, learned nonstandard behaviours, naming, stigmatization, etc, social support theory directs its attention to the positive things that can avert and or lessen crime and delinquency. Kort-Butler describes social

support as social resources on which people can depend on when addressing challenges in life as well as stressors. According to Kort-Butler (2018) social support is not only in the form of informal, where social relations give assistance but can also be formal through entities with official positions like government assistance programmes or the justice system.

Kort-Butler also described social support in different forms: Perceived and received support. Perceived social support is described as the feeling of availability of support while received support is reported as the provision of assistance or help. Kort-Butler also categorized support as: instrumental, informational, or emotional. Instrumental social support is when people receive tangible materials as assistance from macro-level or relationship level. Informational support refers to the situation where people receive advice, guidance, or provision of information that may assist them deal with a problem. Emotional support refers to the showing of sympathy, caring, esteem, value, or encouragement.

Differences in both perceived and received social support emanate from structural conditions; thus, the social background and social setting determine the quantity and the value of the relationships on which an individual can depend for social support. Kort-Butler drew the differences and similarities between social support theory and social altruism theory (Chamlin & Cochran, 1997). Whereas social altruism theory argues that community altruism is distinct and has relevance if offered by the state, social support theory stresses that supportive societies involve both community and state sources. In spite of this difference, both social altruism theory and social support theory accept that the provision of social support goes beyond tangible support; rather, supportive communities also respond to individuals' emotional and informational needs.

Kort-Butler further argued that both social support and social altruism recognize the inverse relationship between social support and lower crime rates at the macro-level. This is because social support may act as a cushion between harmful effects of anomie and community-based factors associated with higher crime rates. Again, Social support has direct and indirect impact on delinquency and other factors of well-being. As a direct impact, individuals who experience social support may be involved in less delinquency. As an indirect impact, social support may act as a cushion between risk factors for delinquency and involvement in delinquent behaviour. Generally, the higher the level of an individual's social support, the lesser the likelihood that person will commit crime. With regards to adolescents, the more support teenagers receive from people and the systems around them, the lower the rates of delinquency.

2.2 Empirical Review

In order to get more accurate description of Professional Quality of Life and Social Support among the clergy, the researcher empirically reviewed related literature. The empirical review centered on the findings of earlier research works on the topic. The study deemed it suitable to review literature on the following areas:

1. Burnout
2. Compassion Satisfaction among the Helping Professions
3. Compassion Fatigue among the Helping Professions
4. Social support – Perceived and Actual
5. Clergy Vocation and Stressors

2.2.1 Burnout

An increasing number of researchers are investigating the phenomena of burnout in the helping professions (Maslach, 2018; Maslach & Leiter 2016; Sodeke-Gregson, Holttum & Billings 2013; Martin, 2018; Bagnall et al., 2016); Burnout has been defined as a psychological syndrome that develops from one's job and environmental stressors characterized by severe physical, emotional, and mental exhaustion, cynicism, and lack of personal accomplishment (Bagnall et al., 2016; Maslach & Leiter, 2016). Maslach has a succinct way of defining burnout; she describes burnout as "a syndrome of emotional exhaustion, depersonalization, and reduced personal accomplishment" (Maslach 1982, p. 3). Maslach expatiates on this by describing burnout as physical, emotional, and mental exhaustion of an individual.

In addition to what Maslach says, Stamm conceptualizes burnout as the secondary component of compassion fatigue (Stamm 2010; Heritage et al., 2018) characterized by emotional exhaustion, low level of personal accomplishment and cynicism (Stamm 2010; Maslach 1982; Heritage et al., 2018). Emotional exhaustion is the primary stress construct of burnout. A lot of definitions have been given for emotional exhaustion which include feeling of being emotionally overstretched; the shortage of emotional drive; lack of physical strength; a loss of vigor; a depletion, feebleness, and fatigue (Dolghie, 2018; Martin, 2018; Danielson, 2017; Bagi, 2013; Maslach et al., 1997). According to these experts, the underlining factors of emotional exhaustion are job overload and work-related struggles (Dolghie, 2018; Lourenco, 2016).

Low personal accomplishment is the self-assessment aspect of burnout. This is usually represented by poor job performance, having a feeling of incompetence, and lacking the ability to be productive at work (Martin, 2018; Dolghie, 2018; Lourenco,

2016; Bagi, 2013; Maslach et al., 1997). This feeling of poor self-efficacy has been associated with depression (Rossler, 2012; Hakanen & Schaufeli, 2012).

Cynicism is the relational construct of burnout. Cynicism is defined as an adverse, or extreme separation response to others (Martin, 2018; Dolghie, 2018; Lourenco, 2016; Bagi, 2013; Maslach et al., 1997). Usually, cynicism is marked by loss of idealism and irritability (Martin, 2018; Danielson, 2017; Maslach, Jackson, & Leiter, 1997).

2.2.2 Compassion Satisfaction among the Helping Professions

Yu, Jiang, and Shen (2016) conducted a study in helping professionals from ten tertiary hospitals and five secondary hospitals in Shanghai, China. The objective of the study was to describe the prevalence of predictors of professional quality of life (compassion fatigue, burnout and compassion satisfaction) among Chinese oncology nurses under the guidance of two theoretical models. A quantitative approach and a cross-sectional design were employed for this research. Six hundred and fifty out of the 669 selected oncology nurses returned valid questionnaire for statistical analyses. The nurses who participated in the study completed the demographic and work-related questionnaire, the Professional Quality of Life Scale for Nurses (the Chinese version), the Perceived Social Support Scale, the Jefferson Scales of Empathy (Chinese version), the Simplified Coping Style Questionnaire, and the Chinese Big Five Personality Inventory brief version. Simple and multiple linear regressions, descriptive statistics, t-tests, and one-way analysis of variance were used to determine the predictors of the main study variables. The results revealed that years of job experience contributed to increased compassion satisfaction levels and decreased compassion fatigue levels. Thus, oncology nurses with more years of nursing experience, who were working in the secondary hospitals and implemented inactive

coping styles, had higher compassion fatigue and burnout. Cognitive sympathy, training and organizational support were recognized as noteworthy protectors, and 'perspective taking' was the significant factor of compassion satisfaction, explaining 23.0% of the variance. Personality traits of openness and conscientiousness were positively related to compassion satisfaction, while neuroticism had a negative relation, resulting for 24.2% and 19.8% of the variance in compassion fatigue and burnout, respectively.

Hunsaker, Chen, Maughan and Heaston, (2015) conducted a study on factors that influence the development of compassion fatigue, burnout, and compassion satisfaction in emergency department nurses in the United States of America (US). The purpose of this study was two-fold: (1) to determine the occurrence of compassion satisfaction, compassion fatigue, and burnout in emergency department nurses all over the US; and (2) to observe the demographic and work-related components which affect the development of compassion satisfaction, compassion fatigue, and burnout in the above-mentioned helping profession. Hunsaker and colleagues (2015) employed the quantitative approach and a nonexperimental, descriptive, and predictive design. In this study, 1,000 emergency nurses were selected all over the US. Professional Quality of Life (PRoQOL) version 5 questionnaire was used to ascertain the occurrence of compassion satisfaction, compassion fatigue, and burnout among this sample. The researchers also employed multiple regression using stepwise solution to ascertain which of the demographic variables and work-related attributes predicted the occurrence of compassion satisfaction, compassion fatigue, and burnout. Findings of the study revealed an average low levels of compassion fatigue and burnout, and generally average to high levels of compassion satisfaction within this group of helping professionals. The results of the Hunsaker study also revealed that

the higher levels of burnout and compassion fatigue among these emergency department nurses is as a result of low level of managerial support. On the other hand, high level of managerial support brought about a higher level of compassion satisfaction. Based on the studies of Yu and colleagues as well as Hunsaker et al, (2015) it can be reported that both job experience and managerial support are predictors of compassion satisfaction.

Ruiz-Fernández, et al., (2021) also conducted a similar study on emergency department nurses in Andalusia, Spain. The objective of the study was to examine professional quality of life in hospital emergency department nurses based on perceived health, perceived social support and a series of socio-demographic and socio-occupational variables. The approach of the study was similar to the Hunsaker et al., (2015) study. Two hundred and fifty-three emergency department nurses took part in the study. Results of the study indicated that 62.5% had high levels of compassion fatigue, compassion satisfaction (45.1%), yet burnout levels were moderate (58.5%). According to Ruiz-Fernández et al., (2021), the low levels of compassion satisfaction displayed by the participants in their study was not because of the high levels of compassion fatigue and burnout. Ruiz-Fernández et al., (2021) asserted that data for their study revealed one of the factors which influences compassion satisfaction is job experience and, as a result, the detected levels of compassion satisfaction have been significantly higher in professionals with lower job experience. It was also revealed in this same study that, the challenges present in the emergency departments serve as a motivating factor at the initial stages of an individual's career - this is the period in which professionals also experience high level of energy. However, as time goes on, and the individual continues in the work, these services may lead to a decline in compassion satisfaction.

This assertion made by Ruiz-Fernández et al., (2021) that professionals with minimal work experience enjoy higher levels of compassion satisfaction differs from the study of Hunsaker and colleagues which states that higher managerial support promotes compassion satisfaction. However, the assertion of Ruiz-Fernández and colleagues is in agreement with Yu and colleagues who also suggested that job experience is a predictor of compassion satisfaction. Nonetheless, these two assertions have a divergent view. While Ruiz-Fernández and colleagues are arguing that professionals with lower job experience have higher levels of compassion satisfaction, Yu and colleagues are arguing contrary that compassion satisfaction level is higher in the jobs with higher job experience.

2.2.3 Compassion Fatigue Among the Helping Professions

Snelgar, Renard, and Shelton (2017) conducted a study to investigate whether spiritual intelligence and intrinsic motivation can serve as precursor to compassion fatigue. Data analysis for this study included both descriptive and inferential statistical analysis. Based on their study, Snelgar and colleagues made the following findings: a positive, significant relationship exists between Spiritual intelligence (SQ) and intrinsic motivation. They found that intrinsic motivation and compassion fatigue also had a significant negative correlation according to the correlation results, while a structural equation modeling suggested a positive relationship. Thus, intrinsic motivation was partially related to compassion fatigue, signifying preliminary backing for the possibility that clergy might reduce their levels of compassion fatigue by improving their levels of intrinsic motivation. This might be achieved through developing their emotional link to their work and their internal ambition to contribute successfully to society.

It is in this regard that Van Schooneveld (2016) connects the scriptural reference in Ephesians 2: 10; that we were created in Christ Jesus for good works, which He prepared beforehand for us to do. Thus, it behooves on us to do something to improve our world. The clergy should indeed serve others in order to make a positive impact in their lives, which is a factor of intrinsic motivation. As noted by Casey (2013), compassion fatigue may be lessened by clergy feeling satisfied and rewarded by the services they render, signifying that being intrinsically motivated is possible to negate the feelings related with compassion fatigue. A possible way to explain the SEM result, which showed that intrinsically motivated clergy are more disposed to compassion fatigue, is that intrinsic motivation is probable to increase clergies' performance levels, focus and/or effort, which therefore in turn heightens their possibility of experiencing compassion fatigue.

Gallardo and Rohde (2018) conducted a study which investigated the occurrence of, and the relationships among, personality types, demographic characteristics, and compassion fatigue. A correlational and comparative research design was used. The research was conducted on 234 long-term care workers, which included registered nurses, licensed vocational nurses, certified medication aides, and certified nurse aides from 7 facilities within the state of Texas in the USA. Findings showed that 70% of the people who participated in the research were in the "high risk" group for compassion fatigue. Personality was a major predictor of compassion fatigue. Multiple regression revealed that Big Five personality traits were mainly related to a risk for compassion fatigue, resulting for 37% of the variance ($p <$ .001). Demographic categories of tenure, licensure type, working hours, and number of clients cared for were also measured for their influence on compassion fatigue. Employment tenure was the single demographic grouping directly connected to

compassion fatigue in this study. The less-than-1-year-of-tenure category revealed the lowest level of compassion fatigue and proved a significantly lower level than all of the other comparison categories. This finding does not concur with the findings of earlier research by Yu et al., (2016) which indicated that the higher the tenure of working experience the lower the level of compassion fatigue.

2.2.4 Social support – Perceived and Actual

Eagle, Hybels and Proeschold-Bell (2019) conducted an investigation to support their argument that perceived support is best hypothesized more as a measure of how an individual evaluates their state rather than a true reflection of quantity and quality of support they receive. To test this concept, Eagle and colleagues made use of survey data from the Clergy Health Initiative Panel Survey to observe the relationship between perceived and received (actual) social support and their relationship with depressive symptoms in clergy (n = 1,288). Generally, their analyses revealed perceived support and actual support had a weak relationship. Greater perceived support had a significant association with lower depressive symptoms. On the contrary, greater actual support had only a little relationship with lower depressive symptoms, which was fully facilitated by perceived support.

According to Eagle and colleagues (2019), perceived support was far more substantial than actual support in terms of predicting depressive symptoms. This is in line with the Ruiz-Fernández (2021) study which showed that perceived social support was significantly correlated to all three dimensions of professional quality of life but had the greatest impact on the occurrence of burnout. The study also demonstrated that variations in perceived support were partially driven by higher levels of actual support and also probably from related factors such as size of congregation that were not associated with actual support. Again, even in the population with high levels of

actual support like the clergy, depression was found to be significantly not related to actual social support and, when measured along with perceived social support, had a very weak association. According to the authors, these findings are not in agreement with earlier research that suggested that perceived and actual social supports are significantly related (Hobfoll, 2009). The findings also do not agree with the idea that perceived and actual social support are weakly associated because they function on different time scales (i.e., perceived support considers a long-term evaluation of support, but actual support only evaluates short-term experiences). They asserted that this research measure of actual support was spread over a relatively long period of time, yet actual support was still weakly associated with the measures of perceived support.

2.2.5 Clergy Vocation and Stressors

Clergy have often been recognized as first point of contact for people with mental health issues and 'doorkeepers' to mental health services (Chalfant et al 1990). The job description of clergy is diverse and includes leadership roles which involve engaging people constantly. Researchers have classified clergy roles into six categories: (a) preacher, (b) deliverer of rituals and sacraments, (c) pastor, (d) teacher, (e) organizer, and (f) administrator (Blizzard 1956; Milstein et al. 2005). These roles are highly demanding and needs a lot of skills and competencies to enable the clergy exercise these functions effectively (Huang et al., 2012).

The role of the clergy to maintain good and sound community regarding mental health cannot be refuted (Shikanda, Kiptiony & Ndiso, 2022). Clergy vocation is among the most reliable and demanded professions. Individuals and families run to clergy for help in a varied traumatic experience (McBride, Sedlacek, Baltazar, Matthews & Chelbegean 2013). Proeschold-Bell et al. (2013) argued that clergy

counselling involves grief as they officiate funerals. Clergy are also the first point of call to many individuals who seek help when depressed. They also often arbitrate over tough conflicts in both church and family members as well as dealing with emergency situations. These add up to the already demanding routine functions of preparing and preaching of sermons, directing of church services, and providing organizational leadership to their churches (Doehring, 2013). If cushioning psychosocial resources are not available, this exposure often leads to traumatic experiences and emotional exhaustion (Shikanda, Kiptiony & Ndiso, 2022).

Adams, Proeschold-Bell, Yao and Kolkin, (2016) conducted research on 84 different studies using the Maslach Burnout Inventory (MBI) which measures three features of burnout: emotional exhaustion (EE), depersonalization (DP), and personal accomplishment (PA). Adams and colleagues (2016) sought studies using comparable versions of the MBI for clergy, social workers, counselors, teachers, police officers and emergency personnel. The aim of the study was to ascertain the level of the above-mentioned features of burnout (EE, DP and PA) associated to these occupations as compared to the clergy occupation. The authors discovered that clergy experienced less burnout symptoms, at least in the emotional exhaustion and depersonalization domains, than the typical comparable helping professionals. Thus, even if clergy are more stressed, or exceptionally stressed (Foss, 2002), they do not seem to be experiencing more emotional exhaustion or depersonalization as other helping professionals do. The lower level of emotional exhaustion for clergy compared to other helping professions like teachers, police officers, etc. may be as a result of unique cushioning features of the clergy role which includes ministry satisfaction, Sabbath-keeping, and mentoring relationships (Barnard & Curry 2012; Beebe 2007).

This finding of Adam et al., 2016 is in alliance with the findings of Shikanda, Kiptiony, and Ndiso (2022).

Shikanda et al., (2022) conducted a cross-sectional correlational study which sought to investigate the influence of emotional exhaustion on mental health of clergy in Kenya. Descriptive statistical methods like mean and standard deviation were used to analyze data. Correlation between the research variables was measured with Spearman's Rank Correlation. Shikanda et al., (2022) submitted in their findings that a section of the clergy who participated in the study were at risk of emotional exhaustion because they spend all day attending to the members of their congregation as well as their communities.

This is contrasted to the viewpoint by Adams et al., (2016) who suggested that clergy had lower level of emotional exhaustion which may be due to cushioning features of the clergy role which includes ministry satisfaction, Sabbath-keeping, and mentoring relationships. Shikanda and colleagues also reported that most of the participants of their study had the notion contrary to the assertion that clergy work was emotionally exhaustive. By this, the participants were suggesting that they got satisfaction from working as clergy. This is in line with the report of Adams et al., (2016). Shikanda et al., (2022) therefore suggested that experiences of emotional exhaustion varied from context to context as a result of personal and environmental factors that may be predictors of such experiences. They further suggested that experiences of emotional exhaustion reported by the participants of the study may be linked to the different roles, responsibilities and leadership expectations associated with the clergy vocation.

Fia, Fosu-Ayarkwah and Kusi (2022) Conducted research to investigate the impact of stress and burnout on the quality of life of pastors in Assemblies of God

Church in the Ashanti Region, Ghana. Fia and colleagues adopted a descriptive survey design for the study. Using stratified and simple random sampling procedures, a sample of 254 was used. Data were collected using a questionnaire and data analysis was done with the use of means and standard deviations, linear multiple regression, independent samples t-test, and one-way analysis of variance (one-way ANOVA). Findings of the study showed that the clergy felt emotionally exhausted as a result of their vocation as clergy. Fia, Fosu-Ayarkwah and Kusi (2022) concluded that the clergy who participated in their study experienced EE due to lack of financial resources, social support and the pressure associated with achieving one's occupational goal as a clergy. This assertion concurs with the report of Shikanda et al., (2022) which suggested that emotional exhaustion differs from context to context because of individual and environmental factors.

Even though the above literature (Adams et al., 2016; Fia et al., 2022 & Shikanda et al., 2022) have divergent views on emotional exhaustion of the clergy, they all agree that the clergy vocation is emotionally exhaustive. Emotional exhaustion can cause the clergy to lose interest and vitality in their vocation, this can also cause cynicism and emotional distance as a result of depersonalization (Abernethy, Grannum, Gordon, et al., 2016). A combination of these constructs can bring about a reduction in the effectiveness in the clergy vocation and therefore resulting in lower personal accomplishment (Abernethy et al., 2016). By this, Abernethy et al., 2016 means the constructs of burnout are interconnected thus one construct can lead to the other.

Adams et al., (2016) also realized that clergy seemed to have generally higher levels of DP than social workers or counselors, almost the same DP levels as teachers, but lower DP levels than that of emergency personnel and police officers. DP in

pastoral work could have disturbing consequences for all involved, considering the highly interpersonal and social nature of the clergy work. Clergy are expected to interact with a great number of people in a myriad of social situations in their work than social workers or counselors. Although clergy mostly do not get any psychological training in managing trauma, clergy may also have bigger religious and spiritual resources for managing secondary exposure to trauma and the suffering of others. Religious beliefs may lead clergy to humanize others in ways that reduce DP. This assertion is in line with the findings of Shikanda et al., (2022) which suggested that the clergy had low level of burnout in the DP domain because the clergy had spiritual exercises which serve as a form of cushioning against burnout in the form of depersonalization.

Social workers or counselors only interact individually with their caseload. The social interaction of clergy may be almost the same as teachers, whose interactions are both with individuals and groups. Maslach, Schaufeli and Leiter (2001) asserted that increasingly frequent interaction with service receivers may result in increased DP. Foss (2002) found that emotional triangulation, personal criticism by service receivers, and adrenaline exhaustion were positively related to DP for both helping professionals as a whole and clergy in particular. Exclusively among clergy (not among other helping professionals), adrenaline exhaustion was related to DP. Clergy probably have a degree of secondary trauma exposure (Bledsoe, Setterlund, Adams, Fok-Trela & Connolly 2013; Hall 1997; Jacobson, Rothschild, Mirz & Shapiro 2014), which may be more recurrent than for social workers or counselors who are not usually first responders. However, clergy experience to trauma and crisis control may be less in frequency than that of police or emergency personnel. Although clergy mostly do not get any psychological training in managing trauma, clergy may

also have bigger religious and spiritual resources for managing secondary exposure to trauma and the suffering of others. Religious beliefs may lead clergy to humanize others in ways that reduce DP. In order to protect themselves and others, police officers are asked to commit violence against perpetrators this could result in higher DP for them.

In all over the studies it was analyzed that, clergy demonstrated higher burnout in the PA domain than counselors. Counselors' role is with a smaller group of individuals in more restricted settings and have built-in restrictions that do not produce the same kinds of interpersonal stressors that clergy usually face, such as being criticized frequently. Additionally, based on their employment scope, counselors may have the potential to regulate their caseload and make more income than clergy. Again, a lot of cultural changes take place among church members that may result in higher burnout in the PA domain for clergy. These include mostly educated laity, less trust in centralized authority, lower commitment to denominations and religious institutions, and lower social status for the clergy role (Hoge & Wenger 2005).

Another discovery made by Adams et al., (2016) was that in terms of Personal Achievement (PA) burnout, Clergy may be similar to social workers this is because clergy and social workers share similar challenges of role complexity, role conflict, and role ambiguity. Again, clergy work is ambiguous in nature, the reason being that indicators of success are not noticeable. In addition, tangible prove of results is hard to find in relation to spiritual development and growth in individuals' lives. A lack of tangible signs of effectiveness may contribute to burnout in the PA domain. It may also be likened to social workers and teachers because clergy do not always see results of their work immediately because the progress in the lives of individuals they help can be slow or difficult to realize at times. It was found that, across studies, clergy

showed lower levels of burnout in the PA domain than emergency personnel or police officers.

Although clergy are regularly called upon to help in traumatic events, the role complexity for clergy may actually provide some variety, giving breaks from intense interactions with congregants that are not always possible for emergency personnel or police. In addition, because of the sacred nature of the clergy work, the clergy experience faith, ministry satisfaction, and existential contentment. These factors may contribute to a greater sense of self-efficacy in their work. This assertion is in agreement with previous research which report that when the clergy exercise faith by depending on God for strength, burnout associated with the clerical work can be mitigated (Hessel 2015; Chandler 2009). Similarly, pastors who resort to prayer and have a regular devotional life often enjoy lower levels of burnout from emotional exhaustion and depersonalization, and tend to maintain higher levels of personal accomplishment (Hessel, 2015; Turton & Francis, 2007).

2.2.6 Professional Quality of Life and the Clergy

Hotchkiss and Lesher (2018) conducted research with the purpose of examining the relationship between self-care practices and the professional quality of life of chaplains. Hotchkiss and Lesher proposed the following hypotheses: (a) Age, years of working experience, educational background, board certification status, job setting, and employment status were predictors of burnout; and (b) Enjoying compassion satisfaction, the practice of multiple and frequent self-care strategies would reduce the risk of Burnout among chaplains; secondary traumatic stress would increase Burnout risk.

2.3 Summary of the Chapter

This chapter provided a comprehensive review of literature under theoretical and empirical frameworks. Three theoretical frameworks (Maslow's Theory of Needs, Job Demands Resource Theory and Social Support Theory) related to social support, professional quality of life and well-being of individuals in the helping professions were discussed.

Job Demands Resource Theory: Benton and Girdley (2023) applied the Job Demands Resource theory to clergy during the COVID-19 pandemic. They found that age predicts burnout, secondary traumatic stress, and compassion satisfaction. COVID-related organizational tasks, role ambiguity, role conflict, and self-care are significant predictors of professional quality of life outcomes. The study emphasized the importance of self-care in mitigating burnout, with combined job demand variables explaining a significant portion of variability in outcomes.

Social Support Theory: Kort-Butler (2018) explored the relationship between social support, crime, and delinquency, building on Cullen's Social Support Theory. It distinguished between macro-level and interpersonal-level impacts of social support, emphasizing its positive role in reducing crime rates. The theory categorizes support into perceived and received, as well as instrumental, informational, and emotional forms. It argues that supportive communities, encompassing both community and state sources, can reduce delinquency rates by providing emotional and informational support. Additionally, it suggests that higher levels of social support led to lower crime rates, especially among adolescents.

The empirical review covered a comprehensive range of literature related to Professional Quality of Life (ProQOL) and Social Support among members of the helping professions including the clergy. The following topics were discussed under

the empirical review: Burnout, Compassion Satisfaction among the Helping Professions, Compassion Fatigue among the Helping Professions, Social Support – Perceived and Actual and Clergy Vocation and Stressors.

CHAPTER THREE

RESEARCH METHODOLOGY

3.0 Introduction to the Chapter

Like a blueprint, this chapter will discuss the procedures engaged for this research (Acquaye, 2016; Fawcett & Garity, 2009). Topics to be considered in this chapter will include research philosophy, research design, population, sample and sampling technique, data collection instrument, data collection procedure as well as data management and analysis. The chapter shall also provide information on ethical considerations as well as study organization.

3.1 Research Philosophy

Research philosophy is the description of a researcher's theoretical perspective; it informs and determines the method being used in research (Crotty 1998; Patten & Newhart, 2018). Research philosophy is essential because it defines the design going to be utilized and why (Easterby-Smith, et al., 1999). Research design and the process of research are influenced by people's beliefs about the world (Collis & Hussey, 2003). Depending on researchers' opinions about research procedures, there are four kinds of research philosophy: positivism, interpretivism, realism and pragmatism (Saunders, et al., 2009).

This researcher's research paradigm or philosophy is Positivism. In the positivism philosophy, researchers treat issues objectively without influencing the actual issue being researched. Thus, positivism philosophy requires a methodology that is very well designed, quantifiable observations and statistical analysis (Remenyi

et al., 2005). Specifically, positivism presumes that researchers make an objective analysis and interpretation for data gathered (Saunders et al., 2009).

This researcher believes that there is a single reality, and this reality can be measured and known. This belief system is contrary to *Constructivists* and *Pragmatists* who believe that reality needs to be interpreted and debated respectively because of multiplicity of realities. This study dealt with issues objectively devoid of impacting the real problem being researched (Al-Ababneh, 2020). Thus, the researcher made use of well-structured methodology, quantifiable observations and statistical analyses (Remenyi et al., 2005). A quantitative approach was therefore utilized to enable the researcher to measure the reality being sought for impartially and statistically. Thus, to be able to examine the relationship among compassion satisfaction, burnout, secondary traumatic stress, and perceived social support among the clergy in the Central Region of Ghana, quantitative method was the best fit for this study.

3.1.1 Ontological Stance

Ontology is the perception we have about what reality is and what exists (Richards, 2003). The researcher's ontological position or stance is Realism (Al-Ababneh, 2020; Richards, 2003). Realists believe that reality exists in the world, and this reality does not depend on human thoughts and beliefs (Al-Ababneh, 2020). The researcher is of the view that objects exist independently of the knower (Cohen et al., 2007). This assertion is opposed to the idealism ontological stance that asserts that reality depends on an individual's mental state (Al-Ababneh 2020; Guba & Lincoln, 1994). The researcher's assumption is that reality is not mediated by human senses.

The researcher has no influence on the outcome (empirical findings) of the research and the researched has no influence on the researcher.

3.1.2 Epistemological Stance

Epistemology involves the suppositions one makes about what knowledge really is (Cohen et al., 2007). The epistemological position or stance of the researcher is objectivism. Objectivists believe that the object or the matter being researched, and the researcher do not depend on, nor are they connected to each other (Crotty, 1998). Contrary to this epistemological stance is the idealist which asserts that the researcher and the object being researched are connected or interdepended on each other (Guba & Lincoln, 1994). This researcher is of the view that the object or the matter (Compassion satisfaction, burnout, secondary traumatic stress and perceived social support among the clergy) being researched, and the researcher do not depend on or connected to each other (Crotty, 1998). Meaning can only be found in the object being researched not in the conscience or mind of the researcher.

3.2 Research Approach

Research approach is a design and process that entails the procedures of extensive assumptions to comprehensive methods of collecting, analysing and interpretating of data (Patten & Newhart, 2018). Research approach depends on the kind of research problem being considered. The research approach is basically divided into two types:

i. the approach of data collection and
ii. the approach of data analysis or reasoning.

Approaches to data analysis are also of two categories:

i. inductive and
ii. deductive

The inductive approach is utilized to analyse qualitative data. Deductive approach on the other hand is utilized to analyse quantitative data. Both the inductive and the deductive approaches are utilized together to analyse mixed type of data (Chetty, 2016).

In order to be able to have quantifiable observations, statistical analysis, and adopt the quantitative approach for this study, the study made use of the inductive approach to data analysis and hence, adopt the quantitative approach. Quantitative research involves numerical data that is built on the assumption that the numbers will define a single reality. The statistical approach is applied to find correlations between and among variables (Lodico et al., 2010). The idea of this approach is to establish, confirm, or validate correlations as well as generalize findings that can make contribution to theory (Leedy & Ormrod, 2001).

3.3 Research Design

The cross-sectional correlational design is employed for this study (Patten & Newhart, 2018). In cross-sectional designs, researchers assess the research variables at one point in time to define a population of interest (Williams, 2007). In a correlational research design, the researcher assesses the relationship between two variables of the study. Patten and Newhart (2018) posited that the aim of correlational research is to establish the relationship between two or more variables. From the above definitions, cross-sectional correlational design can be defined as a study in which the researcher seeks to assess the relationship between two or more variables in a study at a particular point in time without manipulating the research variables used to collect the research data. This study sought to examine the relationship among compassion satisfaction, burnout, secondary traumatic stress, and perceived social support of the clergy in the Central Region of Ghana.

3.4 Population

The population of a study consists of all the elements that meet the criteria for inclusion in a study (Cozby, 2000; Patten & Newhart, 2018). The target population for this study was 1,854 clergy men and women serving in the various Christian denominations in the Central Region of Ghana (Pentecostal, Charismatic, Orthodox and Catholic). This population included clergy who attend the various umbrella denominational monthly meetings, like the Ghana Pentecostal and Charismatic Council (GPCC), National Association of Charismatic and Christian Churches (NACCC), Christian Council of Ghana etc., as well as clergy in individual churches who are not under any umbrella organization. The figure for the target population was obtained through verbal communications with the leadership of the various individual and umbrella denominations.

Table 1. Population List

Denomination	Males	Females	Total
Pentecostal	687	26	713
Charismatics	492	38	530
Orthodox	481	78	559
Catholic	52	-	52
Total	**1,712**	**142**	**1,854**

3.5 Sample and Sampling Procedure

A sample is a fraction of the population (Patten & Newhart, 2018). It is usually not possible to have the participation of all the population on which research is being conducted, therefore a smaller element of the population known as sample is selected for data collection. This sample selected for data collection is used to draw inferences for the entire population (Turner, 2020; Valliant & Dever, 2011). The entire

population can also be referred to as 'target population' and the sample population is referred to as "study population. The procedure for choosing a sample population from the target population is known as the 'sampling method (Elfil & Negida, 2017). There are two main types of sampling methods:

1. probability sampling methods. In this type of sampling method, all members of the target population have equal opportunities to be chosen in the sample (Wretman, 2010; Shorten & Moorley 2014).
2. Non-probability sampling methods. In this type of sampling method, the sample population is not systematically selected and therefore does not affirm equal opportunities for each member of the target population (Shorten & Moorley 2014).

This study used a non-probability sampling called Purposive Sampling otherwise known as judgement sampling. In this method of sampling, the participants for the sample are deliberately selected by the researchers depending on the research question. This method is generally criticized because it has the tendency of biasness of the researchers' judgement and therefore unlikely to represent the population (Teddlie & Yu 2007). However, this study used the purposive sampling technique (Patten & Newhart, 2018) because not everyone is a clergy, and the clergy were the people who had the information needed for the study.

3.6 Study Area

The Central Region is one of the sixteen regions in Ghana. It covers an area of 9,826 square kilometres, which is 4.1 percent of Ghana's land area. The Central Region is the third smallest in area after Greater Accra and Upper East Regions. It shares common borders with Western Region on the west, Ashanti and Eastern Regions on the north, and Greater Accra Region on the east. On the southern flank is

the Atlantic Ocean (Gulf of Guinea) which covers 168-kilometres of Ghana's coastline. The region's total population according to 2021 Population and Housing Census (PHC) is 2,859,821 which represents 9.3% of Ghana's total population (2021 PHC).

The definition of the contextual scope as well as the geographic scope to guide a study is an important element in research. Simon and Goes (2013) define the "scope of the study" to mean the parameters under which a study is operated. The scope thus refers to the domain of the research and what is not. The scope of this study will cover the clergy in the Central Region of Ghana. The scope of the study was in two forms: Thus, the contextual scope and the geographical scope. The contextual scope of this study was limited to how compassion satisfaction, burnout, secondary traumatic stress and perceived social support impact the professional quality of life of the clergy. In terms of the geographic scope, however, this study covered the Central Region of Ghana.

3.7 Sample size

A G*Power a-priori test (figure 2; Faul, Erdfelder, Lang, & Buchner, 2007) analysis indicated that a sample size of 134 was adequate to achieve a medium effect size (Field, 2018; Hahs-Vaughn & Lomax, 2020; Patten & Newhart, 2018). Alpha was set at .05 with a two-tailed specification. The sample size was therefore fixed at 134 respondents. This means that when the sample size is more or less of what the a-priori test indicates, the effect size could change. To ensure consistency, there is the need for post-priori test to compare the effect size, which is also known as the clinical significance (Hahs-Vaughn & Lomax, 2020).

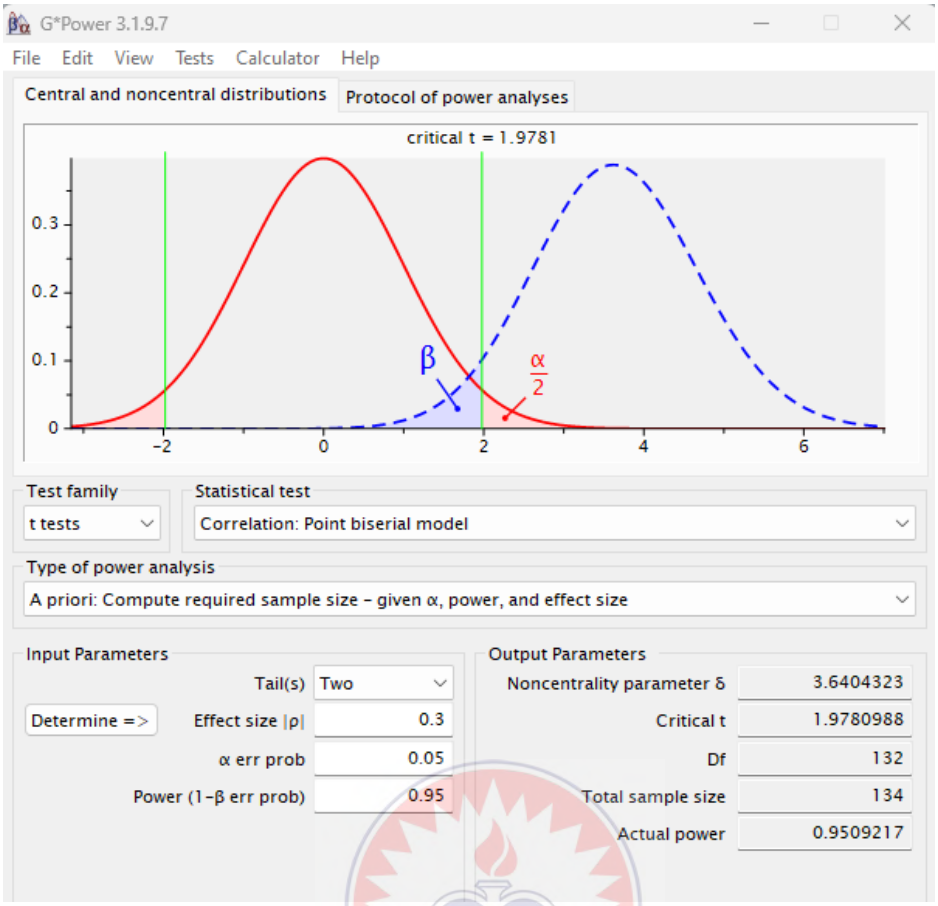


Figure 2 **G*Power a-priori power analyses**

3.8 Research Instruments

Three main instruments were used to gather information from participants. They were the Interpersonal Support Evaluation List (ISEL – Cohen et al., 1983), Professional Quality of Life Scale (PRoQOL; Stamm, 2005), and a demographic questionnaire. Each of the scales directly applied to the respondents of the study. The instruments were also not pilot-tested on any similar sample.

3.8.1 **Interpersonal Support Evaluation List** (ISEL – Cohen et al., 1983).

This instrument is a 12-item Likert-type instrument that is a brief version from the original 40-item ISEL developed in 1983. The questionnaire has three domains – appraisal support; belonging support; and tangible support. Each of the 12 items is

rated on a 4-point scale that ranges from “definitely true” to “definitely false”. Sample items include “there is someone I can turn to for advice about handling problems with my family”, and “when I need suggestions on how to deal with a personal problem, I know someone I can turn to.” All the items are summed up to give a total score (scores range from: 0 –36).

Though some previous studies (Brookings & Bolton 1988; Rogers et al. 2004; Schonfeld 1991) highlight the inconsistency in previous research regarding the factor structure of the Interpersonal Support Evaluation List (ISEL) (Cohen & Hoberman 1983; Cohen et al. 1985), several other studies have demonstrated strong internal consistency reliability for both the total ISEL score and its subscales, supported by Cronbach's alpha and moderate to strong item-item correlations. (Ghesquiere et al., 2017) sought to assess the psychometric properties of the ISEL in a sample of older adults with complicated grief. They also sought to explore whether ISEL scores were related to symptoms of complicated grief. In their findings, Ghesquiere and colleagues stated that their analysis revealed strong internal consistency reliability for the ISEL composite as well as the ISEL subscales, as indicated by Cronbach's alpha. (Ghesquiere et al., 2017) concluded in their study that, ISEL demonstrated strong psychometric properties in a sample of individuals seeking treatment with complicated grief and therefore recommended the use of ISEL in research works.

3.8.2 **Professional Quality of Life Scale** (PRoQOL; Stamm, 2005)

The PRoQOL is an instrument that assesses the quality a person feels in relation to their work as someone who helps (e.g., nurse, teacher, counsellor, pastor). As the most commonly used measure of negative and positive affect, the instrument

recognizes that both the positive and negative aspects of doing a person's work affect the way that work influences their professional quality of life.

The measure has been in use since 1995. The PRoQOL includes the positive emotion of compassion satisfaction (CS) and negative emotion compassion fatigue (CF). Compassion Fatigue is composed of two parts. The first part concerns emotions like anger, depression, and exhaustion. These are all typical reactions of burnout. Moreover, negative emotions caused by fear and work-related trauma are clustered under secondary traumatic stress (Stamm, 2010).

The PRoQOL is a 30-item scored on a 5-point Likert-type scale that ranges from 'never' (1) to 'very often' (5). Sample items in the instrument are "I feel depressed because of the traumatic experiences of the people I minister to", and "I have beliefs that sustain me." Because the instrument was originally developed for counsellors and psychologists, the profession name was changed from "therapy" to "minister" to reflect the participants who are the focus of this study.

The PRoQOL is composed of three unique sub-scales which do not necessarily yield a composite score. Thus, researchers are advised not to use the total score as a representation of professional quality of life, but use each of the three sub-scales as a complete scale assessing burnout, secondary traumatic stress, and compassion satisfaction. Each scale is psychometrically unique and cannot be combined with the other scores.

The PRoQOL in its general sense has been used in projects for more than 30 countries around the world. It is available in English, French, German, and Hebrew. It has been used across many different types of profession. For instance, in this study, clergy are the main respondents hence pastor/pastoring were used to replace help/helper/helping) without any ambiguity.

3.8.3 Demographic questionnaire

Demographic information offers data concerning research respondents and is essential for the determination of whether the people in particular research are a representative sample of the target population for generalization purposes (Lee & Schuele, 2010) The demographic questionnaire for this study sought answers to questions like gender, how long a person had been in ministry, what the home situation looked like (e.g., number of children, caretaking of aging relatives), and the size of the congregation.

3.9 Reliability and Validity of Instruments

To ensure that research studies are dependable, it is necessary to ensure adequate measurement of reliability is achieved (Patten & Newhart, 2018). Validity is as important as reliability because validity focuses on the accuracy of a measure – whether the study truly measures what it claims to measure. In this case, does the study really measure professional quality of life and social support among clergy?

3.9.1 Reliability of Instruments

Reliability, the consistency of scores across time and the closeness of items in an instrument, was assessed via the internal consistency. Table 1 describes the instruments, their Cronbach's alpha index as well as their comparison with both the normed sample of the instrument developers vis-à-vis two sample groups – one in the Greater Accra and another in the Central regions of Ghana.

Table 2. Indices of Internal Reliability of Instruments

Group	Total PRoQOL	CS	Burnout	STS	ISEL
Normed group from instrument developers	-	0.88	0.75	-	
Sample of Ghanaian Senior High School Teachers in the Greater Accra region	0.96	0.68	0.21	0.73	-
Sample of Ghanaian nurses in the Central Region	0.94	0.95	0.42	0.84	-
Current sample of clergy in Central Region	0.91	0.95	0.52	0.71	0.76

Internal consistency was measured via SPSS, with the Cronbach's alpha as the index of internal consistency (Field, 2018). Cronbach's alpha was the index used to measure reliability, and Cohen's (1988) index was used as a measure of classification (i.e., acceptable; strong; very strong). A score of less than 0.60 is considered 'not reliable'; scores between .60 and .79 are considered adequate; and scores at and above .80 are considered excellent.

3.9.2 Validity of Instruments

Validity, the ability of an instrument to measure what it intends to measure was assessed with face validity (Patten & Newhart, 2018). Inspection of the items in each

instrument, based on the expert opinion of supervisors, revealed that the instruments measured what they intended to measure.

3.10 Ethical Considerations

Ethics in research and counselling demand that we recognize the basic rights of humans. In recognizing these basic rights, we respect clients and participants' rights to autonomy, while activating our own principles of beneficence and justice (Remley & Herlihy, 2016). The following ethical standards were observed:

3.10.1 Informed Consent

Approval was gained from the Department of Counselling Psychology when the Head of Department (HoD) signed an introductory letter for me to start data collection. Moreover, my supervisor took me through training on Human Subjects Research Protocol to understand the sensitive nature of integrating research with clinical work, and the role of participants in the study. Informed consent was voluntary and continuous throughout the process (see Appendix C). An integral part of the Informed Consent process was to let participants know that they could pull out of the study without victimization.

3.10.2 Confidentiality and Privacy

Participants were not asked to provide their names nor any identifying information to protect their privacy. Moreover, data were kept digitally under multiple layers of password protection to ensure confidentiality for participants.

3.11 Data Collection Procedure

The invitation to partake in the study was for clergy in the Central Region of Ghana. Sampling was drawn from the entire Central Region through social media: email and WhatsApp and also through snowballing. Invitations were mostly sent to denominations representing Pentecostal, Charismatic, Orthodox, and Catholic clergy.

However, the researcher did not ask participants to identify their individual church affiliations, since this study was to look at the clergy in entirety and not specific individual denominations.

Participants were invited to complete an anonymous one-time online questionnaire delivered through Google forms, with no follow-up. Once the participants selected the Google form link, they were directed to an informed consent form, and upon approving, respondents were taken to the 52-item questionnaire. These items asked questions around ministry-related factors which included, gender, years in ministry, marital status, social support, burnout, secondary traumatic stress, and compassion satisfaction.

3.12 Data Analytic Procedure

Raw data was imported into SPSS version 28. Thereafter, data were inspected to ensure that there were no errors with the importation as well as from non-response from respondents. Table 3 describes each research objective and hypothesis with its corresponding analytical tool.

Table 3. Data Analytic Procedural Format

Objective	Analytic Tool
1. Level of compassion satisfaction	One sample t-test
2. Level of burnout	One sample t-test
3. Level of secondary traumatic stress	One sample t-test
3. Level of perceived social support	One sample t-test
H01: Relationship among compassion satisfaction, perceived social support.	Pearson's correlations
H02: Gender differences in each of the variables	Independent samples t-test (Man Whitney U Test, if there are uneven groups to adequately satisfy the assumptions for Independent samples t-test)

Data screening also involved assessing the data to ensure that assumptions for the different tests have not been violated (e.g., for t-test analysis, no significant outliers in groups; dependent variable to be approximately normally distributed for each group of independent variables. For correlations, assumption of bivariate normality and linear relationship among variables; Field, 2018; Hahs-Vaughn & Lomax, 2020).

CHAPTER FOUR

LIMITATIONS, RESULTS, AND FINDINGS

4.0 Introduction to the Chapter

This chapter explains the limitations that occurred as a result of data collection. The chapter also describes the respondents; specifically, the chapter explains gender characteristics, age, educational level, and type of church that respondents manage. In addition, the data analyzed the differences and relationships between and among variables, and connects the results to the literature reviewed.

4.1 Limitations of the Study

No study is perfect; each one is plagued with multiple limitations. This study aimed to assess the relationship among compassion satisfaction, burnout, secondary traumatic stress and perceived social support of clergy in the Central Region of Ghana. In spite of the best efforts to maximize reach, the sample collected was relatively small (n = 103) and should not be considered a reflection of clergy in the Central Region of Ghana. Future research should include a larger sample size. Moreover, data from diverse groups of clergy could also be included. Another limitation to this study is that sampling was non-probability. Generalizability is therefore not assured.

Again, data for the study was collected digitally. The questionnaire was sent to respondents through email and WhatsApp. This would make it difficult for the respondents whose opinions would have mattered but did not have the technological savviness to contribute to the study. Again, since the study was done under strict confidentiality and therefore did not set any identification verification tool, it was difficult to ascertain if the respondents who provided the answers were the right people. For example, some people could ask other family members like spouses, children, and friends to answer the questions for them.

Finally, the inclusion criteria for the study meant that people with no formal education could not contribute their opinions to the study. This implies that there may be other people in the population who were not allowed to take part in the study because they did not have formal education.

4.2 Results of Data Collected

Results of data include descriptive analysis of demographic information (e.g., gender, age, educational qualification, etc.). Analysis of the research objectives involved parametric data analysis (Field, 2018) like one sample t-test, Man Whitney U test and Pearson's Product Moment Correlation (Hahs-Vaughn & Lomax, 2020).

4.2.1 Demographic Information

The demographic information of respondents consisted of gender, age, intimate relationship status, composition of both nuclear and extended family, as well as highest educational qualification. To understand their clergy-related roles, participants were also asked which unique denominational classification they fell under, the number of years they had worked as ministers, and the numerical strength of their congregation.

4.2.1.1 Gender

Majority of the participants (n = 103) were male (n = 100; 97.1%). The remaining self-reported as female (n = 3; 2.9%).

4.2.1.2 Age

One participant did not indicate how old they were. The average mean age of participants was 44.64 years old (sd = 8.45; min = 28 years old; max = 68 years old). The median age of participants was 43 years.

4.2.1.3 Intimate Relationship Status

Of the 103 participants, none was widowed. The majority (85.4%) however indicated they were married (see Figure 3), with one indicating they were divorced, and 14 (13.6%) indicating they were single.

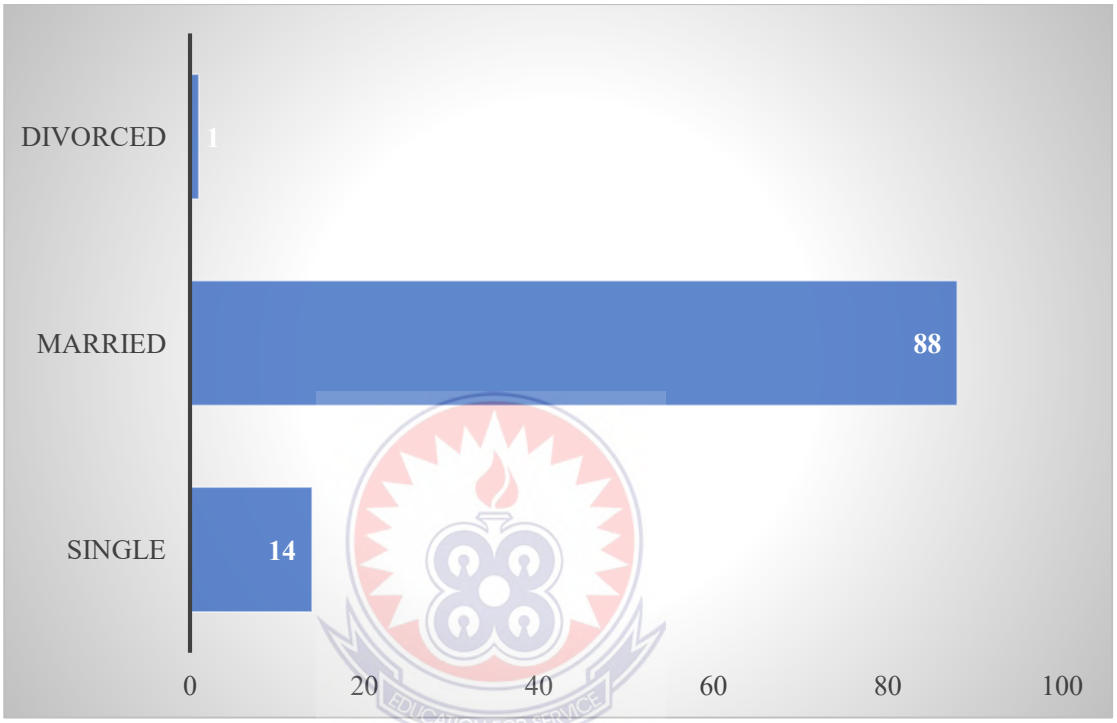


Figure 3 Bar Graph of Intimate Relationship Status

4.2.1.4 Composition of nuclear and extended family

The majority of respondents indicated they had biological and/or adopted children living with them (n = 86; 83.5%). And the majority indicated they did not have aged or ailing extended family members (e.g., in-laws; parents) living with them (n = 61; 59.2%).

4.2.1.5 Highest Educational qualification

The majority of the respondents had some university education.

Table 4 Highest educational qualification of respondents

Education	Frequency	Percent
Secondary / Technical	9	8.7
First Degree	45	43.7
Master's Degree	36	35.0
Doctorate Degree	4	3.9
Others (e.g., diploma / certificate in Theology)	9	8.7
Total	**103**	**100**

4.2.1.6 Denominational Classification

Denomination was classified as Catholic, Orthodox, Pentecostal, and Charismatic. Orthodox included the Methodist Church, AME Zion Church, Presbyterian Church, and Anglican Church. Pentecostal included the Christ Apostolic Church International, Church of Pentecost, The Apostolic Church, and Assemblies of God Church. Finally, Charismatic included Lighthouse Chapel, Royal House Church, Calvary Charismatic Center, International Central Gospel Church, and all other one-man churches within the study area. The majority of the clergy indicated they were Pentecostal (n = 69).

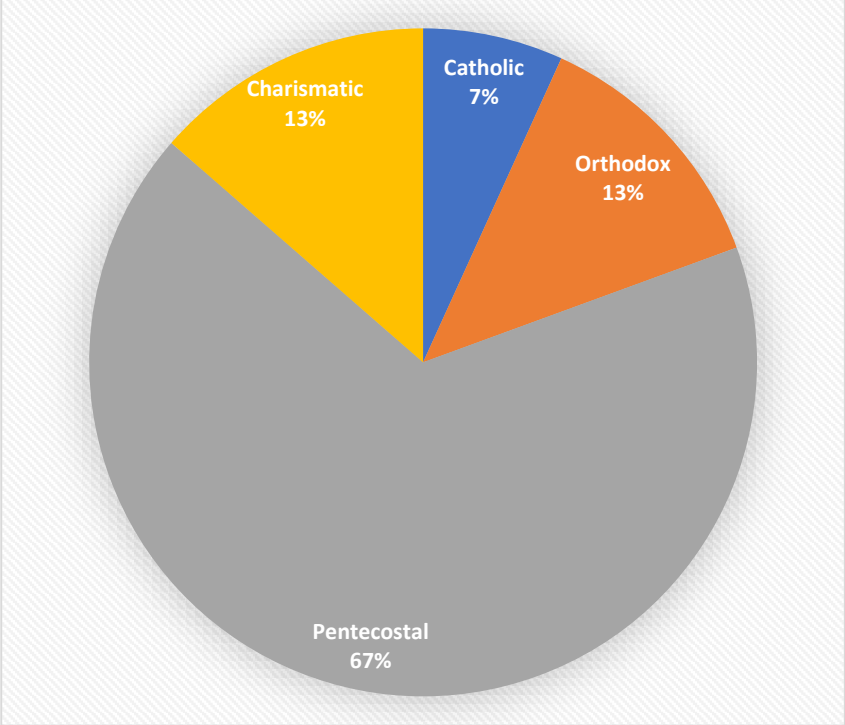


Figure 4 Pie chart of denominational classification

4.2.1.7 Years Worked in Ministry

On average, participants had worked in ministry for a minimum of 1 year to a maximum of 51 years (*Md* = 14 years; *M* = 15 years; *sd* = 9.25).

4.2.1.8 Numerical Strength of Congregation

Participants had between 20 members to 34,650 members (*Md* = 300 members; *M* = 763.23 members; *sd* = 3408.77).

4.2.2 Assessing the Reliability of the Instruments

Reliability of instruments means the consistency with which the instrument consistently reflects the construct that is measured by giving the same score if used over time or across multiple administrations (Field, 2018). This also means how closely related a set of items are as a group.

The reliability of the instrument assessing quality of life which encompasses compassion satisfaction, burnout, and secondary traumatic stress, was excellent (α =

.914; Cohen, 1988). The reliability of the instrument assessing perceived social support was acceptable (α = .757; Cohen, 1988).

4.3 Answering Research Objectives

Four research objectives grounded this study. The first sought to find the level of compassion satisfaction among clergy. The second assessed the level of burnout within the sample of clergy. The third examined the level of secondary traumatic stress among clergy. The final one unearthed the level of perceived social support among clergy.

The one-sample t-test was deemed appropriate to answer each of the four research objectives. The one sample t-test is used to compare a value from a sample to a criterion measure or some other value.

Table 5. Means of Comparison Groups for Variables

Group	Compassion Satisfaction	Burnout	Secondary Traumatic Stress	Perceived Social Support
Normed Group from Instrument development (*n* = 1.076 for PRoQOL)	50.40 (9.77)	50.37 (10.26)	50.18 (10.15)	26.18 (6.80)
Ghana SHS Teachers in Greater Accra Region (*n* = 300)	35.50 (4.93)	29.44 (3.46)	34.62 (5.49)	-
Ghanaian nurses in the Central Region (*n* = 52)	30.44 (6.98)	31.73 (8.98)	26.46 (7.06)	-

If the mean of this current sample is significantly different from the mean of each of the variables being measured (i.e., compassion satisfaction, burnout, secondary

traumatic stress, and perceived social support), it could be concluded that this current sample has more or less of that variable being measured.

4.3.1 Research Objective 1 – Compassion Satisfaction levels

The Amo-Broni (2022) study of Ghanaian nurses in the Central Region used PRoQOL to assess compassion satisfaction, secondary traumatic stress, and burnout in nurses working in the Central Region of Ghana. Because the terrain and characteristics in terms of taking care of others are more aligned with this current sample, the average scores were used as the criterion measure for comparison with this current group.

Table 6. One-Sample T-Test for Compassion Satisfaction

	n	*t*	*df*	*M*	*SD*	*p-value*	*95% CI*
Nurses (30.44)*	103	11.33	102	40.64	9.13	<.001	8.41 – 11.99

* Figure represents test-value or comparison mean

The mean *compassion satisfaction* score (40.64 ± 9.13) was statistically significantly higher than the comparison nurses in Central region, $t(102) = 11.33$; $p < .001$. The mean *compassion satisfaction* score was statistically significantly higher by 10.0 (95%CI 8.41 to 11.99) than the comparison score of 30.44. A standardized effect size attempts to provide a measure of the practical significance of the results. Effect size measured by *Cohen's d* demonstrated a very large effect (Cohen's $d = 1.12$).

4.3.2 Research Objective 2 – Burnout Levels

The Ghanaian nurses in Central region study was still the comparison mean for this research objective. The mean *Burnout* score (21.89 ± 5.41) was statistically significantly lower than the comparison nurses in Central region, $t(102) = -18.46$; $p < .001$.

Table 7. One-Sample T-Test for Burnout

	n	*t*	*df*	*M*	*SD*	*p-value*	*95% CI*
Nurses (31.73)*	103	-18.46	102	21.89	5.41	<.001	-10.89 – -8.78

* Figure represents test-value or comparison mean

The mean *Burnout* score was statistically significantly lower by -9.84 (95%CI -10.89 to -8.78) than the comparison score of 31.73. Effect size measured by *Cohen's d* demonstrated a very large effect (Cohen's $d = 1.81$).

4.3.3 Research Objective 3 – Secondary Traumatic Stress Levels

The Ghanaian nurses in Central region study was still the comparison mean for this research objective.

Table 8. One-Sample T-Test for Secondary Traumatic Stress

	n	*t*	*df*	*M*	*SD*	*p-value*	*95% CI*
Nurses (26.46)*	103	-2.75	102	24.90	5.74	.007	-2.68 – -.44

* Figure represents test-value or comparison mean

The mean *secondary traumatic stress* score (24.90 ± 5.74) was statistically significantly lower than the comparison nurses in Central region, $t(102) = -2.75$; $p =$

.007. The mean *secondary traumatic stress* score was statistically significantly lower by 9.84 (95%CI -2.68 to -.44) than the comparison score of 26.46. Effect size measured by *Cohen's d* demonstrated a small effect (Cohen's d = -.27).

4.3.4 Research Objective 4 – Social Support Levels

The ISEL-12 instrument has not yet been used with Ghanaian samples. The closest sample with similar cultural practices that this instrument has been tested on is a sample of Hispanics living among their people in the United States (Merz et al., 2013). The mean for the 12-item ISEL was 26.18 (SD = 6.80) for those living in Florida, and 27.39 (SD = 9.45) for those living in California.

Table 9. One-Sample T-Test for Perceived Social Support

Comparison Sample to Ghanaian sample	***n***	***t***	***df***	***M***	***SD***	***p-value***	***95% CI***
Florida (26.18)*	103	8.66	102	30.15	4.65	<.001	3.06 – 4.87
California (27.39)*	103	6.02	102	30.14	4.65	<.001	1.85 – 3.66

* Figure represents test-value or comparison mean

The mean *perceived social support* score (30.15 ± 4.65) was statistically significantly higher than the comparison Hispanics living in Florida, $t(102) = 8.66$; $p < .001$. The mean perceived social support score was statistically significantly higher by 3.97 (95%CI 3.06 to 4.87) than the comparison score of 26.18. A standardized effect size attempts to provide a measure of the practical significance of the results. Effect size measured by *Cohen's d* demonstrated a large effect (Cohen's d = .85).

When compared to Hispanics living in California, the mean perceived social support for clergy in Central region of Ghana (30.14 ± 4.65) was also statistically significantly higher. The mean perceived social support score was statistically significantly higher by 2.76 (95%CI 1.85 to 3.66) than the comparison score of 26.18. There was a medium effect size (Cohen's *d* = .59).

This means that clergy in Central Region reported higher compassion satisfaction and higher perceived social support scores than their comparison groups. They however reported lower incidence of burnout and secondary traumatic stress than their comparison groups.

4.4 Testing the Hypotheses

The hypotheses for the study were set to determine the relationship among the main variables, as well as gender differences in each of the variables.

4.4.1 Hypothesis 1 – Relationship among all variables

Hypothesis one set out to establish the relationship among compassion satisfaction, burnout, secondary traumatic stress, and perceived social support among clergy in the Central region of Ghana. The Pearson's Product Moment Correlation (Field, 2018) was deemed the appropriate analysis to understand this hypothesis.

Table 10. Descriptive Statistics and Correlations for Study Variables

Variable	*n*	*M*	*SD*	1	2	3	4
1 CS	103	40.641	9.135	1			
2 Burnout	103	21.893	5.407	-.710**	1		
3 STS	103	24.903	5.739	.260**	.252*	1	
4 PSSpt	103	30.146	4.645	.322**	-.235*	.066	1

** Correlation is significant at the 0.01 level (2-tailed)

* Correlation is significant at the 0.05 level (2-tailed)
CS = Compassion Satisfaction; STS = Secondary Traumatic Stress
PSSpt = Perceived Social Support

Correlations range from -1 to +1. A negative sign is indicative of an inverse relationship, while a positive sign indicates direct or positive relationship. The closer a number gets to one, the stronger the correlation coefficient (Field, 2018; Hahs-Vaughn & Lomax, 2020; Patten & Newhart, 2018).

The null hypothesis was rejected. The null said there would be no differences, but there were multiple differences between and among variables.

Compassion Satisfaction had a strong negative relationship with Burnout (r = -.710; $p < .01$). Compassion Satisfaction had a minimal positive relationship with secondary traumatic stress ($r = .260$; $p < .01$). Compassion satisfaction had a minimal positive relationship ($r = .322$; $p < .01$) with perceived social support.

Burnout had a strong negative relationship with compassion Satisfaction (r = -.710; $p < .01$). Burnout had a minimal positive relationship ($r = .252$; $p < .05$) with secondary traumatic stress. Burnout had a minimal negative relationship with perceived social support (r = -.235; $p < .05$).

Secondary Traumatic Stress had a minimal relationship ($r = .322$; $p < .01$) with Compassion Satisfaction. Secondary Traumatic Stress had a minimal positive relationship ($r = .252$; $p < .05$) with Burnout. Secondary Traumatic Stress had no relationship ($r = .066$; $p > 0.1$) with Perceived Social Support.

Perceived Social Support had a minimal positive relationship ($r = .322$; $p < .01$) with Compassion Satisfaction. Perceived Social Support had minimal negative relationship (r = -.235; $p < .05$) with Burnout. Perceived Social Support had no relationship ($r = .066$; $p > .05$) with Secondary Traumatic Stress.

4.4.2 Gender Differences in Variables

According to Lund and Lund (2023), the independent-samples t-test is used to determine if a difference exists between the means of two independent groups (e.g., male and female) on a continuous dependent variable (e.g., compassion satisfaction; burnout; perceived social support). There are six assumptions that have to be considered when embarking on an independent samples t-test. First, there must be continuous dependent variable; the dependent variable should be measured on interval or ratio scale. Second, the independent variable should be categorial with two groups. Third, there has to be independence of observations. Fourth, there should be no significant outliers in the two groups of the independent variable in terms of the dependent variable. Fifth, the dependent variable should be approximately normally distributed for each group of the independent variable. Sixth, there should be homogeneity of variances, which means that the variance should be equal in each group of the independent variable.

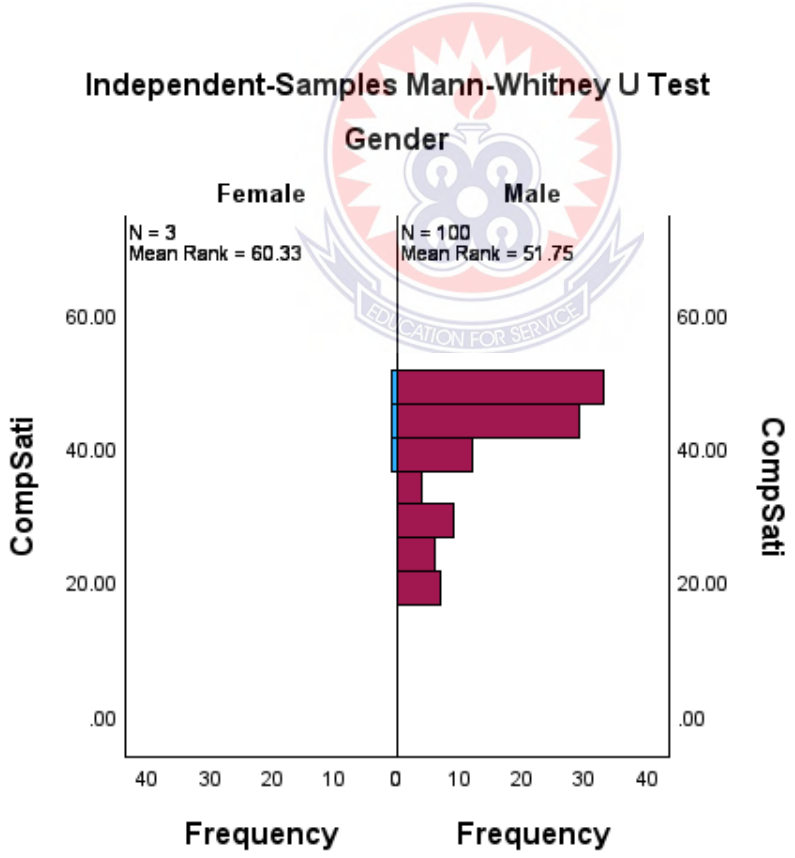
Table 11. Independent samples t-test for variables

Variable	Male [Mean (SD)]	Female [Mean (SD)]	*t*(101)	*p*-value	95%CI	Cohen's *d*
Compassion Satisfaction	*n* = 100 40.53 (9.22)	*n* = 3 44.33 (4.73)	-.709	.48	-14.45 to 6.84	-.42
Burnout	*n* = 100 21.95 5.47)	*n* = 3 20.00 (1.73)	.614	.54	-4.35 to 8.25	.36
Secondary Traumatic Stress	*n* = 100 24.86 (5.79)	*n* = 3 26.33 (4.04)	-.436	.59	-8.17 to 5.22	-.26

Perceived	$n = 100$	$n = 3$			-1.79 to	
Social	30.25	26.67	1.32	.51	8.96	-.77
Support	(4.54)	(7.77)				

We fail to reject the null hypothesis. In layman's terms, we agree that there is no gender differences in compassion satisfaction, burnout, secondary traumatic stress, and perceived social support. This means when it comes to each of these variables, both male and female clergy experience them similarly.

However, because of the violation of the equal groups' assumption, the nonparametric equivalent, Mann-Whitney U test, was performed to understand the mean rank differences.



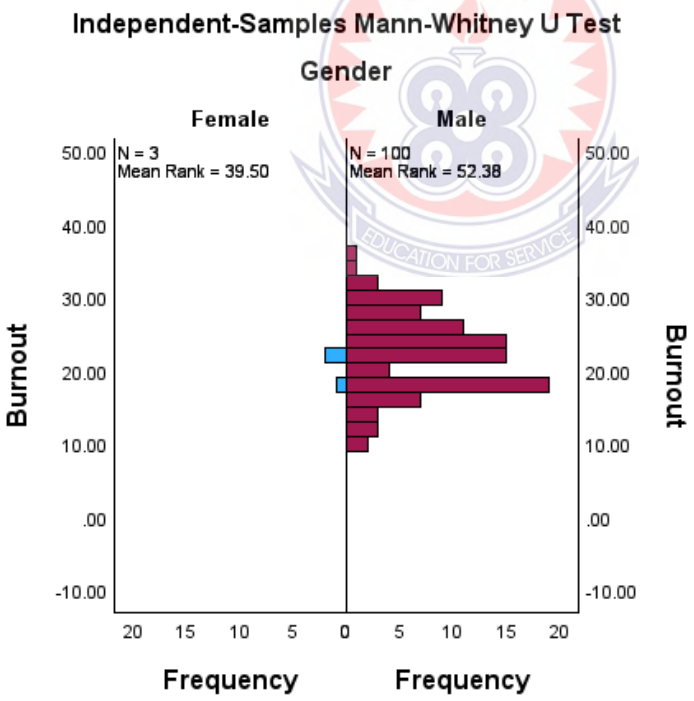
Independent-Samples Mann-Whitney U Test Summary

Total N	103
Mann-Whitney U	175.000

Wilcoxon W	181.000
Test Statistic	175.000
Standard Error	50.853
Standardized Test Statistic	.492
Asymptotic Sig.(2-sided test)	.623
Exact Sig.(2-sided test)	.649

Figure 5. Mann-Whitney U diagrams for Compassion Satisfaction

Retain the null hypothesis that there is no gender difference in compassion satisfaction (p = .65). Distributions of the compassion satisfaction scores for males and females were similar, as assessed by visual inspection. Median compassion satisfaction score for males (51.75) and females (60.33) was not statistically significantly different, U = 175, z = .492, p = .649. This confirms the independent samples t-test that both male and female clergy experience compassion satisfaction similarly.



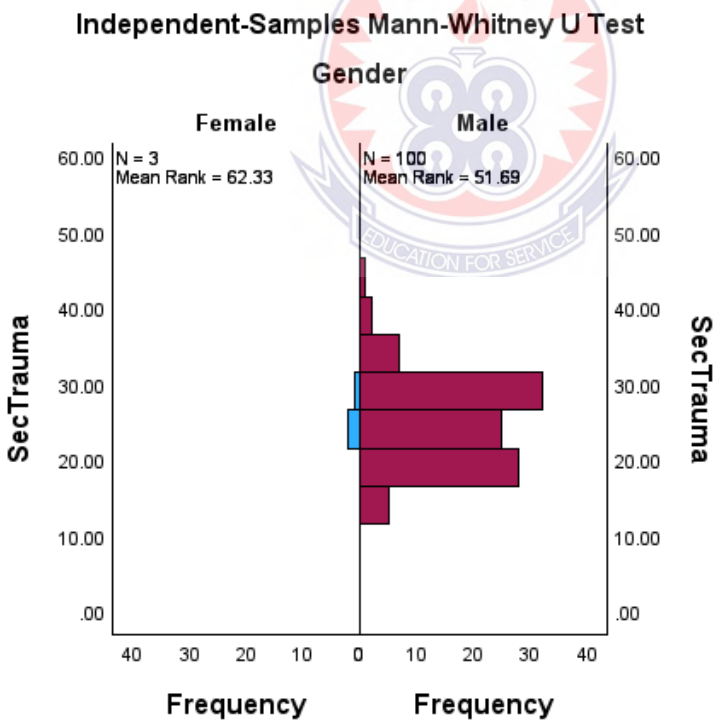
Independent-Samples Mann-Whitney U Test Summary

Total N	103
Mann-Whitney U	112.500
Wilcoxon W	118.500
Test Statistic	112.500

Standard Error	50.863
Standardized Test Statistic	-.737
Asymptotic Sig.(2-sided test)	.461
Exact Sig.(2-sided test)	.482

Figure 6. Mann-Whitney U diagrams for Burnout

Retain the null hypothesis that there is no gender difference in burnout (p = .48). Distributions of the Burnout scores for males and females were similar, as assessed by visual inspection. Median Burnout score for males (52.38) and females (39.50) was not statistically significantly different, U = 112.50, z = -.737, p = .48. This confirms the independent samples t-test that both male and female clergy experience Burnout in similar ways.



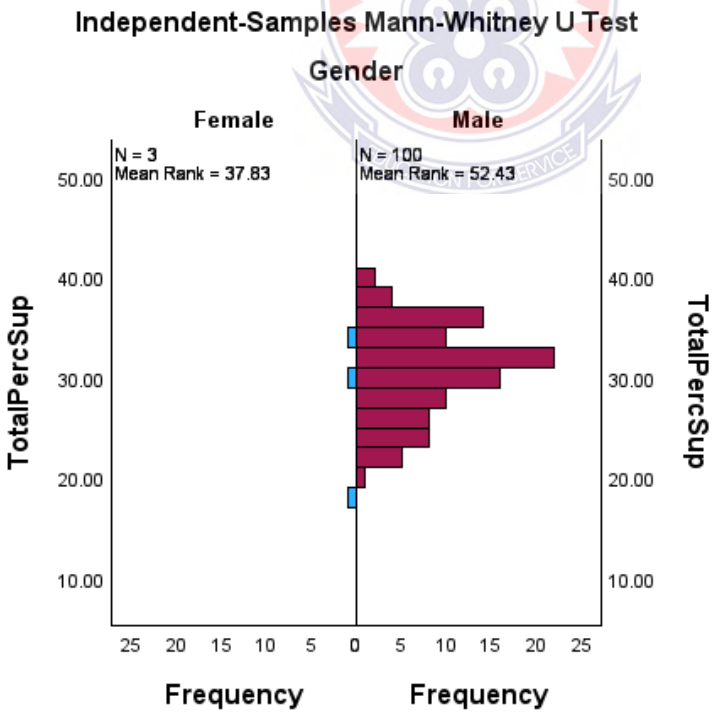
Independent-Samples Mann-Whitney U Test Summary

Total N	103
Mann-Whitney U	181.000
Wilcoxon W	187.000

Test Statistic	181.000
Standard Error	50.896
Standardized Test Statistic	.609
Asymptotic Sig.(2-sided test)	.542
Exact Sig.(2-sided test)	.569

Figure 7. Mann-Whitney U diagrams for Secondary Traumatic Stress

Retain the null hypothesis that there is no gender difference in Secondary Traumatic Stress (p = .57). Distributions of Secondary Traumatic scores for males and females were similar, as assessed by visual inspection. Median Secondary Traumatic Stress score for males (51.69) and females (62.33) was not statistically significantly different, U = 181.00, z = .609, p = .57. This confirms the independent samples t-test that when it comes to Secondary Traumatic Stress, both male and female clergy experience it similarly.



Independent-Samples Mann-Whitney U Test Summary

Total N	103
Mann-Whitney U	107.500

Wilcoxon W	113.500
Test Statistic	107.500
Standard Error	50.856
Standardized Test Statistic	-.836
Asymptotic Sig.(2-sided test)	.403
Exact Sig.(2-sided test)	.423

Figure 8. Mann-Whitney U diagrams for Perceived Social Support

Retain the null hypothesis that there is no gender difference in Perceived Social Support (p = .42). Distributions of Perceived Social Support scores for males and females were similar, as assessed by visual inspection. Median Secondary Traumatic Stress score for males (52.43) and females (37.83) was not statistically significantly different, U = 107.50, z = -.836, p = .42. This confirms the independent samples t-test that when it comes to Perceived Social Support, both male and female clergy experience it similarly.

4.5 Discussion of Results

The study sought to explore the relationship among compassion satisfaction, burnout, secondary traumatic stress, and perceived social support among clergy in the Central Region of Ghana. Through descriptive statistics, the demographic information was analyzed. Thereafter, frequencies, percentages, and correlations were used to answer the research questions.

4.5.1 Discussing the Demographic Information

Exploration of the gender of participants indicated that males were more likely to be clergy than females. These results are consistent with literature that reports males as being in the majority (Fry & David, 2019). This could be because many of these Pentecostal denominations subscribe to the notion that leadership in the churches are the preserve of men and women play supportive roles (Novieto, 2013; Fry & David, 2019).

Denomination was classified as Catholic, Orthodox, Pentecostal, and Charismatic. The majority of the clergy indicated they were classified as Pentecostal (n = 69). This population does not represent the general population of Pentecostal Christians in Ghana. According to the 2021 Population and Housing Census in Ghana (PHC), Pentecostals and Charismatics represents 44.3% of the entire Ghanaian Christian population. The orthodox (Protestants) represents 24.4% of the Ghanaian Christian population. Catholics represents 14.0% of all Christians in Ghana. Christians who were not registered under any umbrella Christian group termed as "other Christian" constituted 17.3% of the Christian populace in Ghana.

Intimate relationship status revealed that apart from one participant who indicated they were divorced, of the 103 participants, 85.4%; n = 88 indicated they were married. The reason for the majority being married might be that the clergy sees marriage relationship a vital aspect of care and an essential resource for life adjustment (McMinn, et al., 2005). Out of the 14 who reported being single, 7 were Catholic priests who probably might have taken the vow of celibacy (Mayblin, 2019).

The nuclear and extended family composition showed that majority of the participants (n = 86; 83.5%) lived with their nuclear families rather than the extended families. This is because over 59% of the participant (n = 61; 59.2%) indicated that they did not live with ailing or aged extended family members. The reason may be because the clergy may want to protect these ailing and aged extended family members from congregational intrusion. On the other hand, the clergy may also want to protect their nuclear families from familial intrusion. Again, most of the denominations transfer or relocate their pastors periodically and the clergy may feel these relocations may have adverse effect on the health of the aged and or the ailing

extended family members (Chandler, 2009; Morris, & Blanton, 1994a; Morris, & Blanton, 1994b).

For highest qualification of education, the most common reported was a bachelor's degree (first degree) at 43.7%; *n* = 45, followed by master's degree at 35.0%; *n* = 36. Secondary and other educational qualifications (e.g., diploma / certificate in Theology) reported 8.7% each whiles doctorate degree reported the least with 3.9%; *n* = 4. This is an indication that the majority of participant 82.6%; *n* = 85 had some university education. (See table 4.1) The higher percentage of university education qualification within the participants may be as result of provision of educational opportunity to the clergy by their various denominations (Clarke, 2021). Again, it might be the desire of the participants to have higher formal education or professional development to enable them to discharge their clerical duties effectively (Clarke, 2021). Another probable reason for the higher percentage of university education among the participants may be inspiration they get from the bible which enjoins Christians especially the clergy to study to receive God's approval. "Study to shew thyself approved unto God, a workman that needeth not to be ashamed, rightly dividing the word of truth" (*King James Version Bible*, 2023, 2 Tim. 2:15).

4.5.2 Discussing Research Objectives and Hypotheses

Almost all participants (90.3%) had high levels of compassion satisfaction. What this means is that the clergy in this sample had satisfaction related to their ability to provide effective care in their job. This result is similar to Shikanda et al., (2022) whose study sought to investigate the influence of emotional exhaustion on mental health of clergy in Kenya. Shikanda and colleagues reported that majority of their respondents were of the view that they got satisfaction from working as clergy. However, the result of this study is dissimilar to earlier studies whose findings

suggested average levels of compassion satisfaction These results are similar to Hunsaker et al., (2015), who indicated in their study of factors that influence the development of compassion fatigue, burnout, and compassion satisfaction in emergency department nurses in the United States of America that the nurses in the sample had high levels of compassion satisfaction. Contrarily, findings of Ruiz-Fernández et al., (2021) in a study of Perceived health, perceived social support and professional quality of life in hospital emergency nurses revealed that participants of their study displayed lower levels of compassion satisfaction. Interestingly, 10% of the clergy in the current study had low compassion satisfaction. This implies that there may be some dissatisfaction connected with their provision of care to parishioners.

Compassion fatigue comprises burnout and secondary traumatic stress (Snelgar et al., 2017). In this study majority of the clergy (68.9%) experienced low burnout, and a little above half of the respondents (50.5%) experienced high secondary traumatic stress. This is an indication that majority of the respondents in the sample were not overexposed to the constructs of burnout which reveals in exhaustion, depersonalization, and reduction of effectiveness in the clergy vocation (Snelgar et al., 2017; Geoffrion et al., 2016: Abernethy et al., 2016).

This is supported by the findings of Snelgar et al., (2017) who stated in their study of "Preventing Compassion Fatigue amongst Pastors: The Influence of Spiritual Intelligence and Intrinsic Motivation" that sample of clergy in their study did not have overly high levels of compassion fatigue. Contrary to these findings is that of Gallardo and Rohde (2018) who investigated the occurrence of, and the relationships among, personality types, demographic characteristics, and compassion fatigue. Gallardo and Rohde stated that 70% of the respondents of their study were in the "high risk" group for compassion fatigue. This may be so because though the sample of

Gallardo and Rohde (2018) were all helping professionals, they were not in the clergy vocation; the working environments were therefore different. Shikanda et al., (2022) argued that experiences of burnout in the form of emotional exhaustion within the helping professions varies from context to context as a result of individual and environmental influences.

Similarly, Adams et al., (2016) in a study of Clergy burnout: A comparison study with other helping professions, supported the claim that clergy had lower burnout symptoms than the typical comparable helping professionals. This low level of burnout in the clergy may be because of certain spiritual exercises the clergy enjoy to cushion them against clergy burnout (Barnard & Curry 2012; Beebe 2007). In spite of the high percentage of the sample experiencing low level of burnout, 31.1% of the sample suffered a significant level of burnout. This is an implication that there is a substantial level of burnout attached to the clergy vocation. This study also found that a little over half of the sample experienced secondary traumatic stress. The reason may be because the clergy is seen as the first point of contact whenever there is an emergency, they usually endure the impact of pain-related stories they hear from church and non-church members of their communities. (Maslach & Leiter, 2016; Parker & Martin, 2011; Stamm, 2009).

A significant percentage (85.4%) of the clergy in this sample demonstrated high perceived social support. This result suggested that majority of the respondents had perceived social support connected to their endeavor to deliver their clerical responsibilities effectively. This result is similar to Eagle et al., (2019), who indicated in their study of Perceived social support, received social support, and depression among clergy, that the sample of clergy in their study appeared to have relatively high social support. It must be noted that Eagle and colleagues sought to bring out the

differences between perceived and received social supports but the current study did not make that distinction. It is also noteworthy that 14.6% of the clergy who responded to this study demonstrated low level of perceived social support which is an indication that a section of the clergy in the sample did not receive the requisite support needed to function effectively as clergy.

In exploring the relationship among compassion satisfaction, burnout, secondary traumatic stress, and perceived social support, the correlational analyses provided multiple indices of interest.

When compassion satisfaction increased, burnout dropped at a statistically significant level (r = -.710; p < .01). These results are similar to Ruiz-Fernández et al., (2021) who also found that Compassion satisfaction and burnout had negative significant correlation. These results are also consistent with the results of Hunsaker et al., (2015) who reported average to high level of compassion satisfaction and average to low level of burnout. It must be emphasized that these two results Ruiz-Fernández et al., (2021) and Hunsaker et al., (2015) were obtained from emergency department nurses, however the results can be applied to the clergy since the two professions: the clergy and the emergency department nurses fall within the category of helping professionals. These results are not consistent with Clarke (2021) whose report suggested that both compassion satisfaction and burnout had average levels.

Surprisingly, when compassion satisfaction increased, secondary traumatic stress also increased (r = .260; p < .01). These results are dissimilar to Ruiz-Fernández et al., (2021) whose results showed that Secondary traumatic stress and compassion satisfaction were significantly and negatively correlated. These two results are not in agreement with McCormack, (2015) whose results suggested that compassion satisfaction and secondary traumatic stress have no significant association. Though

samples in all these three studies: current study, Ruiz-Fernández et al., (2021) and McCormack, (2015) have different vocational backgrounds: clergy, emergency department nurses and funeral directors respectively they are all classified as helping professionals or human service workers.

Compassion satisfaction increased with an increase in perceived social support ($r = .322$; $p < .01$). These results are similar to Ruiz-Fernández et al., (2021) who also found that compassion satisfaction and perceived social support had significant and positive relationship. These findings support reports from earlier studies which suggested that clergy can use social support in its various forms to mitigate the effect of burnout and therefore enhance compassion satisfaction.

Burnout had a minimal positive relationship with secondary traumatic stress ($r = .252$; $p < .05$). These results are consistent with Ruiz-Fernández et al., (2021) Whose results also indicated a positive correlation between burnout and secondary traumatic stress. However, there is a slight difference between results of Ruiz-Fernández et al., (2021) and that of the current study. Whiles Ruiz-Fernández et al., (2021) reported a significant positive relationship between burnout and secondary traumatic stress, the current study reported a minimal positive relationship. McCormack, (2015) and Clarke (2021) had different reports from the current study and that of Ruiz-Fernández et al., (2021). Clarke in their study reported moderate levels for both secondary traumatic stress and burnout whiles McCormack, (2015) reported that funeral directors had no substantial variances in burnout and secondary traumatic stress. Shoji et al., (2015) also supported the argument that burnout has a positive significant correlation with secondary traumatic stress in their longitudinal study "What Comes First, Job Burnout or Secondary Traumatic Stress? Findings from Two Longitudinal Studies from the U.S. and Poland." This study did not only seek to

find the correlation between burnout and secondary traumatic stress, but also sought to examine the directions of the correlations between burnout and secondary traumatic stress among the helping professionals. The results of the study further revealed that the direction of the correlations between burnout and secondary traumatic stress appeared to be unidirectional, with burnout having a strong impact on secondary traumatic stress but not the other way round.

When there was an increase in burnout, perceived social support decreased at a statistically significant level (r = -.235; p < .05). These results are similar to Eagle et al., (2019) and Ruiz-Fernández et al., (2021) who all reported in their studies that burnout was found to have a significant and negative association with perceived social support. Though these two earlier studies Eagle et al., (2019) and Ruiz-Fernández et al., (2021) were conducted from two distinct backgrounds: clergy and hospital emergency nurses respectively, the relationship between burnout and perceived social support were found to be similar. This can be an indication that irrespective of occupational background the helping professionals have some commonalities regarding burnout and perceived social support.

Secondary traumatic stress had no relationship with perceived social support (r = .066; p > .05). These results appear to be dissimilar to Ruiz-Fernández et al., (2021) who indicated that secondary traumatic stress and perceived social support had a strong negative association. However, the results are similar to multiple studies including Hyman, (2004), MacRitchie, & Leibowitz, (2010) and Barr, (2017) who together, found that perceived social support did not have moderating effect on secondary traumatic stress.

4.6 Chapter Summary

Chapter four explained the limitations that resulted from collecting data for this study. Then the data for the study were analyzed statistically to understand the research objectives and hypothesis. Finally, the results of the findings were connected to the literature reviewed by comparing and contrasting to study results globally, regionally, and locally.

CHAPTER FIVE

SUMMARY, CONCLUSION, AND RECOMMENDATIONS

5.0 Introduction to the chapter

The aim of the study was to examine the relationship among compassion satisfaction, burnout, secondary traumatic stress, and perceived social support among clergy in the Central Region of Ghana. This chapter being the final part of this work, will give a summary of the work, outline some recommendations and finally conclude the study.

5.1 Summary of Results

The findings of the thesis can be summarized as follows:

5.1.1 Compassion Satisfaction Levels:

The mean compassion satisfaction score among clergy in the Central Region of Ghana was significantly higher than the comparison group of Ghanaian nurses in

the Central Region. Clergy reported significantly higher levels of compassion satisfaction compared to the nurses, with a very large effect size (Cohen's d = 1.12).

5.1.2 Burnout Levels:

Clergy experienced significantly lower levels of burnout compared to the nurses in the Central Region. The mean burnout score among clergy was significantly lower than the comparison group, with a very large effect size (Cohen's d = 1.81).

5.1.3 Secondary Traumatic Stress Levels:

Similar to burnout, clergy reported significantly lower levels of secondary traumatic stress compared to nurses in the Central Region. The mean secondary traumatic stress score among clergy was significantly lower than the comparison group, with a small effect size (Cohen's d = -0.27).

5.1.4 Social Support Levels

Clergy in the Central Region reported significantly higher levels of perceived social support compared to Hispanics living in Florida and California.The mean perceived social support score among clergy was significantly higher than both comparison groups, with a large effect size (Cohen's d = 0.85 and 0.59, respectively).

5.1.5 Hypotheses Testing

There were significant correlations among compassion satisfaction, burnout, secondary traumatic stress, and perceived social support. Compassion satisfaction had a strong negative relationship with burnout and a minimal positive relationship with secondary traumatic stress and perceived social support. Burnout had a minimal positive relationship with secondary traumatic stress and a minimal negative

relationship with perceived social support. Secondary traumatic stress had minimal relationships with compassion satisfaction and burnout, but no relationship with perceived social support. Perceived social support had minimal positive relationships with compassion satisfaction and secondary traumatic stress, and a minimal negative relationship with burnout.

5.1.6 Gender Differences

No significant gender differences were found in compassion satisfaction, burnout, secondary traumatic stress, or perceived social support among clergy. In summing up the findings of the study, clergy in the Central Region of Ghana generally exhibited high levels of compassion satisfaction and perceived social support, and low levels of burnout and secondary traumatic stress. Gender did not significantly influence the experiences of clergy in terms of compassion satisfaction, burnout, secondary traumatic stress, or perceived social support.

The findings contribute to the understanding of clergy well-being and highlight the importance of social support in mitigating burnout among clergy. Overall, the study provides valuable insights into the well-being of clergy in the Central Region of Ghana and offers implications for interventions to support clergy in their roles.

5.2 Conclusion

The aim of the study was to examine the relationship among compassion satisfaction, burnout, secondary traumatic stress, and perceived social support among clergy in the Central Region of Ghana. The study produced resemblances with and differences from earlier findings in the literature. Respondents experienced low levels of burnout and secondary traumatic stress as clergy. Respondents also experienced

high levels of compassion satisfaction and perceived social support as some earlier studies reported. With the computation of Pearson correlation coefficient, perceived social support was found to be significant predictor of compassion satisfaction and burnout but not of secondary traumatic stress. The results of this study thus confirmed the framework that grounded this study which hypothesized that clergy professional quality of life could be linked with their perceived social support.

5.3 Recommendations

Based on the findings of the study, the following recommendations were made:

5.3.1 Promotion of Compassion Satisfaction

Given that clergy in the Central Region of Ghana reported significantly higher levels of compassion satisfaction compared to nurses, efforts should be made to further promote and enhance factors contributing to compassion satisfaction among clergy. This may include providing training and resources for clergy to develop effective coping strategies, fostering supportive work environments, and encouraging self-care practices.

5.3.2 Prevention of Burnout and Secondary Traumatic Stress

While clergy in the study demonstrated lower levels of burnout and secondary traumatic stress compared to nurses, it is still important to implement preventive measures to address these issues. This may involve offering stress management workshops, promoting work-life balance, providing opportunities for clergy to debrief and seek support, and implementing organizational policies that prioritize clergy well-being.

5.3.3 Enhancement of Perceived Social Support:

Since clergy reported significantly higher levels of perceived social support compared to other groups, efforts should be made to maintain and enhance the supportive networks available to clergy. This could involve facilitating peer support groups, encouraging clergy to build strong social connections within their communities, and providing access to counseling or pastoral care services when needed.

5.3.4 Cultural Sensitivity in Interventions

When designing interventions to support clergy well-being, it is important to consider cultural factors specific to the Ghanaian context. Recognizing the cultural values, beliefs, and practices that influence clergy's experiences can help tailor interventions to be more effective and relevant.

Training and Education: Providing ongoing training and education for clergy on topics such as stress management, self-care, and interpersonal communication skills can empower them to better navigate the challenges of their role and maintain their well-being. Incorporating elements of resilience-building and mindfulness practices into clergy training programs may also be beneficial.

5.3.5 Further Research

Continuation of research in this area is warranted to deepen our understanding of clergy well-being and to identify additional factors that may influence their experiences. Longitudinal studies could provide valuable insights into the factors that contribute to changes in clergy well-being over time and inform the development of targeted interventions. By implementing these recommendations, stakeholders can support clergy in the Central Region of Ghana in maintaining their well-being and fulfilling their important roles within their communities.

5.4 Counselling Implications

Based on the findings of the study, the following recommendations were made regarding counseling implications:

5.4.1 Tailored Counseling Interventions

Counselors working with clergy in the Central Region of Ghana should tailor their interventions to address the specific needs identified in the study. This may involve focusing on enhancing compassion satisfaction, preventing burnout and secondary traumatic stress, and strengthening perceived social support networks. Counseling sessions should be designed to address these factors in a comprehensive and holistic manner.

5.4.2 Stress Management and Coping Strategies:

Counselors can provide clergy with stress management techniques and coping strategies to help them effectively deal with the demands of their role. This may include teaching relaxation techniques, mindfulness practices, and boundary-setting skills to help clergy better manage their emotional well-being and reduce the risk of burnout.

5.4.3 Exploration of Compassion Fatigue

Counselors should explore the concept of compassion fatigue with clergy and help them recognize the signs and symptoms associated with it. By increasing awareness of compassion fatigue, counselors can help clergy identify potential risk factors and develop proactive strategies to mitigate its impact.

5.4.4 Support for Building Resilience

Counseling sessions can focus on building resilience among clergy by strengthening their ability to adapt to and cope with challenging situations. This may involve exploring personal strengths, fostering a sense of purpose and meaning in their work, and encouraging self-care practices that promote overall well-being.

5.4.5 Family and Social Support Systems:

Counselors should assess clergy's family and social support systems and work collaboratively with them to strengthen these networks. This may involve involving family members in counseling sessions, facilitating communication and support among clergy peers, and connecting clergy with community resources and support groups.

5.4.6 Cultural Sensitivity

Counselors should approach counseling sessions with cultural sensitivity and awareness of the unique cultural context in which clergy operate. Understanding the cultural values, beliefs, and practices of clergy in Ghana can help counselors build rapport and trust with their clients and tailor interventions that are culturally appropriate and relevant.

5.4.7 Continued Professional Development:

Counselors working with clergy should engage in continued professional development to stay abreast of the latest research findings and evidence-based practices related to clergy well-being. This may involve attending workshops, conferences, and training programs specifically focused on supporting clergy mental health. By implementing these counseling implications, counselors can play a crucial role in supporting the well-being of clergy in the Central Region of Ghana and helping them thrive in their important roles within their communities.

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APPENDICES

Appendix		Description
Appendix A	-	Request for introductory letter
Appendix B	-	Permission Letter from Department
Appendix C	-	Data collection package

APPENDIX A

Request for Introductory Letter

Augustine Ekuban
P. O. Box GP 1315 Accra
0208141279
pastorekuban@gmail.com

15th October 2022

The Head of Department
Department of Counselling Psychology
Faculty of Educational Studies
University of Education, Winneba

Dear Sir,

Application for Introductory Letter for Data Collection
Student #: 202144193

I wish to apply for an introductory letter to start data collection. My Principal Supervisor is Dr. Hannah Acquaye, and my secondary supervisor is Mr. Joshua Upoalkpaior. My principal supervisor has approved and agreed that I write to request permission to start data collection.

The purpose of my study is **Assessing Compassion Satisfaction, Compassion Fatigue, And Social Support Among Clergy in Southern Ghana.** Data will be collected from all clergy in Effutu Municipality.

I have been trained in Ethics in Human Subjects Research and my informed consent is a reflection of this training. It is expected that data will be collected from 1st to 15th November 2022.

Please find attached the instruments for data collection and the informed consent document.

Thank you.

Yours sincerely,

Augustine Ekuban
(Index number: 202144193)

cc: Mr. Joshua Upoalkpaior

APPENDIX B

Permission Letter from Department

UNIVERSITY OF EDUCATION, WINNEBA
FACULTY OF EDUCATIONAL STUDIES
DEPARTMENT OF COUNSELLING PSYCHOLOGY
P. O. Box 25, Winneba, Ghana
psychology@uew.edu.gh
0332 298 0904

18th October, 2022.

TO WHOM IT MAY CONCERN

Dear Sir/Madam,

LETTER OF INTRODUCTION

I write to introduce to you, AUGUSTINE EKUBAN, the bearer of this letter who is a student in the Department of Counselling Psychology of the University of Education, Winneba. He is reading Master of Philosophy in Counselling Psychology with index number 202144198.

He is conducting a research on the topic: ASSESSING THE RELATIONSHIP AMONG COMPASSION SATISFACTION, COMPASSION FATIGUE AND PERCEIVED SOCIAL SUPPORT AMONG CLERGY. This is in partial fulfillment of the requirements for the award of the above mentioned degree.

He is required to gather information through interview guide to help him on the said research and he has chosen to do so in your outfit.

I will be grateful if he is given permission to carry out this exercise.

Thank you.

Yours faithfully,

DR. PAUL KOBINA A. BEDU-ADDO
AG. HEAD OF DEPARTMENT

Appendix C

Research Package

University of Education, Winneba
Faculty of Educational Studies
Department of Counselling Psychology

Assessing the Relationship Among Compassion Satisfaction, Compassion Fatigue and Perceived Social Support among Clergy

Informed Consent

Principal Investigator: Augustine Ekuban
Faculty Supervisor: Hannah E. Acquaye, PhD

You are being invited to participate in a research study. The study is *voluntary* so you can choose to take part or not.

Purpose of the study: The purpose of this study is to is to assess the relationship among compassion satisfaction, compassion fatigue, and perceived social support among clergy in the Effutu municipality.

What you will be asked to do in the study: When you take part in this study, you will be asked to complete 3 sets of questionnaires. Please note that the information obtained in this research may be used in future research. You will be asked to complete a set of demographic questions and multiple questionnaires that assess your perceived social support, the joys and burdens you share as you go about your pastoral duties. There should be no discomforts with any of these questions.

You will not be given any incentive in taking part of this study.

Time required: We expect that you will do the questionnaire in no more than 30 minutes.

Age requirement: You must be a clergy / pastor / minister of the word in the Effutu municipality to take part in this study.

Study contacts for questions about the study or to report a problem: If you have questions, concerns, or complaints, or think the research has impacted you negatively in any way, communicate with: Rev. Augustine Ekuban or his supervisor, Dr. Acquaye at heacquaye@uew.edu.gh.

When you minister to people, you have direct contact with their lives. As you may have found, your compassion for those you minister can affect you in positive and negative ways. Below are some questions about your experiences, both positive and negative as a minister. Consider each of the following questions about you and your current work situation. Select the number that honestly reflects how frequently you experienced these things in the last 30 days.

1 = Never	2 = Rarely	3=Sometimes	4=Often	5=Very Often

	1.	I am happy
	2.	I am preoccupied with more than one person I minister
	3.	I get satisfaction from being able to minister to people
	4.	I feel connected to others
	5.	I jump or am startled by unexpected sounds
	6.	I feel invigorated after working with those I minister to
	7.	I find it difficult to separate my personal life from my life as a minister
	8.	I am not as productive at work because I am losing sleep over traumatic experiences of a person that I minister to
	9.	I think that I might have been affected by the traumatic stress of those I minister to
	10.	I feel trapped by my job as a minister
	11.	Because of my ministering, I have felt "on edge" about various things
	12.	I like my work as a minister
	13.	I feel depressed because of the traumatic experiences of the people I minister to
	14.	I feel as though I am experiencing the trauma of someone I have ministered to
	15.	I have beliefs that sustain me
	16.	I am pleased with how I am able to keep up with ministering techniques and protocols
	17.	I am the person I always wanted to be
	18.	My work makes me feel satisfied
	19.	I feel worn out because of my work as a minister
	20.	I have happy thoughts and feelings about those I help and how I could minister to them
	21.	I feel overwhelmed because my case workload seems endless
	22.	I believe I can make a difference through my work

23. I avoid certain activities or situations because they remind me of frightening experiences of the people I minister to
24. I am proud of what I can do to minister to people
25. As a result of my ministering, I have intrusive, frightening thoughts.
26. I feel “bogged down” by the system (set back / stalled / hampered by the system)
27. I have thoughts that I am a “success” as a minister
28. I can’t recall important parts of my work with trauma victims
29. I am a caring person
30. I am happy that I chose to do this work

Perceived Social Support

This scale is made up of a list of statements each of which may or may not be true about you. For each statement, check "definitely true" if you are sure it is true about you, and "probably true" if you think it is true but are not absolutely certain.

Statement	Definitely false	Probably false	Probably true	Definitely true
1. If I wanted to go on a trip for a day (for example, to the village or beach), I would have a hard time finding someone to go with me				
2. I feel there is no one I can share my most private worries and fears with				
3. If I were sick, I could easily find someone to help me with my daily chores				
4. There is someone I can turn to for advice about handling problems with my family				
5. If I decide one afternoon that I would like to go to a movie that evening, I could easily find someone to go with me.				
6. When I need suggestions on how to deal with a personal problem, I know someone I can turn to.				
7. I don't often get invited to do things with others				
8. If I had to go out of town for a few weeks, it would be difficult to find someone who would look after my house (plants, garden, etc)				
9. If I wanted to have lunch with someone, I could easily find someone to join me				
10. If I was stranded 30 km from home, there is someone I could call who could come and get me				
11. If a family crisis arose, it would be difficult to find someone who could give me good advice about how to handle it.				
12. If I needed some help in moving to a new house or apartment, I would have a hard time finding someone to help me.				

Demographic Questionnaire

1. How would you describe your gender?
    a. Female [ ]
    b. Male [ ]
2. How old are you as of today? _____
3. How long have you been a Christian? _____
4. What is your intimate relationship status?
    a. Single [ ]
    b. Married[ ]
    c. Divorced [ ]
    d. Widowed [ ]
5. What does the nuclear family life look like for you?
    a. I have no children [ ]
    b. I have biological /adopted children [ ]
6. What does extended family look like for you?
    a. I have aged and/or ailing family members (e.g., parents, in-laws) living with me [ ]
    b. I have no extended family living with me [ ]
7. What is your highest educational qualification?
    a. Secondary / Technical education [ ]
    b. First degree [ ]
    c. Master's degree [ ]
    d. Doctorate degree [ ]
    e. Other(s); please explain _____
8. How many years have you been in ministry? _____
9. What is the size of your congregation? (How many members?) _____
10. Prior to ministry, what profession were you engaged in? _____

Endorsed by:

Hannah E. Acquaye, PhD
Principal Research Supervisor
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