DECLARATION

I, the undersigned, hereby declare that this thesis is my original work. It has not been presented to any other institution for academic credit. All sources used have been appropriately cited and duly acknowledged in full.

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DEDICATION

I dedicate this thesis to the Holy Child Jesus, the greatest expression of God's love and providence, my permanent anchor and invincible protector, and to the memory of my beloved Mother, Mrs. Veronica A. Uche, (1936-2016). Mama, rest on, in God's unfathomable love and peace. Amen.

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ABSTRACT

The study explored the level of self-care awareness and the influence of its practice on the physical well-being of African Catholic women religious in Karen, Nairobi-Kenya. The research adopted qualitative paradigm, and used phenomenological design. It targeted all African women religious living in Karen. Maximum variation sampling technique was used to select four women's religious congregations that participated in the study. Criterion sampling technique was used to select 10 participants for the study, comprising 4 women religious, 2 religious brothers, 2 priests and 2 lay persons. Four research questions guided the study and interview guide was used to collect data. The interviews were transcribed, coded and categorised into themes. The themes were interrelated and presented in a narrative form. The findings revealed that women religious in Karen-Nairobi were prevented from self-caring due to overwork, negligence, wrong concept of religious life, poor remuneration, poverty, influence of entrenched gender role, inability to integrate prayer life, the apostolate and community life as well as a misunderstanding of the meaning of self-care. Suggested remedial interventions included awareness creation, greater access to education, designing and use of a self-care curriculum, regular supervision of self-care practice by superiors, the replacement of life-diminishing structures in the religious life and the Church, revision of life and establishing economic sustainability. The implications of the study findings and limitations were discussed, while recommendations for future research and the integration of study findings into the lifestyle of the target group for optimal, holistic well-being and ministerial effectiveness were also proposed.

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ABBREVIATIONS AND ACRONYMS

ACA: American Counselling Association

AIS: American Institute of Stress

CST: Catholic Social Teaching

DSM: The Diagnostic and Statistical Manual of Mental Disorders (DSM), published by the American Psychiatric Association (APA), offers a common language and standard criteria for the classification of mental disorders.

EI: Emotional Intelligence

LG: Lumen Gentium.

PHC: Primary Health Care

SI: Spiritual Intelligence

UK: United Kingdom

USA: United States of America

Vatican II: Second Vatican Council.

CHAPTER ONE

INTRODUCTION

1.1 Background to the Study

The religious life is a vocation or a state of life in the Catholic Church. Men and women called by God embrace it for the purpose of a radical following and closer imitation of Jesus Christ (Vita Consecrata 84, 1996). This is done through consecration to God through life lived in community and the profession of the evangelical counsels of poverty, chastity and obedience. This form of life has been a part of the Catholic Church from its very beginning (Perfectae Caritatis 1, 1965; Evangelica Testificatio 3, 1971). The two main branches of Religious Institutes are the Active Orders who carry out various services in the world and the Contemplative Institutes who live in enclosed monasteries and are devoted to only prayer and contemplation.

In the course of fulfilling their assigned ministries, religious routinely engage with individuals, groups, families and must balance this with their primary obligations of prayer and the fulfilment of other responsibilities within their religious communities. They literally live entangled in a web of demands on their time, talents and resources. While striving to be conscientiously committed to their assigned duties, there is also the fast pace of living in the modern world to successfully navigate and transcend in order to remain relevant. Necessities and pressures unknown to our forebears are the rule of the day. A case in point is the modern communication and information explosion. There is also the ICT-driven nature of modern living with the necessity of accessing the internet and using the various social media and technological gadgets. These result in information overload, a tenfold increase in the pace and speed of doing business and increased stress levels (New World Encyclopedia, 2014). There is thus the pressure on the modern woman religious to keep physically fit, spiritually awake, culturally rooted, emotionally responsive, psychologically balanced, socially

connected, economically viable, environmentally protective, professionally competent and technologically-savvy. In the mad rush to keep up with this frenzied pace of living, it is easy to forget or lose oneself and one's well-being if the provision and practice of preventive self-care is not made a prime priority. Sadly, and worse still, quite a few women religious have suddenly dropped dead without any previous reported malady, but simply from stress.

This, for the researcher, amounts to a clarion call on the need for both self-care awareness and practice. Literally, self-care means caring for oneself and comprises the different activities a person carries out to stay healthy and feel good. Self-care is also commonly understood as referring to an involvement in certain activities to promote health, well-being, and stress relief (Brucato & Neimeyer, 2009; Jordan, 2010). Its definition has evolved over time with the current understanding of it being expanded to include physical, psychological, and emotional health (Dorociak, 2015). However, no consensus definition of self-care exists at present. Definitions of self-care vary based on the population of interest or the context in which it is being defined. Thus definitions differ depending on who engages in self-care behaviour, what motivates the self-care behaviour and the extent to which healthcare professionals are involved. The perspectives of self-care are also thought to differ between healthcare professionals and the general public, and between healthcare professionals in different disciplines and different roles (Godfrey et al, 2011). This view is corroborated by Webber, Guo and Mann (2014) who maintain that a universally accepted definition of self-care does not exist, and different definitions have been offered by government, industry and practitioners alike. In its document, *Self-Care – A Real Choice*, the UK Department of Health (2005) defined self-care as

> the actions individuals and carers take for themselves, their children, their families and others to stay fit and maintain good physical and mental health; meet social and psychological needs; prevent illness or accidents; care for minor ailments and long-term conditions; and maintain health and wellbeing after acute illness or discharge from hospital (p. 12).

Generally, self-care activities or strategies have been conceptualised as lying across a continuum of functioning. On one end of it there are behaviours that individuals with an illness or disability must engage in to manage their condition in order to prevent further harm. On the other end are activities that healthy individuals participate in to meet everyday needs and take a preventive approach to personal health (Godfrey et al., 2011; Dorociak, 2015).

Although there is a distinct difference between the religious life which is both a vocation and a state of life, and the helping professions which are careers, they are more or less subject to the same types of demands from the people both groups work with. They are also equally affected by the effects of inadequate or non-existent self-care on their well-being. An example of this was the finding in a research in the United States of America by Shapiro, Brown and Biegel (2007) that the helping professions practitioners were at risk for occupationally-related psychological problems. They concluded that as a result, self-care may be a useful complement to the professional training of future therapists. They further identified self-awareness as being at the basis of self-care. Van Beugen et al (2015) were more specific in the object of their research finding which focused on the use of the body attention, ignorance and awareness scale for patients with chronic skin condition management needs in the Netherlands. They inferred from their study that patients needed to be aware of the bodily signals that indicated that self-care was required in order to respond to symptoms of their skin condition with appropriate self-care behaviour.

In like manner, in the midst of their crowded schedules, religious need to be aware of the bodily signals they receive which indicate the need for appropriate self-care. Otherwise they would run the risk of suffering from burnout and other forms of occupationally-related psychological hazards. This is because the demands of their ministries could render them oblivious of the awareness of the necessity of attending to their own personal needs.

On the African scene, Dikeukwu and Omole (2013) conducted a study on 120 patients with diabetes in Johannesburg, South Africa. The participants demonstrated a poor level of awareness; this affected their foot self-care practices which were generally poor and made evident a critical gap in diabetic care in South Africa. It was recommended that health education programmes that empower patients who suffer from diabetes with regard to self-care be integrated into the consultation during clinic visits. These findings are being extended to African women religious as a result of an identified gap in the documentation of their self-care experiences. This deficit in documentation may, in reality, be a factual reflection of the true inadequate state of their self-care awareness and practice.

This study, then, is an attempt to explore the awareness level of African women religious on the need to initiate a significant amount of preventive physical self-care practices that will enhance their overall well-being and ministerial output. The more they are able to care for themselves, the better they will serve others. This is in keeping with the centuries old Latin dictum attributed to the learned Ulpian (170-223), "Nemo dat quod non habet" (The Digest of Justinian, Digest 50.54), meaning that "no one can give what she does not have". It is only by being active practitioners of self-care that they can genuinely and convincingly recommend it to others. Far from being a narcissistic or self-serving venture, self-care, which is the necessary process of caring for oneself, is a form of self-service (Richards, 2013). In practice, caring for oneself is a way of expressing in action a living gratitude for the priceless gift of the self by protecting and nurturing it. A holistic and integrated programme of self-care will provide for the restoration of the whole person at all levels of being after it has been depleted or poured out in the service of others. It will also serve to reduce or completely prevent potential health-related disasters, while serving to delete any existing record of service-related multi-dimensional hazards among women religious.

1.2 Statement of the Problem

Religious are called to a radical following of Christ and to holiness of life as proposed in the Gospels and as expressed in the constitutions of their respective Congregations (cf. Canon 662). In complying with the demands of their vocation (prayer, self-sacrifice and service), more often than not, as observed from the lived experience of the researcher, this state of affairs does sometimes lead to a shift in, if not total loss of focus, for African women religious, in addition to making a big bite into their private time. This is as a result of various factors such as their being overworked and stressed out. This has further consequences like an inability to balance the demands of the apostolate and modern life with the awareness of their own needs as persons. This further progresses to self-neglect, burnout, depression, premature aging, terminal illness, disillusionment or even sudden death brought about by exhaustion. These developments are consistent with findings from various studies done among workers on the effects of occupational or work-related stress. For example, the American Institute of Stress (n.d.) reports that stress is a major factor in up to 80 % of all work-related injuries and 40 % of workplace turnovers. It also results in increased rates of absenteeism, back pain, heart attack, hypertension and other disorders among workers. In addition, in a study carried out among nurses in Greece by Sarafis et al (2016), it was revealed that work-related stress could be damaging to a person's physical and mental health, while its high levels have been connected to high staff truancy and low levels of productivity. The findings further uncovered other consequent negative physical health problems including

> migraines, muscle, back and joint pain, long term physical illnesses, hypertension, irritable bowel syndrome, duodenal ulcer, immune and endocrine system illnesses. The mental health problems work stress generated include anxiety, dysthymia, low self-esteem, conflicts with supervisors, co-workers and patients, depression and feelings of

inadequacy as well as a major risk factor for mild psychiatric morbidity (p. 7).

The above findings may be used as an explanation of the plight many African women religious find themselves in. A literature search revealed that their experiences which are quite identical to the ones just recounted, are generally not documented in similar studies. Therefore, records of follow up actions hardly exist. This study therefore sets out to find out how African women religious may begin to reorganise and readjust their lifestyle to enable them evolve a more balanced and satisfactory pattern of living which will enrich their quality of life, enhance the quality of their relationships and boost the quality of the services they render. In order to be more aware, and therefore, better equipped to relate more meaningfully and fruitfully with the self and the other, women religious will need to be firmly established and balanced in their personal, cultural and institutional identity, holistic health and general orientation to life. From this stance, the skill of self-care (preventive and therapeutic), will come in handy to position them better to engage the ailing and activity-filled world without being overwhelmed by the magnitude and the sheer force of the encounter.

1.3 Objectives of the Study

The following objectives guided this study:

i) To explore the level of self-care awareness among African women religious in Karen-Nairobi, Kenya.

ii) To investigate the causes of the perceived neglect of self-care among African women religious in Karen-Nairobi, Kenya.

iii) To assess the consequences of the perceived lack of self-care among African women religious in Karen-Nairobi, Kenya.

iv) To proffer some solutions for the perceived challenges of self-care among African women religious in Karen-Nairobi, Kenya.

1.4 Research Questions

i) What is the awareness level of the need for self-care among African women religious in Karen-Nairobi?

ii) What are the causes of the perceived neglect of self-care among African women religious in Karen-Nairobi?

iii) What are the consequences of the perceived lack of self-care among African women religious in Karen-Nairobi?

iv) What are the suggested solutions to the challenges of self-care among African women religious in Karen-Nairobi?

1.5 Significance of the Study

This study is important because it will benefit the universal Church by providing it with a holistically balanced and fully dedicated work force that will zealously and mindfully work for the accomplishment of its Divine Mandate to take the Good News to the ends of the earth. For, that is what the empowerment of the African woman religious with the skill of self-care as an expected outcome of this study will amount to.

As Socrates was credited with the aphorism that *an unexamined life is not worth living,* this study will help African women religious to examine themselves on their practice of self-care and enable them to remedy any observed lapses. This study will also spur them to greater fidelity and dedication in the observance of the obligations incumbent on them as religious. It will further help the superiors and the administrators of the various congregations to evaluate and modify the parameters by which women religious are formed and assigned to various ministries. Moreover, formators and superiors will be helped to reinforce the practice of self-care in the formation programme of women religious and in community living.

The study will also help save the lives of many women religious, and the first of these lives is that of the researcher who has been something of a regular workaholic in the not-too-

distant past. Armed with the relevant findings of this study, she and other women religious like her, will transform into veritable apostles of self-care wherever they will live and work in the future. Besides, this study will help motivate various professionals like teachers, healthcare practitioners, counsellors, pastoral and social workers to embrace the obligation and the practice of caring for the human person at all levels of being. Healthcare practitioners will find in it an indispensable resource for the subject of holistic health care. Educationists will find in it a tool for the acquisition of needed knowledge, understanding, values, attitudes and skills. These will be handy for a greater effectiveness of their efforts for the wholesome transformation of their charges. Pastoral workers and those in the social work ministry will also discover in it an invaluable manual for holistic self- and other-care.

Finally, the study is important because it will contribute to the growing body of literature on religious life as it is lived by African women religious within an African context. It will serve as a multifaceted chronicle of the sociological, health and psychological dimensions of the religious life as it is lived within the present-day African context. It will further serve as a useful tool for other researchers who may decide to build on it to further the cause of providing sustainable self-care for African women religious.

1.6 Scope and Delimitations of the Study

The present study concentrated on the influence of self-care awareness on the physical well-being of African Catholic women religious in general, but using those in Karen-Nairobi, Kenya as study sample. It was delimited to this group because of the time and resource constraints on the part of the researcher. The study also concentrated on the need to effect a balance between the personal, spiritual, apostolic and professional lives of the women religious in Karen, Nairobi.

Although there are also male religious in the Roman Catholic Church, this study focused on the female religious. Also, as a result of the trend in modern healthcare which is

towards prevention, this study also proposes to concentrate on exploring self-care from the angle of prevention to help African women religious proactively attain to the practice of self-care before they get caught and irretrievably entangled within the vortex of overwork, stress and burnout.

1.7 Theoretical Framework

According to the online University of South Carolina Research Guides (n.d.), a theoretical framework is

> the structure that can hold or support a theory of a research study. It consists of an understanding of theories and concepts with reference to scholarly literature that are relevant to the topic of study and which relate to the broader areas of knowledge being considered. It is used to limit the scope of the relevant data by focusing on specific variables and defining the specific viewpoint or framework that will be employed in analysing and interpreting the data to be gathered. It also facilitates the understanding of concepts and variables according to given definitions and builds new knowledge by validating or challenging theoretical assumptions. The theoretical framework guides research, explains the meaning, nature, and challenges associated with a phenomenon, often experienced but unexplained in the world in which we live, so that they may be used for acting in more informed and effective ways.

This study is anchored on the Structural Family Therapy of the Family Systems Theory developed by Salvador Minuchin in 1962. This theory gave rise to the dominant form of family therapy in the 1970s (Seligman & Reichenberg, 2014). The justification for the use of the Structural Family Therapy was that since the religious life is a system and an establishment (or family), this theory was seen as providing a footing for a desirable and appropriate modification of the structures in religious congregations which are no longer life-giving in order to address the physical, psychological and emotional needs of its members. Further, since during therapy, Structural Family Therapists focus on family dynamics and not individual personalities (Scharf, 2012), the provisions of this theory were adjudged to be helpful in addressing the structures that may not favour the practice of self-care, and re-position the subjects of this study on the road to attaining the desired goal of becoming more

self-caring and integrated human persons. In this way, all their needs as human persons will be provided for.

The Family Systems Theory

The Family Systems Theory, articulated by Dr. Murray Bowen in 1966, is one of the major theories in behavioural and social sciences and is an offshoot of the General Systems Theory propounded by biologist Ludwig von Bertalanffy in 1936. The General Systems Theory was founded on the premise that all systems, human and mechanical, strive toward growth, development, and stability. A human system is a set of people who communicate, and who have goals or directions. The Family Systems Therapy is a type of family therapy that concentrates on the interactions of family members and views the entire family as a unit or system. Treatment is designed to understand and bring about change within the family structure. According to Scharf, (2012), from a general systems theory perspective therefore, each family is a part of a larger system, a neighbourhood, which is again a part of a larger system, a town, etc. Individuals are wholes that comprise smaller systems, organs, tissues and cells. If any part of a system changes, the whole system reflects the change.

The Family Systems Theory was crafted from this broad theory by various scholars who found that it had many applications to families and other social systems (Morgaine, 2001). Five of these approaches to the Family Systems Therapy are the Intergenerational Approach of Murray Bowen, the Structural Family theory of Salvador Minuchin, the Strategic Approach of Jay Haley, the Experiential Approach of Carl Whittaker and the Humanistic Approach of Virginia Satir. Worthy of note is the fact that the Family Systems Theory is more than a therapeutic technique. It is a philosophy that searches for the causes of behaviour, not in the individual alone, but in the interactions among the members of a group. The basic rationale is that all parts of the family are interrelated. Besides, the family has its own unique dynamics that can be known only by observing the relationships and interactions

among all members. Of the five approaches identified above, the Structural Family Theory and Therapy was considered at some length because of its importance to this study.

Overview of the Structural Family Theory and Therapy

The Structural Family Theory and its treatment model are a strength-based, outcome-oriented approach and treatment modality developed by Salvador Munichin in 1962. It focuses on the family structure and the recurrent patterns of interaction developed by members over time as they accommodate each other (de Los Santos, 2013). It also aims at preventing dysfunctional sequences from repeating by interrupting covert family structures. Structural family therapy is a therapeutic approach that recognises that families possess many strengths and it attempts to move families beyond dysfunctional patterns of interaction (Hadfield, 2000). Its therapeutic goals include the restructuring of the family organisation, the promotion of structural change within the system by modifying the family's transactional patterns, the provision of alternative ways in solving problems and interacting, the development of more appropriate boundaries and the reduction of symptoms of dysfunction. As summarised by Walsh (2011), therapy involves joining, enactment and restructuring. The creation of an effective hierarchical structure is also one of its therapeutic goals since it is assumed that faulty family structures have boundaries that are rigid or diffuse and subsystems that have inappropriate tasks and functions (Corey, 2009).

Strengths of the Structural Family Theory

The structural family theory has been confirmed by various studies and through the evidence of the efficacy of its therapeutic process in harnessing the strengths of families as an approach with many strengths [Hadfield (2000); Nichols & Schwartz (2006) ; Kumpfer (2014)]. Stupart (2014) explained that this was made possible by its relative simplicity, concreteness and directness. A major strength of this approach is that it fosters a life-giving sense of belonging in the client. The general movement in the course of therapy, and life in

general, is directed at the recognition and appropriation of a place of inclusion and identity within and outside the family for the client. Besides, it focuses on the here and now, and requires that all communication among the family members must be spontaneous and honest, using I-statements.

Further, it reassures clients by reminding them of the universality of problems, and of the fact that no problem is entirely unique to their family. Miller and Aponte (2010) observed that the theory builds on the strengths of client. This is achieved by the generation of the momentum for change through the mobilization of the personal strengths of family members and the resources of their ecosystems by the therapist. This therapy has an added appeal of incorporating imitative behaviour which requires that clients will at times model their therapists. Accordingly, the therapist has a variety of important roles to play during the sessions. Some of them involve helping clients identify and put to use any unidentified and underutilised strengths and assisting the family in outgrowing and discontinuing the practice of any counter-productive behaviour patterns that are preventing positive change.

Another role for the therapist entails his enabling the family members to notice, understand and implement implicit or invisible rules and interactions through his objectivity, having joined the family system in the course of the therapy as an insider. In connection with this, Zhuo (2011) observed that structural problems are usually the result of failure to adjust to changes. Therapeutic goals are therefore to be viewed not as a matter of creating new structures, but of activating dormant ones. The therapist further assists in mapping relationships between members and disrupts dysfunctional relationships by restructuring them along more healthy lines. Finally, the therapist guides the family through the various therapeutic techniques and interventions including the modelling of desired behaviours. Having been used effectively for about six decades in the management of family relational

issues, the researcher is optimistic that it will prove equally effective in the attainment of the goals of this study.

Weaknesses of the Structural Family Theory

Like any other human undertaking, the Structural Family Theory is challenged by some weaknesses within its very fabric. One of such challenges derives from the fact that it focuses on issues of power between the generations, but not within same generational relationships. Moreover, for Vetere (2001), the direct and involved therapeutic style of the structural therapist raises concerns of therapist burnout. In addition, Larner (2000) was of the opinion that as many family therapists are interested in integrative practice, both within the field of family therapy and across the major psychotherapeutic domains, the structural family theory's focus on the here and now, limits the ability of the therapist to explain and predict symptomatic behaviour. So he has to search for other models that address the issues that need such attention. Finally, there is also the possibility that the therapist's concern with the well-being and function of the family as a system may overshadow his / her view of the unique characteristics, needs and functioning of the individual family members. For this researcher, an area of concern is the emphasis by the theory of patriarchal leadership within the family. This might weaken the argument for the modification of some of the structures that need to be reviewed and adjusted in the light of modern trends and needs.

Application of the Structural Family Theory to the Study

The presenting symptom of this study, namely, the perceived inability of women religious to appropriately integrate self-care into their lifestyle, appears to be reinforced by the inherent organisational structure of the religious life such as some aspects of the socialisation and formation processes received. These translate in practice to an inability on the part of the individual women religious to integrate the psycho-spiritual and social dimensions of life with the demands of ministry. This state of affairs appears to favour the

indication of the relevance of the Structural Family Therapy for application to this study. The reasons for this are that the model focuses on structure, which is a core organisational principle of the religious life. Since the therapy engages the structure of the community, not the individual woman religious, the model offers the opportunity for the entire community to participate in changing dysfunctional individual and community patterns.

Moreover, the Structural Family therapeutic model, which is problem- and growth-oriented, creates a non-defensive atmosphere in which the members of a community or congregation can change, and works toward helping them improve communication and modify their behaviour. Besides, the techniques of this therapeutic model are active, directive, and well thought-out. Structural family therapists assume the role of authority figures and experts in family therapy. They view the clients within the context of their environment and are also sensitive to the cultural norms of the clients with which they are working. Finally, the model can be combined with other treatment modalities to maximise their effectiveness. In conclusion, there would be a need to combine this treatment model with others such as the cognitive behaviour therapy in order to achieve the desired changes in African women religious. This is because of the overwhelming effects of the socio-cultural variables which appear to place a significant exertion on their day to day choices and conduct.

1.8 Conceptual Framework

As defined by Miles and Huberman (2013), a conceptual framework is a written or visual presentation that

> explains either graphically, or in narrative form, the main things to be studied – the key factors, variables or constructs - and the presumed relationships among them. Conceptual frameworks are simply the current version of the researcher's map of the territory being investigated (p. 20).

The function of the conceptual framework is to help in the assessment and refinement of goals, the development of realistic and relevant research questions, the selection of appropriate methods, justify the research and identify the potential credibility threats to conclusions arrived at. In consonance with the above portrayal, Figure 1 depicts the conceptual framework of the study on the Influence of Self-care Awareness on the Physical Well-being of African Catholic women religious in Karen, Nairobi. The independent variable in the study is the influence of the African women religious' level or degree of awareness of the need to take care of themselves. This is aligned with the early socialisation received, influence of gender role, the religious formation received and the level of education attained by the religious. The consequences of the above factors are overwork, self-neglect and ill health. The intervening variable comprises the measures that will help remedy the challenges posed by the self-care deficit resulting from the interactions within the independent variable. These are sensitisation workshops, psycho-spiritual support and Church support. The dependent variable is the physical well-being of the women religious. Its components are happier and healthier women religious who are full of enthusiasm and zeal, with longer life expectation and performing optimally at the mental, spiritual and professional levels.

The framework establishes the view that there is a cause-and-effect relationship between the independent variable and the dependent variable. It further proposes the view that the three types of variables in the study are interconnected. The independent and the dependent variables of the study share a common interface with the intervening variable to yield the outcome recorded as the dependent variable of having women religious with an enhanced quality of life as recorded above.

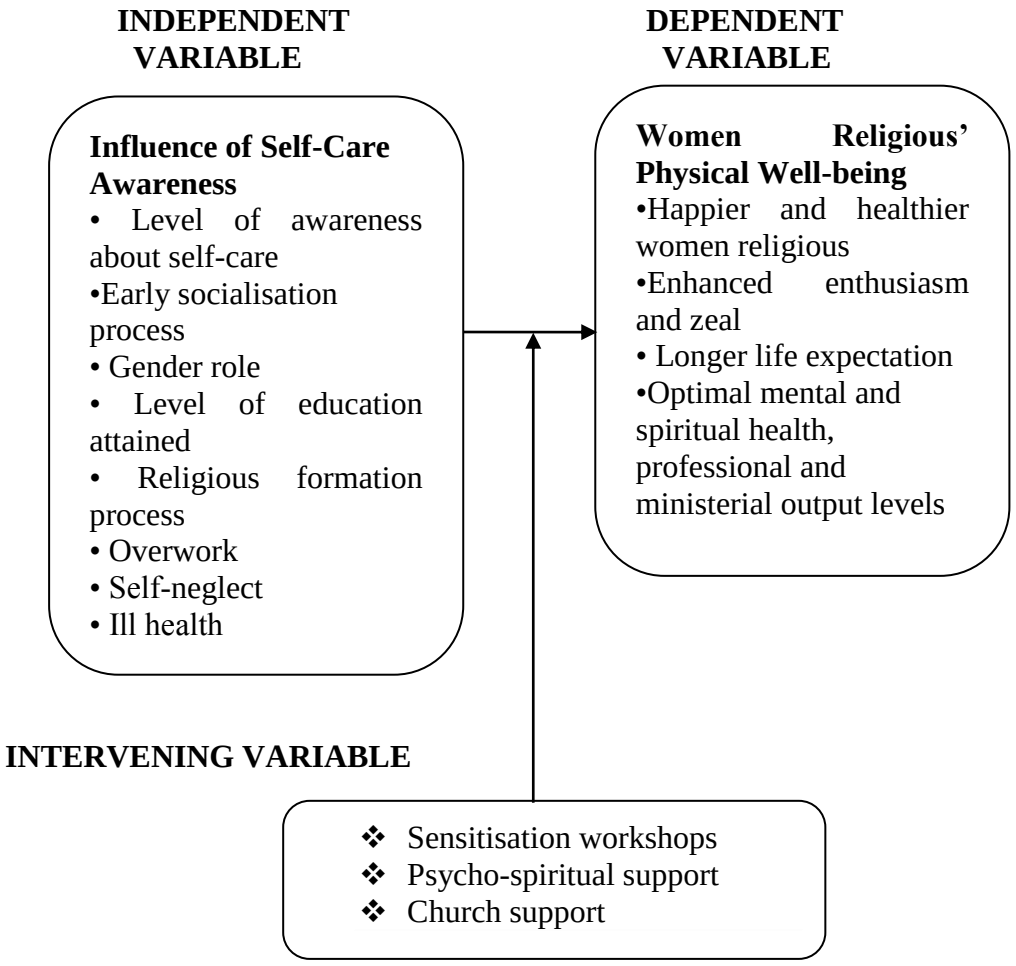

Figure 1: **Conceptual Framework on the Influence of Self-care Awareness on the Physical Well-Being of African Women Religious**

1.9 Operational Definition of Terms

The following terms are defined as used in this study, in the following ways:

Awareness: Consciousness of, perception and sufficient knowledge about something.

Community: This refers to either the whole congregation or to a unit or local group of women religious living together, under a superior or community leader.

Congregation: This term refers to a collective group, or a kind or variety of women religious. They are also known as institutes, societies, or orders.

Formation: An education in the ways of religious life which consists of the process of different stages such as the pre-noviceship, noviceship, first and perpetual vows. Ongoing formation continues after this.

Influence: Effect or consequence.

Ministry: An activity that is done by members of the Church to serve the purposes of the Church or an activity to which a Religious is officially assigned and engages in. It is also known as apostolate.

Physical Well-being: Good health in one's body. The components for this are considered to include good food, adequate rest, physical exercise and balance.

Self-care: The practices, actions or exercises one deliberately engages in on a regular basis to maintain one's good health, reduce stress and be able to meet one's commitments.

Women Religious: Women who are members of a religious congregation, live in religious communities and work in the ministries to which they are assigned by their superiors or leaders.

CHAPTER TWO

REVIEW OF RELATED LITERATURE

2.1 Introduction

This chapter examined related literature, information and studies done by other writers on the subject of self-care around the world in order to contextualise this study into the stream of existing research (Rwiza, 2013). Existing gaps were identified as possible openings for future research. The research questions provided the themes for the literature review.

2.2 Awareness of the Need for Self-care

In ordinary speech, awareness means the ability to feel something, to know or to perceive happenings or events in or around oneself, especially in a tacit or wordless and unspoken manner. According to Morin (2011), self-awareness represents the capacity of becoming the object of one's own attention. In this state one actively identifies, processes, and stores information about the self. It is also defined as a "self-perceptive state emerging from self-observation" (Cassidy, 2011, p. 992). It includes understanding one's own strengths, limitations, preferences, and interests. Self-awareness is part of Social-Emotional Learning (SEL), which provides an important foundation for better adjustment and academic performance for students (Durlak, Weissberg, Dymnicki, Taylor, & Schellinger, 2011). Brown et al as cited in Davis and Hayes (2011), in a study on the benefits of mindfulness, stated that the term "mindfulness" refers to a psychological state of awareness, a practice that promotes this awareness, a mode of processing information, and a characterological trait. Germer et al. (2005, p. 6) explained mindfulness as "moment-by-moment awareness" of one's experience without judgment. It may be pertinent to signal at this point that in order to be aware, one must first be in possession of, and at home with oneself. A healthy self-concept

will help facilitate the practice of self-awareness. This is supported by the following extract provided by Agudo (2003) in her book, *I chose you*:

> Self-awareness implies a "presence" to oneself. It is a sense of gratitude for one's life, for one's being, one's personality, one's potential, gifts and limitations. Self-awareness is also the understanding of oneself. To be unaware of the self is to be alienated from oneself. Wholeness of personality is possible only when the individual is fully aware and present to the self (p. 27).

Awareness may also denote a common or public knowledge, concern and understanding about a social, scientific, health or political issue. Awareness is such an important concept in the contemporary world that various health concerns and social issues have days on the annual calendar assigned to raising public awareness about them each year. In this study, the term is used to refer to the need for the woman religious to be well-informed on the subject, and interested in the practice, of self-care.

There are studies on the global level on the need for self-care among mental health care practitioners, in which awareness was singled out as a significant factor in the integration of self-care into the lives of the health care practitioners. In one of such studies, *Three Tiered Model Toward Improved Self-Awareness* and *Self-Care* done in the United States of America by Dowden, Warren and Kambui (2014), the authors reported that the 2005 American Counselling Association (ACA) *Code of Ethics* encouraged counsellors to practice self-care and strive toward self-awareness because when they engaged in practices that fostered wellness and awareness, they were better positioned to provide effective services to clients. They also reported that the ACA in 2010 offered support to counsellors through their website by providing resources aimed at increasing self-awareness and wellness. They went on to offer professional counsellors a three-tiered model for cultivating self-awareness and self-care. This comprised a three step self-monitoring process while engaged in work, designed to assist them to become more self-aware, while also teaching them a process to

ensure self-care. The three steps were self-checks, self-talk and self-journaling about one's emotions in the course of a counselling session, while alone or meditating and while journaling. Having identified the stressful emotions or events, one determined how best to reduce or remove them. The setbacks and the lessons learned were also noted and new ways of thinking or new strategies for coping were imbibed. Citing Crews et al (2005) and McMurran, Fyffe, McCarthy, Duggan and Latham (2001), they argued that

> through this process, preservice counsellors become keenly aware of who they are and/or who they aspire to be, while also determining what it takes to maintain their perceived self. While self-monitoring enhances self-awareness and self-care, it also heightens interpersonal skills such as empathy, which proves effective when providing counselling services (p. 2).

The above steps or similar ones are usually incorporated within the daily practice of meditation which is a part of the spiritual staple for religious, as stipulated by the Constitutions of the various Religious Congregations such as that of the Congregation of the Handmaids of the Holy Child Jesus, (Article 15, p. 5). Usually though, they are other-directed (to God and neighbour), and refer to self only for the purpose of seeing how far one is striving to love these more. Therefore, it is not explicitly geared towards greater self-love or better self-care. So it may be necessary to implicitly redirect the woman religious towards this so as to make self-awareness a habitual state for the woman religious in the modern world, and ultimately reap the felicitous outcomes of this.

The findings of Dowden, Warren and Kambui were confirmed by Urdang (2010) in her study on *Awareness of Self-A Critical Tool,* done in England. In it she discussed the subject of self-awareness as being applicable to all levels of clinical practice, and argued for the urgency of its development in students of social work. She argued that self-reflectiveness builds clinical competence, can prevent boundary violations and burnout, and offers protection against client violence. She went on to advocate for its incorporation in the

professional development of student social workers. It is this researcher's view that these findings are equally pertinent and applicable to women religious in that the cultivation of an awareness of the need for self-care may also result in better holistic health for the woman religious and enhance her output at the ministerial level. It would appear that its absence is at the basis of her perceived inability to self-care and embrace ministerial tasks enthusiastically as is sometimes observed among them.

An article on *Physician Self-care* by Kirby and Lück (2014), two doctors who work in hospices in South Africa, observed that burnout and compassion fatigue were common occurrences among physicians. They observed, however, that doctors who were less self-aware, tended to lose perspective and become stressed. Those who were more self-aware, tended to experience greater job satisfaction and empathic and mutually healing relationships with their patients. They were also more likely to be patient centred, and their patients were more satisfied. On the Kenyan scene, Busakhala et al (2016) conducted a study on 1,511 attendees (1,238 women and 273 men) and 467 non attendee women at three health centres in Western Kenya, it was observed that more than 80% of women with breast cancer there presented to medical care with established late-stage disease. All residents living close to the health centres were invited to participate in the screening. The attendees underwent clinical breast examination by trained physician oncologists while the non-attendees were interviewed in their homes the following day. In addition, women who consented were interviewed by using a modified Breast Cancer Awareness Module questionnaire. The findings revealed that the women who volunteered for the screening in the health centres were more aware of breast cancer than those who did not volunteer. The conclusion from the study was that screening recruitment should seek to close these knowledge gaps to increase participation. Almost all those surveyed (attendees and non-attendees) expressed interest in future breast cancer screening opportunities.

From the above instances, it is clear that self-awareness is a prerequisite for the reception of any positive benefits by anyone. However, it is not certain if African women religious are sufficiently equipped with this quality. In his *Meditationes Sacrae* (1597), Sir Francis Bacon is famously credited with the authorship of the saying that *Knowledge is Power*. In the absence of an empowering knowledge on the subject of self-care consciously undertaken, the average African woman religious can develop no appreciable awareness of it. But then the legal principle that *ignorance of the law excuses not* holds good in this case. This obliges women religious to strive to catch up on at least knowledge that has a bearing on their well-being.

It may be necessary to indicate that the habitual disposition and attitude of the woman religious flow from the understanding that life in general, and the religious life in particular, is one of sustained service and altruistic self-donation to God and humanity. This can be traced to the socialisation and formation processes they received at the various stages in their lives. Beginning from their biological families, girls are trained to take care of others and not of themselves. This is further consolidated by the training received in the religious life which emphasises love and service of God and of neighbour. So an attitude of serving virtually becomes second nature to the African woman religious. One could almost call it an instinct, which consists of putting others first and oneself last. This could be the root of some of the cases of physical, emotional and mental exhaustion, unmanageable stress levels, burnout, anxiety, depression and sometimes even sudden deaths found among women religious. As indicated above, there are no empirical documentations of these occurrences.

Moreover, the possible deficiency in the level of awareness of the need for self-care among women religious could be directly linked to the anaesthetising interactions among some of the intervening variables already listed in this study. These include the gender role acquired through socio-cultural conditioning received during the process of socialisation

early in life, the religious formation process (initial and on-going) and the educational level of the woman religious. Of these variables, the gender role stereotype appears to be foundational to the other factors which negatively affect the woman religious' awareness of the need for self-care. It is a cross cutting and cross-cultural issue which has remained unyielding and almost defiant to change. Writing from New York, USA, Godsil et al (2016) conceded that:

> Gender stereotypes grow out of our historical and cultural understanding of the roles of men and women in society - many, or even most, of which are outmoded but continue to be powerful. Gender shapes our experiences in many ways, and it never operates in isolation - our race, ethnicity, sexual orientation, religion, class, and other identity characteristics affect how we navigate the world. In the media, workplaces, communities, schools, and homes, issues of gender, race, ethnicity, and class can be polarizing. The roles women have traditionally played, as mothers, wives, and caregivers, and the expectation to be nurturing and selfless can present a gendered trap, limiting possibilities for both men and women (pp.11, 13).

Even within the ranks of the practitioners of a perceived prestigious helping profession like medicine, and in these modern times, it would appear that gender stereotyping also found a way to establish its tentacles. Female practitioners found themselves unofficially loaded with an added responsibility. This was the finding in a study in Australia by Brooks as cited in Outram and Kelly (2014), where female doctors, in addition to the normal duties which their profession conferred on them, felt pressured to look after their colleagues and employees just by virtue of being female. This finding confirms that at no point or rank within the society is a woman or woman religious free from the burden of fulfilling the expectations laid upon her by existing gender roles. And this contributes to stifling, or altogether extinguishing whatever traces of awareness she might have about finding time to caring for herself.

The story is not different in Asia or Europe. In their work, *Gender Roles in Different Cultures,* Wiegand et al (2015) reported their findings as follows. In Japan and Russia, both

men and women believe that women should stay at home while men go to work to earn the income. Many Russian women believe it is ideal if they live for their families. In the traditional Chinese family, the man is responsible for providing for and protecting his family. In Europe, though there are no restrictions due to familial or marital status, women are not allowed to lead religious services. Also, part time work is dominated by females while full time work is dominated by males. In Africa, females are first under their fathers, then under their husbands and lastly, under their sons. They are basically home-makers and child-bearers. Sons are highly prized. Bloggist Veilleux (2012) went so far as to tag them as beasts of burden. In her words:

> In the countryside, women are beasts of burden. They haul wood, water, crops, children. They cook in smoke-filled huts, enough to make my eyes water. They chop wood, sweep the yard, chase the livestock, grind the grain. Many times with a baby on the back. Then they suffer the amorous intent of their husbands at night. Their breasts are mutilated from breastfeeding 8 or more children. Genital mutilation or female circumcision is still quite common. It makes the woman more manageable, I am told.

The above account, with some minimal modifications, also remains the story of the educated African woman. Quite recently, a Nigerian female school mate of this researcher shared with her how her mother had taken pains to instil in her during her years as a growing child the notion that *a woman does not rest,* as a way of ensuring that she curbed any tendency towards seeking some personal time for herself. All these experiences serve to dull both the level of knowledge and the awareness of the need for self-care among African women religious and the resultant unwholesome consequences they could provoke.

In a study on *Gender relations in the utilisation of micro finance resources among women in Kiharu Constituency, Murang'a County, Kenya,* Kamau et al (2014) explored the influence of gender relations on the utilisation of microfinance loans. Data was obtained from two locations of Kiharu Constituency, Murarandia and Mugoiri. The study targeted 140 respondents comprising men (spouses) of women beneficiaries and women who were

randomly selected from the microfinance institution records. Data was collected by the use of interview guides, self-administered questionnaires, and Focused Group Discussions. In addition, in-depth interviews were conducted particularly to key informants - microfinance officers. In addition, secondary sources were used. Findings revealed that gender-based violence influenced and controlled the utilisation of microfinance resources accessed by women. The women respondents revealed that they were required to get express permission from male spouses to utilise the resources and that their spouses violated them for any failure to do so. The women discussants in the focussed group discussions affirmed that they too had experienced gender-based violence from spouses for the same reason. This revealed that gender relations in households favoured male spouses in the utilisation of economic resources. On the contrary, the chiefs responded that there was a paradigm shift in gender-based violence in the study area, and that women were also violating their spouses in their efforts to utilise their microfinance resources. Male spouses who were interviewed revealed that women should not have decision-making power in the utilisation of resources. This was represented by 66.7% of spouses who conceded that men should have more power than women in utilisation of resources, as compared to 33.3% who agreed that both genders should have equal power. The study concluded that gender-based violence in the area seemed to be changing its face as women countered the violence they received from their husbands in the area of the utilisation of microfinance resources.

2.3 Causes of the Perceived Neglect of Self-care

Many factors account for the perceived neglect of caring for the self. In a study in the USA on *Barriers to Wellness for Counselling Students*, Hinton and Goodwin (2016), used the Indivisible Self Model of Wellness (IS-WEL) which was developed by Myers, Sweeney and Witmer (2000), as a framework to organise an exploration of potential barriers to self-care and wellness. They (Hinton and Goodwin) identified various causes for the neglect of self-

care. Among them was what they referred to as the Physical Self. Citing Myers and Sweeney (2004), they explained that this refers to "the biological and physiological processes that compose the physical aspects of a person's development and functioning" (p. 2). The three components of this are balanced nutrition, exercise and adequate rest which promote physical and psychological well-being. The results of various scientific studies have raised the awareness that a healthy diet combined with physical activity reduces health concerns and improves overall well-being and quality of life. From this researcher's personal experience and from reports from workshops conducted on the rights of women religious in the Church in 2005 by the Centre for Women Studies and Intervention, a Nigeria-based Non-Governmental Organisation, it is mostly not possible for a good number of women religious to have good quality, nutritious and balanced meals because they do not earn enough money to enable them do this. The reasons for this include not only poor academic qualification, but also the failure of the relevant ecclesiastical authorities to honour the terms of engagement between them and women religious Congregations.

It was observed in South Africa that many older persons visit primary healthcare (PHC) facilities for the treatment of minor ailments. This resulted in the public healthcare sector being burdened by high volumes of patients and long waiting periods. As a result, professional nurses in these facilities were not able to spend enough time on proper physical examinations and the assessment of needs, health education and support to these persons to enable them apply independent self-care. Rabie, Klopper, and Watson, (2016) carried out a study there to determine if the socio-economic status of older persons affects their ability to apply self-care independently without support from professional nurses in the PHC facility. The study adopted a quantitative, descriptive research design. 198 persons out of which 192 responded were asked to complete the Appraisal of Self-care Agency (ASA-A) and Exercise of Self-care Agency (ESCA) questionnaires. The data analysis revealed that these older

persons suffer from a lack of knowledge and the ability to acquire knowledge with regard to self-care. This condition had a direct relationship with their low socio-economic status and low literacy levels. Their low literacy levels combined with a low socio-economic status affect their ability to apply self-care independently without support from a professional nurse in the PHC facility. The study concluded that more attention should be given to older persons with a low socio-economic status as their ability to apply self-care independently without the support from a professional nurse is limited. This would lead to their paying less frequent visits to PHC for minor ailments, decrease healthcare costs, relieve overcrowding in PHC facilities and prevent possible unintentional self-neglect.

In a study on *Alcohol use, drunkenness and tobacco smoking in rural Western Kenya,* Lo et al (2013) examined the prevalence of smoking and alcohol use and abuse in an impoverished rural region of Western Kenya. They picked from a population-based longitudinal database of demographic and health census data, 72 292 adults who were asked to self-report their recent (within the past 30 days) and lifetime use of tobacco and alcohol and frequency of recent drunken states. The findings showed an 11.2% overall prevalence of ever smoking and 20.7% of ever drinking. The prevalence of current smoking was 6.3% of which 5.7% smoked daily. 7.3% reported drinking alcohol within the past 30 days. Of these, 60.3% reported being drunk on half or more of all drinking occasions. The study conclusions were that tobacco and alcohol use were prevalent in this rural region of Kenya, with the abuse of alcohol being likely influenced by the availability of cheap, home-manufactured alcohol. Appropriate evidence-based policies to reduce alcohol and tobacco use should be widely implemented and complemented by public health efforts to increase awareness of their harmful effects on a multitude of diseases and conditions. Programmes and interventions were needed to promote responsible alcohol consumption and tobacco use cessation, prevent

the initiation of these behaviours and promote public health awareness of alcohol-related harm across all levels of the population.

The above findings show that substance abuse or substance use disorder contributes to the inability of people to take good care of themselves. This, however, may not be ordinarily applicable to African women religious, but serves to provide an example of a cause of not taking care of one's health and general well-being. A more relevant cause of their inability to self-care would be as provided by the report presented below. In a publication of the St. Luke's Institute, Maryland, USA, Alexander (2013), writing from the vantage point of a therapist working with Catholic priests as well as Catholic men and women religious suffering from burnout, acknowledged the lack of good self-care as one of the most daunting tasks facing them today. He listed several features which help to perpetuate the lack of self-care. These included fewer vocations, training that traditionally has emphasised service first, the giving nature of most Catholic clergy and religious and overwork as some of the causes of its neglect. Other causes identified by this researcher from lived experience are inadequate supervision as well as a lack of resources both human and material among the African women religious.

The above could be as a result of a lapse in emotional intelligence. Colman (2008) as cited by Kumar (2015) defined Emotional Intelligence, also abbreviated as EI, as the capability of individuals to recognise their own, and other people's emotions; it is also to discern between different feelings, label them appropriately, and to use emotional information to guide thinking and behaviour. It is also the ability to manage and/or adjust emotions to adapt to environments or achieve one's goal(s). The concept of Emotional Intelligence was fully developed by Daniel Goleman, an American author, psychologist, and science journalist in the mid-1990s. He divided Emotional Intelligence into 'personal' and 'social' skills or competences. Since then, other researchers have built on the foundation he

laid to contribute to the further evolution of the concept. One of such researchers, Jerus (2015) concisely summed up emotional intelligence as consisting of self-awareness, self-management, social management and relationship management. According to him, implicit in the concept was that intrapersonal awareness and mastery precede service, empathy and connection to others. So then, self-care is seen as a prerequisite to achievement and interpersonal success. He maintained that inattention to self and others displays extremely limited emotional intelligence because it shows a lack of self-awareness and social awareness. This synopsis of self-care as a direct corollary of emotional intelligence hits the nail directly on the head of the matter. It paints a vivid picture of the person who does not self-care, and if the truth be admitted, it is a fair representation of the actual situation in which many African women religious find themselves. For, ignoring their own personal needs, deficient in self-awareness and sound emotional health, they plunge into an avalanche of services which, being possibly misguided, can only wind up in desolation and grief. Thus, when one ignores one's personal needs, the concern one may manifest for self and others is utterly unbalanced and cannot thrive. This is because a healthy self-care is at the root of all meaningful connectedness, personal or social. This aspect of ignoring one's personal needs while wearing oneself out for the welfare of others is a phenomenon recognised by the researcher as being a common feature of African women religious. Even though studies on this have not been carried out among women religious, it might safely be inferred that it would also be useful to include the teaching of emotional intelligence and self-awareness in the formation curriculum for women religious.

In a study situated in South Africa on *Self, self-care and self-management concepts: implications for self-management education*, Omisakin and Ncama (2011) submitted that these terms were both significant and foundational stones in the structure of self-management education. They defined self-management as the methods, skills, and strategies by which

individuals could effectively direct their own activities toward the achievement of objectives. It includes goal setting, decision making, focussing, planning, scheduling, task tracking, self-evaluation, self-intervention and self-development. The term is also linked with models of coping with adversity through self-help, self-reliance, and family and community reliance. Even though the intervention by Omisakin and Ncama was originally intended for people living with chronic health conditions, it can be fittingly applied also to the African women religious. Now, the average African woman religious traditionally lives in a well- community well-regulated by a horarium, under the leadership of a Superior who mostly tells her what to do, how to do it and where and when to do it. Any perceived 'individualistic' moves at self-development are frowned upon. For example, the Constitution of the Congregation of the Handmaids of the Holy Child Jesus, (as well as the Constitutions of other Congregations) clearly spells out this provision, counselling against such planning of one's life's endeavours and choices (Article 44, page 12). This situation could prove to be problematic and would require of an incumbent superior a hefty dose of emotional intelligence, discernment and other skills to help the women religious actualise their potentials. The above point is equally relevant for the average African woman religious who, from the researcher's point of view, manifestly lacks self-management awareness and skills. In a situation where many African women religious are either uneducated or half-educated, the provision of self-management education would appear to be a desirable panacea to most, if not all the effects of the lack of emotional intelligence identified and labelled as being causative of the neglect of self-care among them.

On the other hand, the neglect of self-care could be as a result of particular women religious "wearing too many hats". This means holding two or more positions of responsibility at once. It is not uncommon to find a Religious who is a local superior, the principal of a school, a member of the Congregation's provincial leadership team as well as

spiritual directress to a number of lay people all at once! This was the finding reported in an article on women religious in the USA by Kenel (2000) and was attributed to the sharp reduction in the number of women religious available for the filling of the different kinds of ministerial positions. The result was that a few people were overloaded to such an extent that their ability to live and function satisfactorily in their positions was compromised. The same author also reported the inability of women religious to set and get other people to respect appropriate boundaries for themselves both in their ministry and in their community setting as resulting in high levels of stress for them.

Barnard and Curry (2011) identified the desire to please others among the causes of burnout among clergy in North Carolina, USA. This could also happen among women religious. With the addition of the numerous activities, errands, housework, spiritual exercises, community functions, Church meetings, etc., there is not much time left for personal self-care. The fear of displeasing those they minister to who require their services at odd hours makes them run the risk of neglecting to care for themselves. This translates to an inability to maintain one's personal boundaries, resulting in their violation. Barnard and Curry also discovered there was an inability among some members of the clergy who participated in a study to differentiate who they were and what they valued from their role as clergy members and their effectiveness in that role. This resulted in burnout for those concerned. This was because they did so at the expense of the neglect of leisure, family, friends, and self-care. This kind of situation is clearly indicative of a flagrant flouting of the need for balance and support in the execution of the apostolate. It is possible that many women religious are also guilty of the same tendency and could benefit from these findings to amend their attitudes. If they do not consciously integrate and systematically implement a determined course of self-renewal at stated intervals, the risk of self-neglect cropping up cannot be ruled out. It must be observed that there is a general paucity of literature on this

occurrence among women religious at the global, regional and national or local levels. And since similar experiences about the neglect of self-care have been observed and recorded among the practitioners of the helping professions such as teachers, counsellors and social workers, as well as among parents in families, the findings from studies done using these other target groups could be extended to serve the purposes of this enquiry.

There is a further possibility of there being a regrettable fundamental misunderstanding of the true nature of the demands of the vocation to the religious life and a possible underlying gap in the psychological and spiritual maturity this requires in both the leaders and the followership. Nwagwu (2008) appears to capture this succinctly in her work, *Consecrated Life in the Church: Discipline and Praxis.* She reported the surprisingly ignorant and anachronistic views held by some religious on physiological functions. This unwitting and unnecessary repression and negation or outright rejection of the human dimension of persons results in a summary dehumanisation of their personality. She reported that:

> Often, the insistence on emptying of self, forgetfulness of self, submission or surrender of oneself, the challenge of living the hidden life, self-acceptance of humiliation and disposition towards sacrifice, have all become ways of uncalled for disregard of God's given talents in others. Such has led to some confusion with various religious persons maintaining a form of dualism between the body, spirit and soul, as though not part of the human person (pp. 188-189).

This kind of situation clearly calls for the appropriate updating of such religious in the areas where they find themselves wanting in order to relate properly with themselves and others as citizens of a modern twenty first century.

Writing in *Luke Notes,* Alexander (2013) appraisingly observed that:

> It often can be quite difficult for many lay people to practice good day-to-day self-care, but it can be even harder for Catholic clergy and religious who frequently are on-call, work long hours six to seven days a week and regularly must respond to unexpected crises. Each person must decide for himself or herself the benefits of better physical and emotional health versus the seductiveness of being rewarded for overwork (p. 1).

A further observation made by Alexander (2013) was that it was extremely difficult for people in a helping role to shift from their care-giver mode to that of a care-receiver. This was particularly so for individuals who had been poor at implementing self-care even before entering the priesthood or religious life. These observations could have been directly made about the African woman religious who finds herself unable to detach from the care-giver duties she is accustomed to performing. This identified inability often epitomises another hurdle that must be cleared in order to achieve the requisite self-care. This will ironically guarantee her innermost yearnings - that of being better able to serve the people of God.

Finally, the possible neglect of self-care in an African woman religious could be attributed to a lack of spiritual intelligence. Spiritual Intelligence (abbreviated as SI) is defined as:

> a set of mental capacities that contribute to the awareness, integration, and adaptive application of the nonmaterial and transcendent aspects of one's existence, leading to such outcomes as deep existential reflection, enhancement of meaning, recognition of a transcendent self, and mastery of spiritual states (King and DeCicco, 2009, p. 69).

Zohar and Marshall (2000) in their book, *Spiritual intelligence: The ultimate intelligence*, identified the following ten indicators of a highly developed Spiritual Intelligence. These include the capacity to be flexible (actively and spontaneously adaptive), a high degree of self-awareness, a capacity to use and face suffering, and a capacity to face and transcend pain. Others are the quality of being inspired by value and vision, a capacity to inspire others and a reluctance to cause unnecessary harm. The other indicators are a tendency to see the connections between diverse things (holism), a marked tendency to ask 'why?' or 'what if' questions and to seek fundamental answers. And finally, it entails being what psychologists call 'field independent', that is, possessing a facility for working against convention. These were further condensed into seven core elements by Amram (2007) to comprise developing awareness and knowledge about oneself; living with love and trust for

oneself and others, and finding purpose in every experience in daily life, including misery and painful experiences. Others are transcending the individual self to an interconnected wholeness, developing the attitudes of open acceptance, inquisitiveness, and concern for all things in the world as well as living harmoniously with self, veracity, divinity, and nature. It is, finally, developing inner freedom and responsibility for wise behaviour. As Covey (2004, p. 53) expressed it, "Spiritual intelligence is the central and most fundamental of all the intelligences, because it becomes the source of guidance for the others". Although the investigation of the benefits of spiritual intelligence on the well-being and performance of human beings is still largely in its infancy, it could be conjectured from the observation of its effects among people who practise it that spiritual beliefs, practices and commitments seem to be linked with positive results at various levels. These include areas such as psychological and physical health and well-being, marital satisfaction and stability, positive interpersonal performance and functioning, as well as better improved quality of life. Spiritual intelligence is all about the intelligence concerning the meaning and the value of life. If a religious loses it, she loses her figurative spiritual sense of smell, and with it, her fundamental sense of purpose and direction.

2.4 The Consequences of the Perceived Lack of Self-care

The effects of the lack of self-care are enormous. Though its documentation among women religious is not readily available, various studies have been done on it among the helping professions. These studies examined its negative manifestations such as serious physical, psychological and behavioural disorders and dysfunction, which, when put together, portray the burnout spectrum. In a study on *Job Burnout*, Maslach, Schaufeli, and Leiter (2001) defined burnout as a prolonged exposure to chronic emotional and interpersonal stressors on the job and outlined its signs and symptoms. It was observed to occur commonly in the fields of human services and education where empathy demands are high and the

emotional challenges of working intensively with other people in either a caregiving or teaching role are considerable. Its main effects manifest in reduced personal accomplishment and an eroded sense of effectiveness. Its common signs and symptoms at both the individual and team levels are as subsequently listed. At the individual level there are the physical manifestations of frequent illness such as headaches, gastrointestinal disturbances, immune system impairment and sleep problems, including nightmares. There are also an overwhelming physical and emotional exhaustion, feelings of cynicism and a sense of ineffectiveness and lack of accomplishment. Other symptoms include over identification or over involvement, irritability and hypervigilance, social withdrawal, professional and personal boundary violations and poor judgment. Burnout further manifests in perfectionism, rigidity, addictive behaviours and engages in interpersonal conflicts. Finally, the person so affected questions the meaning of life, his or her prior religious beliefs, experiences numbness and detachment from the job and has difficulties in concentrating on anything. At the team level, it manifests through low morale, high job turnover, impaired job performance including decreased empathy and increased absenteeism as well as staff conflicts.

Newell and MacNeil (2010) corroborated the view that burnout may occur at the individual organisational, or client levels (or in combination), and that the single largest risk factor for developing it is human service work in general. They also observed that the incidence of burnout is a frequent occurrence among the previously unprepared practitioners of the helping professions such as social workers, teachers, psychotherapists, aid workers and healthcare workers. In the face of the paucity of literature on this occurrence among African women religious, it might be helpful to apply or extend the available findings to them. Factors strongly associated with professional burnout include the regular manifestations of emotional expectations involved with human service work. Burnout can also be fostered by a practitioner's difficulty in interacting with, and understanding clients and their situations.

Alexander (2013) summed up these symptoms as culminating in declining personal health, lowered work performance, and emotional and behavioural issues.

Kwag and Kim (2009) in their study on the effects of organisational members' job burnout examined the factors which affect workers' job burnout, the effect of their job burnout on job performance and the moderating effect of the supervisor's support. 100 structured questionnaires were distributed to Korean employees in Busan and Gyeongnam, Korea, with a 97% return rate. Using descriptive analysis, reliability test, factor analysis, discriminate analysis, correlation analysis, multi regression analysis, and hierarchical regression analysis, the collected data were analysed with the SPSS 12.0 analysis package for windows. The major findings of the study were that firstly, role overload and role conflict were the major antecedents of job burnout, particularly of the exhaustion and disengagement components. Secondly, job burnout was related to lower levels of job performance. Thirdly, the moderating effect of supervisor's support on the relationship between role overload and the members of exhaustion was statistically significant. These findings are evocative of the observations of Kenel (2000) above about the phenomenon of women religious wearing too many hats.

Fayankinnu and Ogungbamila (2015) investigated the extent to which job satisfaction and workplace commitment were related to occupational burnout among head teachers in Nigeria. The participants were 207 head teachers (116 males, 91 females) drawn from 16 Local Government Areas in Kwara State, Nigeria. Their ages averaged 41.13 years with a range of 32 to 54 years. The respondents had spent an average of 26.18 years on the job. They responded to measures of job satisfaction, workplace commitment, and occupational burnout. Job satisfaction was assessed using Minnesota Satisfaction Questionnaire. Workplace commitment was measured using Buchanan's Organsational Commitment (OC) scale. Occupational burnout was measured using Maslach Burnout Inventory. The results

showed that job satisfaction significantly increased the extent to which head teachers experienced occupational burnout. Similarly, workplace commitment significantly predicted occupational burnout such that head teachers who were committed to their workplace tended to report occupational burnout. Finally, workplace commitment increased the level at which job satisfaction led to occupational burnout among head teachers. The above findings also resonate with the lived experiences of African women religious who, while excelling at their various assigned ministries, often presented with occupational burnout and generalised fatigue.

In their own study, Otieno, Matanga and Odera (2014) investigated the relationship between leader behaviour and experienced occupational tedium among primary school teachers in Nyanza province, Kenya. The ex-post facto research design was used to establish the relationship between the independent and dependent variables in the study. Purposive and stratified random sampling techniques were used to select the study sample. The population of the study was 399 primary school teachers drawn from 32 primary schools and 8 District Quality Assurance and Standards Officers (DQASOs) in Nyanza province. Data was collected by means of both structured and unstructured questionnaires and in-depth interviews. The analysis was performed using the Statistical Package for the Social Sciences (SPSS) Version 16.0. The two tailed t-test and product-moment coefficient of correlation were run to establish the differences and relationships between the independent and dependent variables. The level of significance was set at 0.05. The content analysis of the written free responses was also carried out. The findings established that primary school teachers in Nyanza province experienced high levels of occupational tedium and that the occupational tedium syndrome among them appeared to be most prevalent in the form of emotional exhaustion and reduced personal accomplishment. It was recommended that individual teachers, educational management personnel, planners and policy makers should

have an informed understanding of occupational tedium and its early warning signs and consequently equip themselves with skills, abilities, behaviours, conflict management and resolution policies and strategies needed to minimise the incidences of occupational tedium. The recommendations of this study appear to echo the need as perceived by this researcher for an awareness of the importance of preventive self-care by all the stakeholders in the organisation and living out of the religious life.

Rothschild and Rand (as cited in Newell and MacNeil, 2010), also identified other negative effects of the neglect of self-care such as vicarious traumatisation (VT), secondary traumatic stress (STS), and compassion fatigue. They explained that although these conditions are distinct from each other, available literature often erroneously used the terms interchangeably. They stated that vicarious traumatisation refers to a process of [cognitive] change resulting from [chronic] empathic engagement with trauma survivors. It represents the resulting cognitive shifts in beliefs and thinking that occur in practitioners who are engaged in direct practice with victims of trauma. Examples of such alterations include changes in one's sense of self and in one's world views about key issues such as safety, trust, and control. They also incorporate changes in spiritual beliefs. Newell and MacNeil (2010) also defined secondary traumatic stress as the natural and consequential behaviours and emotions resulting from knowing about a traumatising event experienced by a significant other [or client] and the stress resulting from helping or wanting to help the traumatised person [or client]. It develops from an empathic engagement with a client suffering from a traumatic experience. Its symptoms appear similar to those of post-traumatic stress disorder (PTSD) experienced by primary victims of trauma. These occur in such forms as intrusive thoughts, traumatic memories or nightmares associated with client trauma and insomnia. They also manifest as chronic irritability or angry outbursts, fatigue, difficulty concentrating, avoidance

of clients and client situations, and hyper vigilant or startle reactions toward stimuli or reminders of client trauma.

Furthermore, Newell and MacNeil (2010) asserted that compassion fatigue, another term also used interchangeably with secondary traumatic stress and vicarious trauma, is a more general term describing the overall experience of emotional and physical fatigue. Social service professionals experience this due to the chronic use of empathy when treating patients who are suffering in some way. It is best defined as a syndrome consisting of a combination of the symptoms of secondary traumatic stress and professional burnout and was first identified in the 1950s in nurses. It manifests and is characterised by a gradual lessening of compassion for the persons one cares for over time. The ministerial activity of women religious is often as emotionally charged as that of the members of the helping professions, and when combined with inadequate self-care, can produce the same effects on their health and well-being. The researcher has, in the past, known women religious who ministered to refugees and developed compassion fatigue, for example. Appropriate knowledge on preventive coping strategies can help alleviate or altogether eliminate these unhealthy side-effects of their ministries.

2.5 Suggested Solutions to the Perceived Challenges of Self-care

As diagnosed by Maslach (2003), burnout, a chief consequence of the lack of self-care, is a complex phenomenon which incorporates other states such as emotional exhaustion, depersonalisation and reduction in one's sense of personal accomplishment. Gilham (2014) clearly established its multi-factorial nature and advocated that interventions to prevent and reduce it must occur at the micro, mezzo and macro levels. He further prescribed that the interventions must include spiritual strategies, as these have particular value and benefit for its practitioners. Burnout is a chief consequence of the lack of self-care. It is this researcher's view therefore that the successful prevention of burnout would amount to a major solution to

the lack of self-care among African women religious. Any effective strategies identified, adopted and applied in this regard will ultimately be equally valid for the remedying of self-care deficit among this study population.

There are a plethora of approaches that have been developed among the helping professions and among patients of life-threatening diseases on self-care interventions. Clode and Boldero (2005) designed a self-care wheel comprising three parts, namely, Identification, Prevention and Support. According to this model, identification consists of personality, job satisfaction and self-care assessment. Prevention has to do with lifestyle balance, management skills, boundary issues and coping strategies. Support entails personal, peer, family and social support. Newell and MacNeil (2010) recommended the general bio-behavioural strategies approach which consists of practices such as maintaining physical health, balanced nutrition, adequate sleep, exercise, or recreation. This approach also includes the use of positive forms of self-expression such as drawing, painting, sculpting, cooking, or outdoor activities, maintaining spiritual connections, psychotherapy as well as the use of emotional and social support from close family and friends. However, this researcher considers the coinage *bio-psycho-social-spiritual model* by Egan et al (2011) to be more expressive and most inclusive. This arose from the findings of a nation-wide New Zealand (NZ) study conducted between 2006–2008 on the understandings, experiences and ways to improve spiritual care primarily in hospices. Rettger et al (2015), reported on the Psycho-Spiritual Integrative Therapy (PSIT) model, used with considerable success for the treatment of women with primary breast cancer. This is "an integrated psychotherapeutic approach which explicitly targets the treatment of the whole person", body, mind, emotions and spirit. It could also be used as part of the suggested solutions to the lack of self-care among the African women religious. Lastly, the American Institute of Stress (AIS, n. d.) features on its

website *The ABC's of Prevention* of Compassion Fatigue. These stand for Awareness, Balance and Connections.

These three counsels (Awareness, Balance and Connections) are quite succinct, and are, in fact, interwoven. They are also deemed by the researcher as being an apt and concise formula for the resolution of the issues hindering the provision of self-care among African women religious. They will therefore be subsequently examined and elaborated upon and will form the framework upon which the discussion of the selected, identified solutions will be anchored. Other pertinent solutions which dovetail with these will also be scanned or mentioned in passing as judged appropriate by the researcher. This is in order to weave a simple, but comprehensive web of sustainable solutions to this multifaceted and life-depreciating phenomenon.

Considering the structure of the religious life, the proposal of solutions to the lack of self-care among African women religious would need to be multidimensional, aiming simultaneously at the individual level, the communal or congregational level. It will also be at the inter-congregational and the ecclesiastical levels, or, as advocated by Gilham (2014), occurring at the micro, mezzo and macro levels. The therapeutic interventions already discussed in the theoretical framework for this study would also come in handy here. The insights on the provision and implementation of self-care to be discussed in this section will necessarily be borrowed from those already in use among the various helping professions. This is primarily because of the absence of identified empirical studies on the subject of self-care among African women religious. It is further as a result of the marked similarities between the presenting symptoms of the lack of self-care which are experienced by both the women religious and the practitioners of the helping professions alike. Additionally, the remedying of the various causes for the neglect of self-care identified in the earlier part of

this chapter would also help provide some solutions to the perceived challenge of self-care among African women religious.

At the individual level, the need for Awareness, the first component of the tripartite preventive self-care approach proposed by the American Institute of Stress (AIS, n. d.) deserves to be singled out as the pivot on which the entire intervention process will revolve. This is because without it, no other intervention made to provide solutions to the lack of self-care will be meaningful. African women religious minister to diverse populations, and out of zeal literally throw themselves into their assigned duties. These duties may require physical exertion, a wholesale accompaniment of a person, family, group or community through active listening, empathising, and sharing in the pains of these persons. The duties also demand to some degree, the absorption of the pains or distress communicated by them. A long-term and unprotected exposure of the religious to these symptoms may leave her emotionally drained and unable to cope any further with the demands of her ministry. Newell and MacNeil (2010) identified the lack of awareness about the existence and possibility of these hazards as increasing the vulnerability of a practitioner to their effects. It is therefore desirable that the woman religious become aware, as a preventive measure, of the risk factors and symptoms associated with her work and be enabled to take appropriate steps to protect herself from letting them overwhelm her. Awareness leads to greater self-knowledge and self-acceptance. The subject of awareness was discussed at length earlier in this study. Its resurgence in this section bears witness to its prime importance in the subject of the provision of self-care. The issues discussed about awareness there are equally endorsed for incorporation in this section. As can be recalled, Dowden et al (2014) proposed a *Three-tiered Model for Self-Awareness and Self-Care* which utilises a developmental approach to enhance self-awareness and self-care among trainee counsellors. This method is theoretically anchored on the Cognitive Behaviour Therapy (CBT), developed by Aaron Beck in the 1960s. According to Dowden et

al (2014), it is a psychological approach that highlights thought or cognitive modification as a means of changing emotions and behaviours. The model comprises the three hinges of self-checks, self-talk and self-journaling.

Prevention, which is one of the strategies for effective self-care, stems from awareness. As portrayed by Clode and Boldero (2005), prevention looks at how one copes with stress and examines the range of skills needed to reduce stress in one's professional life. It also offers ideas on balancing priorities in one's life as well as setting boundaries within and between professional and personal life. Gilham (2014) synthesised the following as effective strategies for the prevention of burnout at the personal level: goal setting and time management, positive thinking and avoidance of negative thinking, using relaxation techniques, employing humour and participating in outside activities. He also proposed having a variety of experiences or tasks at work, building and maintaining support networks, changing one's way of responding to, or adapting to distressing events, as well as self-monitoring one's stress. This researcher believes that since these strategies that have proven effective for the prevention of burnout, they will equally be so for the provision of self-care since burnout is a consequence of self-care deficit.

Kravits, McAllister-Black, Grant and Kirk (2010) defined coping as a dynamic process that functions to promote survival and adaptation in response to stimuli appraised as threatening. In line with Folkman and Greer (2000), they went on to state that coping strategies are learned patterns of behaviour influenced by personality traits, historical patterns of relationship, and situational stressors. They asserted that successful coping and adaptation could be promoted by stimulating belief in one's personal power to control life circumstances. It could also be used to create achievable goals and generate a positive mood. Among the coping measures commonly utilised, as identified by Clode and Boldero (2005) are problem-focussed coping, emotion-focussed coping, religious or spiritual coping and

social support. Stress management and relaxation techniques were also categorised among the forms of coping.

Since this study is about women religious for whom religious or spiritual matters are not just a central concern, but a primary life project, it will be pertinent to say a word here about religious or spiritual coping, although further details concerning this measure can be more appropriately supplied in the course of a psycho-educational session. Clode and Boldero observed that people usually turned to religious or spiritual strategies in the face of uncontrollable stressors. Egan et al (2011) reported a nation-wide study in New Zealand. It examined understandings, experiences and ways to improve spiritual care in hospices. The study employed a mixed methods approach which included 52 semi-structured interviews and a survey of 642 patients, family members and staff from 25 (78%) of New Zealand's hospices. The findings revealed that the majority view held that spirituality was a useful, important, inclusive and broadly defined concept, and was found to be important at the end of life. These findings were all the more remarkable because New Zealand is a secular country. Rettger et al (2015) in a study on the use of *Psycho-Spiritual Integrative Therapy for Women with Primary Breast Cancer* reported that higher levels of spirituality and faith were associated with higher levels of perceived cancer-related growth in cancer patients, and most cancer patients reported a reliance on religious and / or spiritual beliefs to cope with cancer. They further reported that

> Psycho-Spiritual Integrative Therapy (PSIT) is an integrated psychotherapeutic approach explicitly targeting treatment of the whole person. It is both an approach to psychotherapy and a spiritual practice focused on a lived spirituality. As such, PSIT supports breast cancer patients seeking meaning and purpose as well as deepened spirituality. PSIT integrates psychotherapy and spiritual practices in order to help clarify and fulfil the individual's life purpose and to build skills for resolving obstacles in life transitions, including cancer survivorship (p. 265).

Gilham (2014) concluded from the findings of various researchers that for individuals of faith, a relationship with an Ultimate Being had been linked to enhanced coping, a sense of mission and purpose, and hope for the future. Moreover, prayer was often found to be a source of strength which had helped individuals in distress to overcome physical and psychological suffering. Dombo and Gray (2013) also specified the use of spiritual practices as a tool for self-care to help douse the doubts faced by practitioners regarding their faith. These usually emanated from the discouragement they encountered in the course of performing their work. Koenig, McCullough, and Larson (2001) further asserted that religious rituals have also proven efficacious to ease anxiety and dread as well as promote a sense of security and alleviate isolation. These rituals included attending religious services, scripture reading, spiritual meditation, holy communion, reconciliation and faith sharing, among others.

Apart from individual religious engagement, a communal expression of faith also holds a healing dimension to it. Far from being a mere expression of faith, fostering a sense of belonging in a community at the mezzo and macro levels is a method for promoting support and increasing empowerment through spiritual, social and psychological self-care. Spiritual sharing, collaboration, or practice done with others, can enhance teamwork, boost camaraderie, release energy, help workers to regain meaning in their work and stimulate coping ability and a sense of belonging (Dombo & Gray 2013; Gilham, 2014).

If religious or spiritual coping can be this effective for lay patients who turn to it out of distress, how much more effective will it not be for the women religious whose entire lifestyle is anchored on it? Kenel (2000) emphatically maintained that a strong prayer life "can serve as a motivator and a source of the inner strength that is required to carry on one's ministry and communal life with enthusiasm even in the midst of stress and tension" (p.38). Therefore, the need for the African women religious to fully exercise the practice of spiritual

intelligence by using the spiritual resources at their disposal, as a core solution to the lack of self-care among them, cannot be over-emphasised. Prayer, meditation, spiritual direction, Bible study, Eucharistic adoration must be taken back on board. All these go to buttress the importance of the use of religious or spiritual coping.

At the regional level, the use of coping as a preventive measure was highlighted by Omisakin and Ncama (2011) in their study on the *Self, self-care and self-management concepts: implications for self-management education* as comprising the type and use of management skills needed for successful living both at the personal and professional levels. The purpose of their paper, which was written from their background of working in the nursing field examined the concepts of the self, self-care and self-management. It attempted to reach a better understanding of the interplay between these concepts in the self-management education process. They posited that at the personal level, the ability to effect self-management is, and can be described as a visible manifestation and implementation of self-awareness. Omisakin and Ncama (2011) summed up the merits of self-management education thus:

> In self-management education, people learn who they are and gain the collective power to determine the direction of their lives. Because human beings cannot be separated from their social and historical contexts, reality is not a static entity but a process of transformation. By engaging in acts of enlightenment and empowerment, human beings become liberated and therefore become more fully human. Self-management education gives further insight into one's being, one's own life's purpose, and one's position in life. These three, help one locate oneself (even in the middle of environmental chaos and personal mental conflicts); promote acceptance of one's situation; open doors to personal clarity; and add supports to one's self-meaning, leading to development of self-care and self-management traits that promote self-healing (p. 1737).

This skill also yields other dividends such as goal setting, decision making, focussing, planning, scheduling, task tracking, self-evaluation, self-intervention and self-development. It is evident that this skill overlaps with the self-awareness skill of identification. Self-

management also functions synergistically with models of coping with adversity through self-help, self-reliance, as well as family and community reliance.

Kathuri-Ogola, Mugenda and Kerre (2014) undertook a study on the *Challenges Faced and the Coping Strategies Adopted by Family Caregivers in Dealing with People Living with HIV/AIDS in Thika District, Central Province, Kenya.* They reported that according to the National AIDS Control Council (2000), more than 1.4 million Kenyans are living with HIV and AIDS, and that the Thika District has been one of the regions with a high HIV infection prevalence. Their paper documented the challenges and coping strategies family caregivers (FCGs) of People Living with HIV and AIDS (PLHWA) encounter. One hundred and seventy-seven (177) primary FCGs of PLHWA, drawn through stratified random sampling from three divisions in the study area were used. The data were collected using interview schedules and focus group discussions and analysed quantitatively and qualitatively. The quantitative data was analysed with the use of the Statistical Package for Social Sciences (SPSS) where descriptive statistics and inferential statistics were computed in order to understand the patterns and nature of relationships. The qualitative data was analysed using content analysis, where labels were assigned to various categories and themes of the data. The results showed that the FCGs faced numerous challenges in care provision, the most prominent ones being financial, food provision, stress, stigma, inadequate medicine and supplies, difficult care recipient, and strain on education. Consequently, they adopted some coping strategies to ensure economic endurance, psycho-social well-being and spiritual support. These included increasing their resource base through getting loans/borrowing (50.3%), positive living (36.2%), prayers (36.7%), use of Community Health Workers (CHWs) (24.6%) and improving knowledge of disease (13.6%). In the context of the numerous challenges they were facing, over two thirds (69.5%) of the respondents felt that they were coping well as caregivers while the rest thought they were not coping well.

Recommendations included the need for FCGs-targeted interventions by the Kenyan government with specific focus on identified needs such as economic empowerment, provision of psychosocial support, supplies of basic needs and medication, and training on care giving to enhance the quality of the care given to the PLWHA.

Finally, the practice of awareness demands the need to set and maintain one's boundaries. Cooper (2012) defined professional boundaries as a set of guidelines, expectations and rules which set the ethical and technical standards in the social care environment. Boundaries set limits for safe, acceptable and effective behaviour by workers. This is an acceptable measure when one is tired, stressed or overworked. However, some women religious feel guilty about setting and using boundaries and so are unable to turn down demands that threaten or infringe on their personal maintenance time.

Wagman (2012) defined Balance, which is also the second arm of the AIS preventive approach, as the ability to organise one's time and energy in ways that enabled one to meet important personal goals and renewal. Allen (2013), in a study from Peru, South America, took a second look at the need for self-care and balance among educators. Educators commonly had a reputation for expending themselves for their students with little thought for themselves, as manifested by the frequently resultant excessive stress, work-related illness, burnout, and attrition. The study results not only verified the persistent pattern of excessive stress, overwork, and illness among them, but also confirmed that educators typically ignored their own needs. But rather than reiterate the conventional remedies usually proposed for these maladies such as induction and mentoring programmes, salary incentives, or teacher help lines and wellness programmes, he advocated a different, but practical and dynamic approach. Its procedure comprised the skilful maintenance of a healthy balance which they could apply to all their activities such as classroom management, curriculum design,

assessment strategies, professional development, prevalent attitudes, and even work-life rhythm. He advanced that:

> Balance is best understood as a practical goal and continuous process rather than an ideal state or final destination. The most accurate and humane idea of balance would take into account all the aspects of our being – our minds, bodies, and spirit, our practical concerns, individual desires, attributes, and idiosyncrasies – as well as the flux of our daily lives. Consequently, we would move toward better balance by cultivating understanding, appreciation, and harmony rather than trying to impose artificial symmetry and proportion on our lives. Our shared goal would be to find peace and pleasure in the whirl of human events (p. 157).

To achieve this, he explicitly highlighted the following as the necessary themes to incorporate in the quest for attaining balance: the personal and the professional; the formal and the familiar; the mind and the body; teaching and learning; being and doing; efficiency and effectiveness; doing things right and doing the right things, as well as retaining one's own cultural identity and exploring that of others. He insisted that the only other alternative to finding and enjoying balance is to face burnout. For women religious, the list could be adapted to include creating a balance between the religious and the so-called secular domains, the mystical and the material, the personal and the communal, the biological (one's natural), the religious families, the social (one's personal friends) and the ministerial (contacts at work) domains. The list could go on, fed by the various areas that create conflicts in one's life. For without balance, one's life would be a jumble of stress and struggle, duty and necessity, striving and confusion.

In a study from Nigeria, Africa, Ugwu, Orjiakor, Enwereuzor, Onyedibe and Ugwu (2016) examined the everyday living of business women who traded on petty goods and earned very little in a low-to-middle income country (LMIC). They explored their conceptions of balance, how they managed intersecting roles, and how they coped with daily hassles and the stress to maintain wellbeing. The study adopted the reflective life-world approach. Twenty women who traded on a range of items and earned between $0.41 to

$62.98 were interviewed using a semi-structured guideline. The analysis was conducted using interpretative phenomenology. The findings revealed that the conceptions of balance for the women incorporated the notions of satisfactory progress across roles, proper time apportionment to roles, conditional balance as well as harmony and / or synchrony across roles. Their conception of business-life roles was quite integral. Negative physical and psychological experiences impacting health and wellbeing, identified as being a result of combining both roles, were commonplace but were typically considered a normal part of living. Engagements in extra-social roles appeared to have a double-edged effect. Placing the family first, time management, and prioritising were some of the important measures of ensuring balance and wellbeing. Financial gains and personal satisfaction were top motivational reasons that kept the women committed to pursuing simultaneous roles. The conclusion arrived at was that there was a strong overlap between what balance means for petty trading women and employees. Since most studies in the work-life balance literature have explored how employees pursue balance and the various strategies that work for them in their contexts, this research introduces a different view of the striving for balance by a specific group of people. The unique social platform it presents offers a more communal perspective of issues in pursuing balance.

Muindi, Nzulwa, Nyakairu and Muinde, W. (2015) carried out a study on *Work Life Balance Practices Adopted in Horticultural Farms in Kenya.* The study was premised on the fact that organisations in the modern day competitive world can only perform at optimal levels if each employee is committed to the organisation's objectives and works as an effective team member. An inability to create a balance between work and personal life could affect employees' effectiveness and productivity in the workplace. As the nature of the workforce continues to diversify, it will become increasingly important for organisations to consider all the factors influencing their employees' ability to balance work and non-work

commitments, and to find a way of incorporating them into their operating policies. The objective of this study was to investigate the extent to which work life balance practices are adopted by horticultural farms in Kenya. The study adopted a census research design. The results of the study indicated that horticultural farms in Kenya have adopted practices relating to time and to the job to a great extent while practices relating to the place and to the benefits have been adopted to a moderate extent only. The study recommended that greater attention be paid to practices relating to the job as well as employee benefits as these scored lower ratings than practices relating to time and place. In particular, the farms should introduce employee assistance programmes and study leave in order to empower the employees to make better use of the other practices they have been provided. Further, the farms should consider introducing flexible working hours and increased work autonomy so that the employees can schedule their work in a manner that allows them to attend to non-work matters during off peak working hours and seasons.

From the foregoing, it is evident that the subject of balance is a universal and topical one that spans various professions and life styles globally. It is a determinant factor for the integral well-being of all and sundry. Clode and Boldero (2005) also recognised balance as a value worth working for and numbered among the harvest to be gathered from creating and maintaining it, the fruits of a nourishing peace and increased productivity, pleasure and appreciation, understanding and harmony. They further identified four obstacles to balance which include not having enough time and energy, enough time with self and community members, harbouring too much worry and being tied to too much paper work and administration. These are pitfalls which African women religious would need to be on the watch for, because without balance, one's life is in a state of total disarray. Balance will help unclutter one's life and make it richer, more satisfying, nurturing and productive.

Wagman (2012) described connections, the third leg of the AIS preventive self-care model, as the ability and the fact of having rewarding and self-affirming relationships with others. It was also identified as support and as one of the strategies for balance. It consists of the maintenance of a personal support network for the purpose of providing one with a forum for sharing feelings, queries and ideas, reducing isolation and helping one deal with the problem of stress. Often, one's immediate family is one's most essential support system. However, this is seldom recognised in the religious life since keeping strong ties with one's biological family is not particularly encouraged. In order to maximise opportunities for social contact, one could contact old or neglected friends, participate in celebrations such as birthdays or other special events and engage in sharing one's interests through regular sporting activities or hobbies.

An exploratory study carried out at the University of California, USA, by Turner et al (2015) surveyed 363 interns to assess the frequency of use and the effectiveness of self-care strategies used during the internship year. Among the most frequently used strategies were family and friend social support, active problem solving, and humour. The most effective strategies were family and friend social support, seeking pleasurable experiences, and humour. A strong positive relationship was found between total scores for Frequency and Effectiveness subscales, and women reported significantly more use and effectiveness of strategies. Among the recommendations provided was that intern training programmes be intentional about their promotion of self-care through the use of modelling, didactic and experiential workshops, and other activities that involve all members of staff.

In Ghana, Amoah and Jørgensen (2014) studied social capital, health and health care among street children in Kumasi, Ghana, West Africa. The study was prompted by the fact that the interest in the relationship between social connections and the health-related wellbeing of a given population had received a major boost in public health recently. This

relationship either produced or prevented health risks and health problems. The paper qualitatively explored this relationship, using the case of the street children in the Kumasi Metropolitan Area in Ghana. The sources for the information and data were both primary and secondary. In-depth interviews, focus group discussions and observation methods were also employed. Semi-structured interview guides were used for almost all the interviews and discussions and a total of 26 informants participated in the study. Primary data was gathered from fifteen of these and from the children of the streets aged between 13 to 17 years. The findings revealed that contrary to the notion that street children were incapable of making social connections, the children demonstrated a high sense of pro-social attitude by building and maintaining social relationships which proved beneficial to their health-related wellbeing. The study therefore recommended that reaching out to the children and other vulnerable groups should strongly involve their social networks as such networks have greater influence on their health-related choices and decisions. It was moreover suggested that a social marketing approach should be adopted in the design and implementation of relevant policies in order to systematically and successfully influence the health-related behaviour and choices of people. The paper, however, concluded that social capital was a contextual concept and should be assessed and applied as such so as to reduce its potential adverse effects on health-related wellbeing of people.

Simatwa, Odhong', Juma and Choka (2014) studied the prevalence, strategies and challenges of substance abuse among public secondary school students for the school managers in Kisumu, Kenya. Substance abuse was spreading at an alarming rate among public secondary school students, and if not checked, could destroy the youth who were still in their formative years. The study adopted a descriptive survey design. The study population consisted of 13,243 students, 43 principals, 43 deputy principals and 43 heads of guidance and counselling departments in 43 public secondary schools in the Kisumu East Sub County.

Stratified random sampling was used to select 320 students, 20 principals, 20 deputy principals and 20 heads of guidance and counselling departments. Questionnaire and interview schedules were used to collect data. The study established that the factors that influenced students most into substance abuse were peer pressure, media influence, frustrations and copying of role models. The three strategies used most frequently by the managers to curb this menace were the use of professional counsellors, teachings on substance abuse, and training of peer educators, while the challenges they encountered were found to be the rehabilitation of substance abusers, reducing the prevalence of substance abuse, and improving the academic performance of substance abusers. The study's recommendations were that a comprehensive curriculum on substance abuse be introduced in schools, areas around the schools should be made as drug free as possible, the education of students on substance abuse should start in primary schools, the Teachers' Service Commission should post full time professional counsellors to public secondary schools, and the government should establish free rehabilitation centres to cater for students who were substance abusers. The findings of this study are significant to the managers of public secondary schools in Kisumu East Sub County because it may help them to better understand the issues related to substance abuse among students in their schools and to come up with effective strategies to be used in addressing substance abuse related issues. It is significant to educational planners and economists whose concerns are the optimal utilisation of inputs and outputs for efficiency of educational systems.

The above studies from various parts of the world help to establish the fact that social support is crucial for the thriving or survival of any group of persons in the world. For African women religious, the message to take away from these examples is the need to learn to share with others and ask for help as and when needed. It would also be helpful to learn how and when to say no to more and more responsibilities, striking a balance between work

and leisure / social pursuits, getting proper rest, regular nutritional meals and enough physical exercise. Alexander (2013) pointedly observed that many overly conscientious clergy and religious forget to do or don't make time for all these dynamics of self-care, and advised that they should avoid getting too hungry, angry, lonely or tired. He further explained that self-care skills involved planning, assertiveness and listening to, and respecting one's feelings as legitimate signals for action.

2.6 Specific Interventions at Various Levels

At the individual level, it would be helpful to make self-care as practical as possible by creating a holistic self-care plan or list that incorporates little practices for each of the levels of one's being-body, mind and spirit. This is the recommendation of McDermott (2013) in his work titled *Creating Your Holistic Self-Care Plan.* He further suggested that if one decided to make a self-care plan or list, it was advisable to keep it in a place where it could be seen every day**.** Keeping it visible would help one to think about and commit to the strategies in the plan. In addition, taking little steps at a time would make the achievement of the desired change more attainable. It is counterproductive to take giant ones especially at the beginning. Picking simple things to start off with would result in greater strides as time went on. For example, at the spiritual level, one could decide to start with five minutes meditation each day rather than thirty minutes.

As already pointed out in the theoretical framework of this study, and as noted by Gilham (2014) the interventions for the remedying of the neglect of self-care would need to be effected at the micro, mezzo and macro levels. These would correspond to the individual, congregational, inter-congregational and ecclesiastical authorities' levels. In practice the interventions would require that some amount of modification be made to the organisation of the religious life, and even that of the institutional Church, in recognition of the signs of the times. It is, however, pertinent to point out that there would not be any need to resort to

importing or imposing anything from outside the Church for this, because most, if not all, the tools and resources for it are already present within the Church. All that would be needed would be to put them to work. It is the view of this researcher that the place to begin this intervention is to return to, heed and implement, in the first place, the Catholic Social Teachings (CST). According to the information on the website of the United States Conference of Catholic Bishops (USCCB, 2005),

> The Church's social teaching is a rich treasure of wisdom about building a just society and living lives of holiness amidst the challenges of modern society. Modern Catholic social teaching has been articulated through a tradition of papal, conciliar, and episcopal documents.

The documents were developed by the Catholic Church for over a hundred years and dwell on the issues arising from the social, economic, political, and cultural spheres as they affect the welfare of human persons on the global scene. The first social encyclical titled *Rerum Novarum,* (Of New Things) was written by Pope Leo XIII in 1891, while the last one titled *Laudato Si* (Praised Be) was written by Pope Francis in 2015. Since they are not regularly taught or preached about, and their principles are generally not applied even in Catholic institutions, the faithful are largely ignorant of them. However, the researcher believes that if this is true among the general body of the faithful, it should not be so among Catholic women religious. For the religious life, by its very nature belongs to the life and holiness of the Church (LG 44), and so should be seen to uphold and even personify all the values and attributes of the Church. As synthesised by the Catholic Bishops of New Zealand (2010) the ten guiding principles of the Catholic social teachings are human dignity, human equality, respect for human life, the principles of association, participation, common good, solidarity, stewardship, subsidiarity and the universal destination of goods. Rakoczy (2015) condensed these further to the four core principles of the dignity of the human person, the pursuit of the common good, the value of solidarity, and subsidiarity, a term which signifies that higher decision-making bodies should not restrict lower-level action. She justified this by the fact

that each of them had been woven through successive papal encyclicals and other documents such as those of the second Vatican Council. Some examples of these principles are as follows. On the life and dignity of the human person, Pope John Paul II affirmed that human persons are willed by God; they are imprinted with God's image. Their dignity does not come from the work they do, but from the persons they are (John Paul II, Centesimus annus 11, 1991).

The US Conference of Catholic Bishops further reiterated that

> All human beings, therefore, are ends to be served by the institutions that make up the economy, not means to be exploited for more narrowly defined goals. Human personhood must be respected with a reverence that is religious. When we deal with each other, we should do so with the sense of awe that arises in the presence of something holy and sacred. For that is what human beings are: we are created in the image of God (Genesis 1:27), (Economic Justice for All, 28, 1986).

Moreover, on the dignity of work and the rights of workers, the Church officially teaches that

> A just wage is the legitimate fruit of work. To refuse or withhold it can be a grave injustice. In determining fair pay both the needs and the contributions of each person must be taken into account. 'Remuneration for work should guarantee man the opportunity to provide a dignified livelihood for himself and his family on the material, social, cultural, and spiritual level, taking into account the role and the productivity of each, the state of the business, and the common good' (GS, 67). Agreement between the parties is not sufficient to justify morally the amount to be received in wages (Catechism of the Catholic Church, 2434, 1994).

In the words of Johansen (2007), to live at a subsistence level is to live at the minimum condition of human dignity, and, as St. Thomas Aquinas wrote in the *Summa Theologica*, "No one is obliged to live unbecomingly", 2a 2ae, Q. Ixvi, art. 2

The whole point of fishing out the above teachings from their 'hiding places' is that if they were put into practice, African women religious would be better empowered to be self-caring. This is because, with their dignity as human persons acknowledged and respected, their dignity and rights as Church workers will also be safeguarded and supported by the

solidarity received in the course of living and working. In this way, they will be protected against the evil of poor remuneration and the dangers of overextension and self-neglect through organisational manipulation.

In addition to implementing the CST tenets, there would also be a need to do the same to the recommendations of the historic ecumenical Vatican II Council which was held from 1962-1965. Reporting on the unprecedented changes that resulted from it, Poruthur (2014) declared:

> In the last few decades, structures previously considered sacrosanct have disappeared. The understanding of religious life has considerably changed; as also how consecrated persons think of their vows. A new road map needs to be prepared. First of all, the human foundation of religious life must be affirmed.

The same author also drew an overdue attention to the fact that a new era dawned in the history of the Church with the epoch-making Vatican II as attested to by the renewal that was brought into every sphere of ecclesiastical life. He also observed that religious tended to reflect on their life in isolation from the rest of humanity. It was in order to correct this anomaly that the Vatican Council Fathers directed in the document on the renewal of the religious life that:

> The manner of life, of prayer, and of work should be in harmony with the present-day physical and psychological condition of the members. For this reason, constitutions, directories, books of customs, of prayers, of ceremonies and such like should be brought into line with conciliar documents (Perfectae Caritatis 3, 1965).

Some other Vatican II documents also pointed in the same direction as the following examples show. The Declaration on Christian Education, *Gravissimum Educationis* directed that due weight being given to the advances in psychological, pedagogical and intellectual sciences, children and young people should be helped to develop harmoniously their physical, moral and intellectual qualities (Gravissimum Educationis 1, 1965). The decree on the training of priests, *Optatam Totius*, (which the researcher applies here to religious), instructs

that "they should be taught to use correctly the aids provided by pedagogy, psychology and sociology" (Optatam Totius 20, 1965). Further, the Pastoral Constitution on the Church in the Modern World *Gaudium et Spes*, placed the following responsibility on pastoral agents:

> In pastoral care sufficient use should be made, not only of theological principles, but also of the findings of secular subjects, especially psychology and sociology: in this way the faithful will be brought to a purer and more mature living of the faith (Gaudium et Spes, 62, 1965).

From the above statements, it is clear that every class of people in the Church was adequately provided for in the scheme of the renewal: clergy, religious and laity. So if women religious assiduously follow up on this, it would help make the challenge of self-care a thing of the past among them.

However, it has been observed that as an organisation, the Catholic Church has within its very organism some very real embedded factors that might cause some hiccups. Newell and MacNeil (2010) termed this phenomenon *organizational risk factors for burnout*. They recommended in their study on *Preventive Methods on Professional Burnout, Vicarious Trauma, Secondary Traumatic Stress, and Compassion Fatigue for Clinicians and Researchers* that:

> Social work educators should teach students the key features, warning signs, and symptoms associated with professional burnout and Secondary Traumatic Stress (STS), as well as self-care strategies and techniques as preventive practice behaviors. One approach to educating new social work students about professional burnout is to integrate content in this area across foundation-level micro and macro social work courses. Helping students to understand these organizational risk factors prior to their beginning field education experiences may serve to decrease their vulnerability to professional burnout (p. 63).

So like every other human organisation, the Church is not exempt from these *organisational risk factors for burnout*. Without the risk of being adjudged disloyal to the Church, the researcher believes that it will be necessary to bring them to the notice of unsuspecting neophytes-pre-novices, novices and junior professed Religious at appropriate times within their years of formation.

One of the things that could qualify as an organizational risk factors for burnout in the Catholic Church could be what Baumeister et al (2003) pointed out in their study on whether self-esteem causes better performance, interpersonal success, happiness, or healthier lifestyles. They noted that the Judeo-Christian tradition had long considered modesty and humility as virtues conducive to spiritual growth. They recalled that in this tradition, high self-esteem was suspect because it opened the door to sentiments of self-importance. As a result, religious devotees cultivated an unattractive appearance (e.g., shorn hair, no makeup, unfashionable clothes, no jewellery), spoke with self-effacement, and submitted to degrading exercises (e.g., begging, prostrations, self-flagellations).

It is possible that vestiges of this mentality have managed to subsist in the religious life to date, and are posing an obstacle to the cultivation of self-care among African women religious. This is because it could be considered contrary to modesty and humility to be self-caring, and thereby attract unwelcome disapproval. This view is corroborated by Agudo (2003) who also supplied a way forward. She proposed the necessity of looking at the Christian spiritual traditions which had been long-held from a psycho-theological perspective, and acknowledging that the process of growth and evolution needed continuity according to the plan of God. She concluded that remaining stagnant would mean deterioration and death.

Furthermore, Alexander (2013) also noted the existence of another obstacle that would need to be surmounted before the practice of self-care can receive a nod of legitimisation:

> Even if someone clears the first hurdle of actually implementing better self-care, most organizational systems (including the Church) tend to reinforce and reward individuals who overwork and excessively sacrifice for the job. This means that there can be some hidden costs to making positive self-care changes, at least initially (p. 60).

In the face of these impediments, any woman religious who desires to venture on this path will need to be equipped with a very healthy self-concept, firm principles, strong convictions and enough courage to work through the difficulties that she will encounter in order to practice self- care with any measure of continuity and perseverance.

As part of the move to providing these interventions, it might be helpful to heed the recommendation by Gilham (2014) to the effect that agencies must seek solutions to problems without assigning blame and use resources wisely and efficiently. Moreover, agencies must have mechanisms for identifying individuals who are experiencing stress and assist them in self-care. and providing a supervision model which will contain a comprehensive approach to teaching self-care during psychotherapy training. When imported into the terrain of religious life formation, this supervision model will translate into a philosophy to be adopted by superiors which would recognise and normalise personal stress instead of attributing it to other causes such as laziness. There would also be need for organisational flexibility in adapting work responsibilities to the needs of the individual woman religious instead of adapting the women religious to the needs of the Congregation as is the practice at present. These innovations would further need to include the establishment of support systems for women religious such as administering the Maslach Burnout Inventory and self-care inventory at predetermined intervals to women religious in active ministry. If the results indicate a deficiency, there should be a remedial follow-up.

Finally, as reported on the web page of the American Institute of Stress (n. d.), Mother Teresa of Calcutta, now a canonised Saint of the Catholic Church and the Foundress of the Missionaries of Charity, well understood compassion fatigue, one of the consequences of the work of caring for the distressed. According to Meyers (2006), she as a result, wrote in her plan to her Superiors that it was mandatory for her nuns to take an entire year off from their duties every 4-5 years to allow them to heal from the effects of their care giving work. It

would be worth the while for African women religious superiors to emulate this and make similar spiritual- and emotional-intelligent provisions for their charges.

2.7 Conclusion

The thrust of this chapter was the exploration of the body of literature related to the subject of self-care at the global, regional and local levels, examine their contents, determine how similar or dissimilar they were to the theme of this study and clarify the specific contribution this study would add to it. This investigation was pursued in accordance with the stated objectives of the research. It was gratifying and heart-warming for this researcher to discover the literal avalanche of available literature on this subject. There is every reason to applaud and commend the initiative and resourcefulness of the various scholars, researchers and even bloggers for the sheer volume of meaningful and life-transforming material available on it. This helped to provide information on the evolution, current insights and trends on the subject of self-care as it has, and is still, unfolding at all levels across the globe. It became clear from the literature review exercise that the subject of self-care is a cross-cutting one which embraces the human person at every level of being: physically, spiritually, psychologically, socially, emotionally and professionally. It is therefore a prerogative or entitlement of every human person, as it aims at positively reinforcing the quality of human life. As a result, it is imperative that no stone be left unturned until its implementation is fully realised.

It is, therefore, to be observed from the foregoing that the subject of self-care is topical, and cuts across the various human vocations and disciplines. The available literature on it is also quite extensive. However, there is an irreconcilable gap in this seeming abundance. This observation pertains to the vast yawning scarcity of materials on the same subject with reference to women religious in general, and to African women religious in particular. It was a humbling and disconcerting pill for the researcher, being a woman

religious herself, to swallow. This study set out to examine the awareness and implementation levels, as well as the existing possible gaps and remedial measures on self-care among its target group in this technology-driven, and information and knowledge-explosive era of the 21st century. But to the chagrin of the researcher, there was hardly any material about this to lay hands on. Given the long and rich historical presence of women religious in the Church and on the world scene, it is surprising that so little by way of empirical research has been conducted on their way of living in general, and on the practice of self-care in particular, as has been the case with married people, the ministerial priesthood and the helping professions. In this regard, the religious and their lifestyle clearly need to be updated in line with the signs and realities of the times.

This literature review exercise was consequently largely unable to evaluate material that was directly related to women religious' self-care issues. This was because even though some scanty studies exist on it at the global level (courtesy of the American women religious), there was virtually nothing to fall back on at the regional (African) and national (Kenyan) levels. It is necessary that these lacunae be remedied, because in addition to providing knowledge on the religious life, such studies could serve as a basis for correlational or cross-cultural studies on the same topic, possibly due to the different socio-cultural contexts from which the study samples on such studies would be taken. It is hoped that this study, as well as others that will be, hopefully, undertaken by other researchers in due course, will contribute in some measure to bridging these observed gaps. This study will, to begin with, contribute in the capacity of bridging this identified gap for empirical literature on the religious life as lived in the African region, and to the much needed provision of an African slant, perspective and voice, to the further development or elaboration of the subject of the study.

CHAPTER THREE

RESEARCH DESIGN AND METHODOLOGY

3.1 Introduction

This chapter describes the research design and methodology used in collecting data for the study. The researcher extensively discusses themes such as the locale of the study, the target population, the description of sample and techniques, the research instrument, the trustworthiness of the research instrument, data collection procedures, data analysis techniques and the ethical considerations.

3.2 Locale of the Study

The chosen location for this study is the Karen suburb in Nairobi, Kenya. Information collected from the website of the National Museums of Kenya described it as an affluent suburb of Nairobi in Kenya, lying south west of the city centre. It was one of the former white-only areas where most European settlers resided during the colonial times. It is generally believed that the suburb is named after Karen Blixen, the Danish author of the colonial memoir *Out of Africa.* The choice of this location for the study is due to the fact that Karen is home to the researcher as her residence is located in it. It is also home to many Catholic men and women's religious congregations as a result of which it is often currently referred to in Catholic religious circles in Nairobi as a *mini Vatican City.* Consequently, locating the various congregations for the required research samples as well as the administration of the research instrument was made easier for the researcher.

3.3 Research Design

A research design is the procedure of inquiry adopted by a researcher. This study adopted a qualitative paradigm, specifically phenomenology design (Creswell, 2013). This process involves data typically collected in the participant's setting, and the researcher describing the lived experiences of individuals about a phenomenon in the very words of the

participants (Creswell, 2014). The qualitative research paradigm also comprises other approaches such as the narrative research, grounded theory, ethnography, case studies and phenomenological research. This study employed the phenomenological approach because it is an examination of the research participants' lived experience of the phenomenon of self-care and its significance in their lives.

3.4 Target Population

The target population comprised the members of a group from which the researcher took the sample population. The target population for the present study comprised all women's religious congregations in Karen: Superiors as well as finally and temporary professed women religious. According to the information obtained from the secretariat of the Regina Caeli Catholic Parish, Karen, the number of the women's religious congregations registered with the Parish was twenty and the estimated number of women religious in the area over three hundred.

3.5 Sampling and Sampling Procedures

The researcher adopted purposive sampling technique for this study. She used maximum variation sampling technique in selecting the four women's congregations that participated in the study. The justification for this sampling technique was to get diverse perspectives of the phenomenon under study. The researcher also used criterion sampling technique to select the four female religious who participated in the study. The reason for this was to get participants from different African countries who had experienced the phenomenon being studied. The study further used criterion sampling technique to select two priests, two religious brothers and two lay persons who participated in the study. The reason for using these participants and the sampling technique was that the participants had had direct contact with, and so had experienced women religious in the apostolate. The researcher

also wanted to elicit their opinion on the phenomenon under study as well as to enhance the transferability of the study.

Table 1

Participants of the Study

Target Population	Population size	Sample Size	Sampling Procedure	Percentage
Female Religious Congregations	20	4	Maximum Variation	20%
Male Religious Congregations (clerical)	4	2	Criterion	50%
Male Religious Congregations (non-clerical)	3	1	Criterion	33.3%
Lay Persons	780	2	Criterion	0.26%

3.6 Description of Research Instrument

This study employed interview guide to collect data from the participants. It had two parts. The first part consisted of the section on the participants' demographic profile, and the second part comprised the interview questions. These were arranged in five sections: the first four sections had questions which were based on the research objectives and terminated with a concluding fifth section. This instrument was chosen because it afforded the participants who were believed to have had an experiential knowledge of the phenomenon being studied the opportunity to give their own detailed accounts of it in their own words and in their own environment. It also allowed the researcher the advantage of choosing the best participants for the study and some flexibility in changing or modifying the questions asked as judged necessary (Creswell, 2013). In this way sufficient in-depth data and information was gathered to ensure a rich research process with credible results.

3.7 Trustworthiness of the Study

In order to ensure the trustworthiness of a qualitative study, it is crucial to examine and establish its presence in the study. The researcher established the trustworthiness of the study based on the following four techniques, namely, credibility, transferability, dependability and confirmability (Guba & Lincoln, 1985). According to these scholars, these are the four big steps to evaluate honesty in qualitative study.

The researcher ensured trustworthiness in the entire research, that is, from the problem identification to the report writing. The researcher had an in-depth observation of the phenomenon under study and did a rigorous literature search on the same. She adhered to academic honesty in the literature review and identified the gaps that the current study filled. For data collection instruments, the researcher sought the assistance of her supervisors and other experts in fields relevant to the study. They made constructive comments about items on the instruments and the researcher effected the changes. Later, the researcher subjected the instruments for pilot testing to participants similar to the sampled group. The researcher had constant debriefing with her supervisors, and peer scrutiny with her colleagues (Tracey, 2010), about the findings from the pilot testing. The researcher later went for data collection and achieved this goal by establishing a rapport with identified participants and requesting them to feel free to express their feelings about the subject of the study openly. She assured them of confidentiality and left them the choice of assenting or refusing to participate in the study.

The researcher established the credibility of the data by spending about twelve weeks in the field in order to develop an in-depth understanding on the phenomenon under study. She later sent the themes generated from the interviews back to the participants for member checking to determine their accuracy. To ensure transferability, the researcher had a rich and thick description (Creswell, 2013) of the phenomenon under study, the study site, and the

participants. This gave her participants a better perspective of the study and made them feel they were a part of it. The researcher ensured confirmability by striving to maintain neutrality in connection with the research study's findings. In other words, the findings reported were wholly based on participants' responses and not influenced by any bias or personal motivations of the researcher. She also established dependability through a review or evaluation of the processes of data collection and data analysis employed by her supervisors, two colleagues and an external researcher. This was in order to ensure the accuracy and completeness of the research procedures.

There is thus the assurance that the findings made are consistent and that through the use of these same processes, they could be replicated by other researchers. In the final report, the researcher also had frequent debriefing sessions with her supervisors and made ample use of their suggestions to enhance the accuracy of the accounts provided. She also examined previous research findings in order to assess the degree to which her own findings were congruent with those of past studies.

Reflexivity

The position of the researcher about the phenomenon under study was that the target group lacked sufficient self-care awareness and practice. She also believed that gender role was a strong factor in the inability of African women religious to be aware of the necessity of caring for themselves. However, in order not to allow these biases rule the study, the researcher held this positionality constant by approaching this study with a sense of newness especially as it was being conducted with all the rigour of formal, empirical research. The researcher also wishes to acknowledge the awareness of certain biases born of her rich personal experiences as an African woman religious who has served in various capacities (as teacher, pastoral assistant, leadership of Sisters' conference at the diocesan level, social worker, school administrator and as member of the leadership team at the Provincial level of

her religious congregation) which may shape or influence the way she views and interprets the data she has collected. She believes that these experiences also enhanced her awareness, knowledge of, and sensitivity to the issues involved in the study with a view to strengthening any positive findings and ultimately charting a new course. Moreover, she consciously engaged in bracketing through setting aside her beliefs, feelings, and perceptions in order to be more open to the research findings and report them objectively and faithfully. She thus allowed the findings to be shaped by the participants and not her interests, beliefs, motivation or biases.

3.8 Description of Data Collection Procedure

Kombo and Tromp (2006) defined data as *raw* information, and this by itself, is not knowledge. The researcher collected data through face to face interview. Mvumbi and Ngumbi (2015) defined interviewing as the process of collecting data through guided conversations with people in which the researcher approaches certain individuals who are believed to have rich information about the issue under study. The researcher personally contacted and introduced herself to each participant and explained the research topic, objectives and ethical considerations to them. The researcher returned on a mutually agreed date and time to carry out the interview with the participant. A recording machine was used to audiotape the interviews and the participants were courteously informed beforehand of its use. The researcher also took down some notes to complement the recordings. The same questions were posed to the participants. Each interview lasted for an average of 90 minutes, and was carried out within the participants' environment.

To administer the interview, the researcher moved from one location to the other to connect with the participants concerned. On the actual day of the interview, the participants met with the researcher at the agreed time and venue. Prior to the interview, each participant was given sufficient time to study and understand the contents of the participant's consent

form before being requested to complete it. The participants' demographic information form was next filled and was followed by the interview. A high-quality recording machine was used for audio-recording the information received. Since the data was collected from ten different persons in different locations, the researcher made a plan to finish collecting data from each participant before moving to the next one for the same purpose. At the end of the exercise, the researcher thanked and affirmed each participant for the time they generously spared to participate in the research and the meaningful contributions they had made. On getting home, the researcher backed up the copy of each interview she had made on her computer in order to forestall the possibility of total loss of data should the recording device develop any unforeseen mechanical problems.

3.9 Description of Data Analysis Procedure

Qualitative research data is usually presented in the form of words. It is subjective, rich, and consists of in-depth information. According to Wong (2008), qualitative data analysis is the process of systematically searching and arranging the interview transcripts, observation notes, or other non-textual materials that the researcher has accumulated to gain a better understanding of the phenomenon being studied. The researcher used the manual method for the analysis. This involved the transcription of the interviews, reading the transcripts in order to get a global sense of the whole, reading the interview transcripts a second time after which the data were coded. Coding involved the subdivision of the data into ideas and categories by tagging or marking similar passages of text with a code label that will enable them to be easily retrieved when needed for further comparison and analysis. The categories were subsequently interrelated and the themes or topics emerged from there. These were then used to provide understanding, explanations, and interpretation of the phenomenon being studied. The presentation of the findings was structured on the research questions.

3.10 Ethical Considerations

The researcher obtained permission from the Psycho-Spiritual Institute to conduct the study. This was provided in writing and enabled the researcher gain access to the participants. The researcher additionally made arrangements with the participants as to the possible dates to hold the interviews. On the day agreed on for the interview, the researcher explained the contents of the participants' consent form and informed each participant that the research was purely for academic purposes and that participation in it was voluntary. The consent form was then given to each participant who read through and signed it as an indication of their willingness to participate in the research (see Appendix A). The consent form also had on it all the information the participant needed to know about the research and the researcher as well as an assurance of confidentiality concerning whatever information he or she provided. To ensure confidentiality, the respondents were not asked to write their names or addresses on it. Furthermore, the reports of the findings did not mention the congregations of the participants or request any information that might reveal their identity.

The researcher was aware of their vulnerability stemming from the self-disclosure that the interview would necessitate, and was ready to help out with this in the course of the interview if necessary. Finally, in accordance with the ethical practice of research, only the researcher was privy to the information in the recording machine. This was carefully stored by her, to be eventually destroyed after it had been transcribed and there would no longer be a need for it.

CHAPTER FOUR

PRESENTATION, INTERPRETATION AND DISCUSSION OF THE FINDINGS

4.1 Introduction

This chapter presents and discusses the findings of the research study which set out to investigate the influence of self-care awareness on the physical well-being of African Catholic women religious in Karen-Nairobi, Kenya. To achieve the objectives of the study, ten participants drawn from Karen-Nairobi, took part in an in-depth semi-structured interview conducted by the researcher. The interviews were transcribed, coded into themes, analysed and interpreted in a narrative form. The findings are discussed in details and presented below by the researcher. In addition, the participants' points of view were noted and evaluated in the light of the evidence provided by the earlier review of related literature. The codification of the data into themes necessitated the use of thematic analysis for their presentation. The findings were discussed and interpreted in relation to the research questions, as follows:

i. The awareness level of the need for self-care among African women religious in Karen- Nairobi;
ii. The causes of the perceived neglect of self-care among African women religious in Karen- Nairobi;
iii. The consequences of the perceived lack of self-care among African women religious in Karen-Nairobi;
iv. The suggested solutions to the challenges of self-care among African women religious in Karen-Nairobi.

4.2 Demographic Profile of the Participants

The total number of participants in this study was ten with the following distribution: four women religious, two religious brothers, two priests and two lay persons. They included five men and five women and their age range was 42 to 65years. Their nationalities were Burkinabe, Kenyan, Nigerian, Tanzanian, Ugandan and Zambian. Their educational qualifications were as follows: one of the women religious had a diploma, another graduated

from college while the remaining two had a Master's degree. The two Religious Brothers had a Master's degree. One of the Priests had a Bachelor's degree and the other one had a Master's degree. One of the lay persons had gone as far as college while the second one had a Ph. D. Among the participants were two formators, two students, one regional superior, one delegate superior, two administrators, one lecturer and one professor.

Table 2

Participants' Demographic Profile

S/N	Participants	Age	Nationality	Educational Background	Status: Year of First Profession, Ordination, or Marriage	Current Apostolate / Position
1	Woman Religious	56	Zambian	College	1985	Superior
2	Woman Religious	45	Tanzanian	Diploma	2006	Formator
3	Woman Religious	44	Kenyan	Master's degree	1996:	Administrator
4	Woman Religious	42	Burkinabe	Master's degree	1997	Superior
5	Religious Brother	57	Nigerian	Master's degree	1984	Formator:
6	Religious Brother	42	Nigerian	Master's degree	2000	Student
7	Priest	55	Kenyan	Master's degree	1992	Lecturer
8	Priest	43	Nigerian	Bachelor's degree	1998	Student
9	Lay Man	64	Ugandan	Ph.D.	1987	Professor
10	Lay Woman	65	Kenyan	College	1976	Administrator

The findings are presented below along with the discussion. They are based on the research questions, and in relation to the review of related literature and theoretical framework. There was a hundred percent (100%) participation rate as all ten proposed participants willingly took part in the interviews.

4.3 Analysis of Research Question One

The first research question of this study was: What is the awareness level of the need for self-care among women religious in Karen-Nairobi? There was evidence from the interview data indicating that the women religious in Karen-Nairobi, Kenya had an awareness of self-care. This was expressed in the explanatory responses about self-care that they gave, using the discourse of taking care of oneself physically, spiritually and psychologically. They further used the discourse of the examples of the self-care that they practised themselves, the benefits of self-care and the consequences of neglecting it among women religious to describe their experiences. Some examples of the personal self-care practices that they reported they engaged in were taking balanced diet, sleeping on time, walking around leisurely and enjoying the walk as well as just relaxing with God.

Three of the responses on the awareness of self-care given by the participants are presented below. For Participant 2, "self-care is about taking care of oneself physically, psychologically and spiritually. It comprises good diet, exercise, modest rest, good relationships, intellectual nourishment, prayer life, meditation and spiritual direction" (March 23, 2017). Participant 3 had the following view of self-care: "Self-care is something that I enjoy very much, and in doing it, I maintain my health. And my health can mean physical, spiritual, emotional and social health" (March 23, 2017). Participant 1 briefly explained it as "taking care of oneself. Self-care also means to be self-sustaining" (March 23, 2017).

However, Participant 7 expanded the awareness of the meaning of self-care to include the provision of other needs such as the financial needs of the individual woman religious and those of her loved ones. He also incorporated in it the need to have the foresight to plan for one's future upkeep during the retirement years and to sustain the connections with one's biological family:

> Self-care is personal care. But self-care needs to be looked at broadly, like in terms of provisions, which might require money for you to

> address. There could be some needs at home, for example, and which you keep on worrying about: maybe your sister is sick, your brother can't afford school fees. Your parents may be aging, but you can't provide them with even basic things like medication. If you don't take care of them, it's not self-care. Because you become sick eventually. Your self-care also requires you to care about your future, about your retirement, about your relations with people at home. But the system you work in has kind of ignored that, which means the system is not really very balanced (April 1, 2017).

The above intervention broadens the scope of self-care beyond what it is generally considered to comprise, that is, one's personal needs, to include the needs and well-being of one's significant others and the implications of their exclusion from the details of the operation of the Church's machinery. This is an obligation laid on the African woman religious by the African cultural extended family system as elaborated by Ekeopara (2012) from Nigeria in his study on the *Impact of the Extended Family System on Socio-Ethical Order in Igboland.* It is a practice which is not taken cognisance of by the structure of the religious life. And this probably is not the usual way women religious conceptualise self-care as the three earlier contributions show.

It would appear, then, that the real problem with self-care is not that women religious are not aware of it, but that the deficiency in its implementation among them stems from the imbalance in the operation of the machinery of the Church of which women's religious congregations are a part. It would appear also that any effort to question or seek to modify the status quo is met with a stern disapproval. This is how Participant 7 again expressed it:

> Of course, you're just meant to work for the system, sustain the system, but your personal sustenance? No one talks about that. And you know we have been brought up to think that this is the right way. But we've never taken the time like St. Peter to ask: "What about us? What do we gain from this system?" Yet we have internalised the fact that this is the way it's supposed to be: this is the Divine way. And anybody who says the contrary is like a heretic. We have a big problem (April 1, 2017).

In the western world from which the religious life as it is lived in Africa was imported, there are, for example, social welfare and various insurance packages which

provide for the needy, at least, to some extent. For example, as indicated on the website of the Irish Department of Social Protection, the following are some of the supports that nationals and elderly citizens are eligible to receive: basic supplementary allowance, rent supplement, child benefit, family income supplement, workplace supports, partial capacity benefit, illness benefit, invalidity pension, electricity allowance, cash electricity allowance, natural gas allowance and free television licence, etc. Besides, elderly persons aged 66 and above are eligible to travel free of charge on all State public buses and trains. And so women religious in such milieux are possibly not overly burdened with providing for the financial needs of their loved ones. This is the opposite of what obtains on the African soil. And it does spawn real obstacles for the woman religious as she strives to be faithful to her vocation.

The participants further used the discourse of environmental pressure and control to explain the issues affecting the practice of self-care among women religious. The findings on these issues are presented using the following themes: the lifestyle of women religious which burdens them with overwork and leaves them with inadequate time for self; this is closely twinned with poverty which makes it impossible for them to access desirable quality and forms of refreshment after spending themselves in the apostolate.

4.3.1 The Lifestyle of Women Religious

Religious do not live in isolation. Their lifestyle which is already designed, established and handed over to them from the day they joined their respective congregations, follows a regular pattern of prayer, meals, work and rest, all done in community. The observance of this pattern of lifestyle undoubtedly has many advantages, but it also results in some challenges to achieving self-care among them. The women religious participants in this study shared their experiences and views concerning this, as reproduced below. This is how Participant 3 expressed it:

> The kind of lifestyle we women religious have does not give us time for ourselves: we are working, working, working, working. We don't have

> time for recreation, we don't have time to go for games; working, working, working, working for others, for others, for others, and not for ourselves (March 23, 2017).

The same point is emphasised by Participant 4:

> We have too many responsibilities, and sometimes there is lack of personnel and not enough Sisters in the community to do the works to which we are assigned. We are very few and we have many tasks to carry out. So you find yourself stressed and go on working for a full 24 hours. The following day, you collapse (April 10, 2017).

The above two extracts make it clear that the overwhelming workload incumbent on the participants prevents them from undertaking appropriate self-care as they would have liked to. The first extract expresses the heaviness of the work schedule by repeating, *work, work, work, work,* while the second extract goes on to state the outcome of the work overload: *The following day, you collapse.* This is in line with the view expressed by Kenel (2000) in the literature review about women religious "wearing too many hats", through holding two or more positions of responsibility at once, a situation brought about by the sharp reduction in the number of women religious available for the filling of the different kinds of ministerial positions. This view was also supported by the observation by Alexander (2013) that good self-care is more easily conceptualised than practised, especially for religious who frequently are on-call, work long hours six to seven days a week and must regularly respond to unexpected crises.

Apart from the issue of wearing too many hats, there is also a presenting issue, in this case, of an inability on the part of women religious to create and maintain healthy boundaries for themselves. Kenel (2000) also insightfully recommended that training that addresses boundary issues ought not to be limited to boundary violations that result in sexual abuse or illicit sexual activity; it should also cover those that contribute or militate against satisfaction in community living. The development of appropriate boundaries, fortunately, is one of the

goals of the Structural Family Therapy of the Family Systems Theory to which this study is anchored. Participant 7 expressed his views on this as follows:

> As religious, your time is kind of scheduled, every time is covered. But it's important that you create some time for yourself. Look at some of the community time tables: you have time for prayer, time for apostolate, but the time for personal leisure is not there. So if you know the benefits of self-care and the negative consequences of its absence, then you have to kind of sneak in some moments of personal care (April 1, 2017).

The above situation bears witness to an inability to achieve a desirable measure of balance in the daily lives of women religious. This is consistent with the study literature review which identified balance as one of the strategies for remedying the challenge of self-care (Wagman, 2012; Allen, 2013). The intervention from Participant 7 serves to confirm the study justification and invites African women religious to begin to reflect on, reorganise and readjust their lifestyle to enable them evolve a more balanced and satisfactory pattern of living which will enhance their quality of life, the quality of their relationships and that of the services they render. In addition, Participant 10, a lay person, added the following observations, in corroboration of the tight work schedule of women religious and its effect on their lives:

> You women religious have a very tight programme. Your programmes are so tight such that you do not have time for yourself, to rest, to reflect and even socialise, even going for an outing, a pilgrimage; it is such that your day is just packed, packed, packed. And also the fact that you have to operate under the direction of your Superiors could contribute (April 2, 2017).

Moreover, Participant 6 who is a Religious Brother ascribed the issue of overwork by women religious and their attendant neglect to virtual exploitation by the Church. He bluntly asserted that:

> The life of women religious is a bit complicated in the sense that some who are in the communities are mostly neglected, and even the Church is also an agent causing this neglect for the women religious. We see women religious as slaves, as servants, so they work and work till they die. Like I mentioned earlier in this interview that *Monkey dey work*,

> *baboon dey chop,* we want them to work and bring everything they have, and we sit down and enjoy the fruit of their labour, without even helping them to take care of themselves. They are stretched in order to meet the obligations of the apostolate (April 2, 2017).

Based on these participants' experiences and views as expressed above therefore, it can be argued that the workload does not only affect the women religious' ability to take of themselves, but also prevents them from achieving and maintaining a healthy balance in their lifestyle. Apart from affecting their present well-being, it even compromises their future well-being because it alienates them from all forms of socialisation and the opportunity to connect to family members and friends; and this is in addition to leading to physical and mental incapacitation through ill health and mental breakdown. Anaby, Jarus, Backman and Zumbo (2009) in their work on the role of occupational characteristics and occupational imbalance in explaining well-being, observed that one of the key factors for promoting well-being lies in balancing one's daily life occupations and the nature of the occupations. Moreover, the issue of any type of lifestyle is a very important one as it has far-reaching consequences on its practitioners. In the literature review for this study, Allen (2013) posited that without balance, one's life would be a jumble of stress and struggle, duty and necessity, striving and confusion and that the only other alternative to finding and enjoying balance is to face burnout.

4.3.2 Poverty

Along with the men religious, women religious voluntarily take a vow of poverty which commits them to sharing their resources and their time and talents within their communities and with other people in need. A vowed member of a religious community does not have personal possessions, but like the early Christians they "place all things in common" (Acts 2: 44). This means that any money earned or gifts received are for the good of the entire community. However, to vow poverty is not synonymous with living a life of

destitution. A vow of poverty helps remind women religious that they are completely dependent on God's providence, are interconnected with all peoples and the vow gives rise to solidarity, sharing and service (National Association of Vocation & Formation Directors, 2013, *Religious Vows: Committing to Life and Love).*

In the course of this study, the women religious participants shared how their experience of financial poverty or want subjected them to the nightmarish experience of being unable to care adequately for themselves. Participant 3 revealed that:

> Poverty is one of the issues that affects our practice of self-care in that you might not have some of the resources that you need for you to, for example, eat well, go to recreation sites to have recreation. You want to go for an outing, for a tour, and because you don't have the money, the resources, you cannot go (March 23, 2017).

Participant 8 corroborated the existence of financial want among women religious. In his own narrative, he described other ways in which women religious are coerced by this lack into sourcing for the funds with which, for example, to finance their medical care or education:

> There is the issue of sustainability. Some of our African female religious lack the finance. So for instance, if somebody is sick, you find that the person cannot be sent to hospital because they are saving costs. There is this language I have found that is at home among female religious: "no money" syndrome. Secondly, when a religious is going for further education, the congregation supports her half way and she looks for the other half of the required fees, if it is a good congregation. Some other congregations will allow the religious to look for the fund in its entirety and even try to see whether the person can get more from her source so that they can get something from it as well before she goes to school (April 5, 2017).

Participant 6 contributed this summary of some of the adverse effects of the experience of financial want on the women religious:

> This is what makes some of them not to concentrate and to deviate from the principles of the religious life. So in essence, some women religious find it difficult to take care of themselves, because 1) they don't have much in the community; 2) their superiors are not taking good care of

> them; 3) they're stretched in order to meet the obligations of the apostolate, or those who gave them the apostolate (April 2, 2017).

In the secular world, there has been a fairly long history of linkage between women and poverty, to the extent that the term, the 'feminisation of poverty' was coined. This was because it was recognised that poverty wore the face of a woman both literally and figuratively, since the majority of poor people were women. The feminisation of poverty is not only a consequence of lack of income, but is also the result of the deprivation of opportunities and gender biases present both in societies and governments. By the time the First World Conference on women was held in 1975, women's poverty attracted global attention and led to the formulation of some recommendations that were geared towards improving the lot of women in various countries. In September 2000, world leaders adopted the United Nations Millennium Declaration. The declaration committed them to a new global partnership to reduce extreme poverty, and set out a series of eight time-bound targets (the Millennium Development Goals) with a deadline of 2015. This was deemed to have been successful as the number of people living in extreme poverty was reported to have reduced by more than half. The United Nations Sustainable Development Goals (SDGs), otherwise known as the Global Goals, replaced the Millennium Development Goals in 2016. These are 17 goals with 169 targets that all 191 UN member states have agreed to try to achieve by the year 2030. The first of the 17 goals is to end extreme poverty in all its forms by the year 2030.

It does appear that in the Church also, as evidenced in the lives of the women religious, the incidence of the feminisation of poverty is being perpetuated in that in spite of all the overwork that is an inalienable part of their lives, women religious do not manage to earn enough money to cater for their needs, nutritionally, health wise, educationally, spiritually and socially. But unlike the women on the global scene, there are no strategies known to this researcher put in place by the Church to help alleviate the burden of poverty

and create sustainability among women religious congregations. It may be concluded that the progression of women in society has not been followed by the Church and women continue to remain as second class citizens within the Church, designated by Christ as the light of the world (Matthew 5:14).

One of the basic assumptions of the Structural Family Theory on which this study is hinged is that families must fulfil a variety of functions for each member, both collectively and individually, if each member is to grow and develop. Among its therapeutic goals are the restructuring of the family organisation, the promotion of structural change within the system by modifying the family's transactional patterns, the provision of alternative ways in solving problems and interacting, the development of more appropriate boundaries and the reduction of symptoms of dysfunction. These would appear to be areas the organisation of both the religious life and the Church as a whole might do well to borrow a leaf from.

4.4 Analysis of Research Question Two

The second research question of this study was: What are the causes of the perceived neglect of self-care among women religious in Karen-Nairobi? Based on the research findings, it is evident that even though self-care is generally recognised as a genuine need among women religious, its neglect among them appears to be a rather common occurrence. The participants in the study pinpointed the various causes of this phenomenon on the reasons given below. They are discussed under the themes of overwork, negligence, lack of vocations, wrong concept of religious life, lack of balance in the life of women religious, misunderstanding of the meaning of self-care, lack of control over one's life, poor remuneration and gender role.

4.4.1 Overwork, Negligence and Lack of Vocations

Participant 3 conceded that there is overwork, working for long hours of the day and sometimes even at night, to the extent of not even having time to eat while another one identified negligence as causes of the neglect of self-care. Her own words on this are:

> There's a lot of work, a lot of overload, to the point of taking advantage of self-care. You find that you are bogged down: a lot of tasks from one activity to another. From morning to evening, you have no time even to sit down and relax (March 23, 2017).

As articulated by Participant 4, one of the causes of the neglect of self-care is:

> Sometimes negligence. Why I say negligence is that if, for example, it is time for a Sister to go and rest, she can, without a second thought forfeit the rest in favour of spending time with a visitor. Besides, she will even accompany him to the bus station. In Europe, where I stayed 9 years, such a thing will not obtain because if your visit was unscheduled, you will not be welcomed in the first place. Once it's time for the Sisters' siesta, nothing can change it. But as we don't have that kind of discipline here, sometimes I find it difficult myself to stick to that (April 10, 2017).

Participant 4 further identified the dearth of vocations and the lack of qualified personnel as culprits in the failure of women religious to self-care:

> Also there is a lack of vocations. Nowadays, vocations to the religious life are reducing. Or lack of qualified sisters for that work. In our case, it can be also lack of language. Because our congregation originated in France, most of the sisters, are unwilling to come on mission to Kenya because of their inability to speak English (April 10, 2017).

Challenges of the above kinds were identified and discussed at length in the review of literature. They serve to confirm the observations of Alexander (2013) concerning the causes of the neglect of self-care among Catholic religious and clergy. He summarised these as being due to "fewer vocations" and "training that traditionally has emphasised service first, the giving nature of most Catholic clergy and religious". This challenge of the dearth of vocations was confirmed in a report by Phillips (2013) in the *Catholic Herald Newsletter,* an English publication, of a statistic revealed by Jose Rodriguez Carballo, the secretary of the Congregation for Institutes of Consecrated Life and Societies of Apostolic Life, that over

3,000 men and women religious leave the consecrated life each year. Lipka (2014) also concurred with this when he reported that in the United States of America, the number of women religious fell from roughly 180,000 in 1965 to about 50,000 in 2014. The statistics for this alleged trend in other parts of the world could not be readily ascertained.

4.4.2 Wrong Concept of Religious Life

The causes of the neglect of self-care have also been attributed to other reasons apart from the points discussed above, particularly overwork. Some of the women religious participants believe that they have been formed to see their lives as service-oriented. Two of them confirmed this during the data collection. For example, Participant 4 gave this testifies that

> Sisters sacrifice themselves for others. In doing so, we don't take enough care of ourselves. We are formed to uphold the value of service. We serve without first counting the cost (April 10, 2017).

The experience of Participant 3 authenticates the above observation made by Participant 4:

> From morning to evening, one has no time even to sit down and relax, due to expectations that one is there to serve, to serve, to serve (March 23, 2017).

Nonetheless, it would appear from the views of some other participants that there is an element of brainwashing and even misplaced zeal in the failure of women religious to self-care. For Participant 7, there is definitely something wrong in what is fed as knowledge to women religious:

> First of all, you have been taught to empty yourself, sacrifice yourself. So you just have to work, for the institution, to maintain the structures. Don't care about yourself: they say this is selfless love. So you really work like a machine, as though you don't have personal needs (April 1, 2017).

For Participant 6, the failure of women religious to self-care is traceable, more than anything else, to the wrong concept they have of the religious life and escapism:

> First, I will say, wrong concept of religious life. We feel that when we work so hard, we are fulfilling the commitment to our vows, of poverty, for example. If really we fully understood the meaning of the vows, we wouldn't have tied ourselves in working without resting; in working without taking proper care of ourselves. That's what makes us to be negatively committed if I can put it that way. Again, sometimes, we neglect to take care of ourselves out of what I can call escapism. Running away from the reality of life. I remember one female religious told me one day that "If I start taking proper care of myself, people outside will not know that I am living the vow of poverty". So there's a misconception, and it's a big problem. That's why most of us go in rags. Some will put on a pair of shoes for decades. Some of us don't mind wearing torn habits. We say it is poverty. So that wrong notion of religious life is a big factor in our not taking care of ourselves (April 5, 2017).

The attitude of harbouring a wrong notion of the religious life identified above confirms the observation by Nwagwu (2008) who lamented the "unnecessary repression and negation or outright rejection of the human dimension of persons". She observed that this results in a summary dehumanisation of their personality. Such an attitude can be traced to a fundamental lack of the skill of emotional intelligence. As also reported in the literature review, Jerus (2015) concisely summed up emotional intelligence as consisting of self-awareness, self-management, social management and relationship management. According to him, implicit in the concept was that intrapersonal awareness and mastery precede service, empathy and connection to others. So then, self-care is seen as a prerequisite to achievement and interpersonal success. He maintained that inattention to self and others displays extremely limited emotional intelligence as it shows a lack of self-awareness and social awareness. So there is an urgent need for the women religious who have manifested a deficiency in this area to become aware of it and begin to work out ways of correcting it.

4.4.3 Inability to Integrate Prayer life, Apostolate and Community Life

Religious face a regular challenge of integrating their prayer lives, apostolate or ministry and the life in community. The inability to integrate these was also a factor that was considered as being a cause of the neglect of self-care among women religious by Participant

2. When asked about it, she concisely explained it in her own words as "lack of balance between prayer life, the apostolate and community life" (March 23, 2017). The real complaint by Participant 2 may not really stem from a lack of balance as she termed it. It may really be a symptom of time management skills on the part of the women religious. In a study on time management deficiencies among law students, Bartholomew (2013) observed that time management complaints started early among the target group, but generally went unresolved. As a result, practising lawyers identified time famine as a leading cause of job dissatisfaction. She concluded that to better arm graduating students, law schools must incorporate lessons in time management as an essential component of the Law School curriculum and practice-readiness. By learning foundational time management skills during law school, students have a better chance of managing time famine in practice. In the same vein, women religious could achieve better integration of prayer life, apostolate and community life if they were exposed to some inputs on time management at some point during their years of formation.

4.4.4 Misunderstanding of the Meaning of Self-care

The notion of self-care appears to currently labour under an undeserved and disproportionate weight of misunderstanding, suspicion and non-acceptance among women religious. The need to persuade women religious to fully embrace the practice of self-care is at the heart of this study. This is because as Agudo (2003) pointed out in the literature review, Catholic traditional spirituality has always warned the faithful about that "evil" self so that "self-love" was considered sinful. From the beginning of this study, from the background to the study, the researcher found it necessary to explicitly clarify that self-care is not a form self-centred or selfish fixation on one's self. The misunderstanding of its true meaning has kept many well-intentioned women religious suspicious and distant from embracing its practice. Richards (2013) explained that far from being a narcissistic or self-serving venture,

self-care, which is the necessary process of caring for oneself, is a form of self-service. Participant 5 ventured a reason for the misconception in his contribution:

> It is the mentality. We're Africans, we live communal life. When you concentrate on taking care of yourself, you may be seen as selfish. And then, that label will affect the women religious and prevent them from enjoying life as they know it (March 29, 2017).

With such a discouraging background therefore, any woman religious who is courageous and convinced enough to embrace self-care must be armed with a very healthy self-concept and tenacity to weather the storm of criticism that she will encounter before she can practice self-care with any measure of continuity and profit. Participant 8's contribution to this reflection provided a befitting synopsis of the gulf that exists between the meanings of narcissism and self-care:

> Narcissism refers to the idolisation of the self. But when the self is not idolised, but adorned, it becomes appreciation of creation. So it all depends on getting the balance or equilibrium right. When the self is idolised, there is a problem. But when the self is adorned as an appreciation of creation, then the other selves around contemplate it. It becomes like adoring God in yourself. If you neglect yourself, not taking cognisance of self-care, your entire system suffers. The self is important then; there could be extremes, yes, but there is the need to create a balance where the self is appreciated (April 5, 2017).

4.4.5 Lack of Control Over One's Life

The fact of women religious not being in charge of their lives and programmes was identified as posing a drawback for their practice of self-care. This would appear to be in keeping with the vow of obedience which they profess. The Vatican II document, *Perfectae Caritatis*, explained that in professing obedience, religious offer the full surrender of their own will as a sacrifice of themselves to God and are so united permanently and securely to God's salvific will (Perfectae Caritatis 14, 1965). Participant 10 ventured the following response as a reason for the neglect of self-care among women religious:

> Because they're not individually responsible for their programmes. Some body is in charge of their programmes. So even when they feel tired, even if they know they're not able to perform, they still have to continue working because somebody else expects them to finish the

> assignment. And the other thing is that probably they are given assignments which probably is not their area of interest. Maybe they have a different qualification, but they have to do a different job. Like one could train as a teacher, and she is made to work in the chapel (April 2, 2017).

Participant 9 supplied the following other cause for the neglect of self-care:

> Internally, there are often misunderstandings, strictness, restrictions; these, among other things, can affect the health of a person. There is often little room for self-care. Externally, there is too much control. People are no longer themselves (March 27, 2017).

While the vow of obedience continues to remain at the core of the religious life, it must, nevertheless, be noted that since after the Second Vatican Council, religious obedience is no longer immediately identified with authoritarian mandates and hierarchical structures but has become participatory in nature (Poruthur, 2014). It is described as a call to listen to persons, events, circumstances, signs of the times in today's world. It is a call to discern the will of God, and to dialogue with others (Thomas, 2013). To do otherwise would amount to subscribing to a life lacking in spiritual intelligence, a core element of which is the development of inner freedom and responsibility for wise behaviour, as recognised by Amram (2007) in the literature review of this study.

4.4.6 Poor Remuneration

Women religious constitute a significant percentage of the workforce of the Catholic Church, but rank among the poorest paid staff. This results in their inability to self-care. In the lived experienced of this researcher over the years, the remuneration received at the end of each month did not go by the name of *salary,* but was termed an *allowance.* And it was not what could be called "a living wage", meaning that it was grossly inadequate for the provision of the barest necessities of life. This phenomenon appears to be a problem for women religious at the global level, and not only for African women religious. Its perennial occurrence among the women religious in the United States of America caused it to be chronicled in a work titled *The Rise and Fall of Catholic Religious Orders: A Social*

Movement Perspective, by Patricia Wittberg, a woman religious. She observed that "the teaching Sisters' stipend was less than what was needed for basic subsistence and many Orders made up the difference by offering private music lessons or by relying on gifts of food or money from individual parishioners" (Wittberg, 1994, p. 52). In connection with this, Participant 8 observed with a rhetorical flourish:

> What do some Sisters work for? How much are they paid? Some of them are paid as little as Ksh 5,000 or Ksh 10,000. When they gather these together, they start struggling. Then their generalate will request that they send half of it for the maintenance of other Sisters and manage the other half for their needs. Who will not be burnt out with such struggles? So there are so many Sisters who are not burnt out from the rigours of the apostolate, they are burnt out themselves. If you see them, you see purgatory. I am not joking (April 5, 2017).

As already detailed in the literature review, from this researcher's personal experience and from reports from workshops conducted on the rights of women religious in the Church in 2005 by the Centre for Women Studies and Intervention, a Nigeria-based Non-Governmental Organisation, it is mostly not possible for a good number of women religious to have good quality, nutritious and balanced meals because they do not earn enough money to enable them do so. This is a very crucial issue with far-reaching implications for African women's religious congregations.

In the present day United States of America, the women's religious congregations have a huge problem with the maintenance of their retired elderly members. As a result, they have to resort to begging and appealing for help from the Church, generous parishioners and public spirited organisations. As reported by Carey (2008) and Roberts (2013), religious congregations were not able to set aside substantial retirement savings because their members used to work in Church institutions as nurses, teachers or pastoral workers for little or no compensation. So when they retire, there are not enough funds to support them and they face an uncertain future in which they must look to those they served for help. Although several efforts were begun in the 1980s to care for them, it is unlikely that they will be able to raise

all the money required because the actual need far surpasses what is collected annually. It may not be too far-fetched to predict that the same fate awaits African women's religious congregations if they do not begin to plan about how to effectively care for their members now and in the years ahead.

4.4.7 Gender Bias

One of the causes of the neglect of self-care by women religious as reported by the participants is the problem posed by gender bias. This attitude is born of negative cultural perceptions of women around the world. In response to the enquiry as to whether gender discrimination affects the ability of women religious to self-care, the participants gave the responses presented below. Participant 3 responded:

> Of course. When you look at our upbringing, you see there are a lot of activities that are carried out by women. You have no time for yourself: you are there for the community. That contributes a lot to you lacking the time for taking care of yourself. That attitude is carried over into the religious life, without being conscious of it. We're supposed to be there for people. You know, more of us is for people, and less for ourselves. It's really natural for me, from a background of religious life (March 23, 2017).

Participant 6 reflected on the cultural roots of the society's attitude towards women and how it continues to negatively affect women religious:

> Yes, the society is a big contributing factor, because the society has assigned these so-called gender-construed roles to women and men. So, whatever the height of education that some women religious may attain, they still remain like slaves. We say, "Ah, a sister is not supposed to do this, a sister is not supposed to do that". What is it that a sister is not supposed to do, that a brother or a priest is supposed to do? Due to our ignorance, we find it difficult to understand our own roles and be dignified as human beings (April 2, 2017).

Participant 8's response contributed a response from his lived experience of the way gender discrimination plays out in real life relations between lay people and consecrated persons:

> We live in a male-dominated world. As a result, people usually offer support to a priest first before they do so to a female religious. And if a lay person gives a priest a gift of Ksh 10,000, he will give a sister Ksh 1,000. So automatically, gender plays a role in making female religious

> second class citizens, so to speak. But the sisters themselves must equally work hard to address this gender issue because when they are not sensitive to this, they become like slaves to others (April 5, 2017).

In his response, Participant 7 acknowledged the existence of the cultural bias against women and regretted the failure of the Church to consolidate on the foundation laid by Jesus Christ to liberate the woman:

> Of course the general perception about women is an exploitative one: that women have to be willing to die for their children, die for their husbands, sacrifice everything, their time, their energy till they're totally spent. That attitude, which is cultural and social, has been brought into the Church, unfortunately. The attitude towards the woman in society has not been redeemed by the Gospel despite what Jesus did to try to liberate the woman (April 1, 2017).

The above perceptions by the participants were highlighted in a study conducted in America by Godsil et al (2016) and reflected in the literature review of this study. It was further corroborated in another report by Outram and Kelly (2014) from a study in Australia where female doctors, in addition to the normal duties which their profession conferred on them, felt pressured to look after their colleagues and other employees, just by virtue of being female. So, if such perceptions and practices are reported to still be in existence within the Church, one would be tempted to wonder about what has become of the mission of the Church to Christianise the cultures. Perhaps, the Church might consider launching a more vigorous effort in this domain.

4.5 Analysis of Research Question Three

The third research question was 'What are the consequences of the perceived lack of self-care among women religious in Karen-Nairobi?' It elicited various responses from the study participants. All the participants agreed that the consequences of failing to self-care are basically negative and they occur at all levels: at the personal, interpersonal and general levels. The findings revealed such issues as poor holistic health and impoverished relationships with self and others, deviance and the development of a toxic personality

manifested by lifelessness, misplaced priorities and stagnation. So the consequences are costly and weighty indeed. These accounts are presented in greater details below.

4.5.1 Poor Holistic Health

The failure to self-care can have, and does have, far-reaching negative consequences first of all, for oneself, and then one's relationships, as well as on the wider society. One's physical health deteriorates, professional output crumbles, social relationships become anaemic and psycho-spiritual health withers, all in evidence of a decaying intrapersonal, interpersonal and systemic fabric. Participant 3 had this to say about it:

> One may fall sick, experience fatigue, burnout, low energy and low immunity. It may also lead to death. Accidents can occur while driving because the concentration is not there (March 23, 2017).

Participant 2 chose to dwell on its intrapersonal and interpersonal effects on the religious:

> These can be poor health, inability to discern and make good decisions, too much complaints, negative thinking, poor relationships with people, too much anger, high blood pressure, overweight, cancer, trying to find compensation, for example, in too much drinking, or indulgence in sex (March 23, 2017).

Participant 7's response outlined the dire penalties for failing to care for oneself:

> You can have psychosomatic sicknesses or disorders, or physical sicknesses. You can have physical break down because the body becomes weak with fever, blood pressures, depression: there are a lot of related sicknesses that you can catch. You can be exhausted, burnt out, fall sick, and at a very early age become old (April 1, 2017).

The above observations confirm what Maslach, Schaufeli and Leiter (2001) discussed in their study on job burnout which is a major outcome of workers' failure to self-care. A common feature of burnout is exhaustion at the physical and mental levels. They explored the various outcomes of the phenomenon such as its stress-related health outcomes which cause mental dysfunction and manifests in the forms of anxiety, depression and drops in self-esteem. Burnout, they further observed, also results in lower productivity and diminished effectiveness at work.

Shapiro, Brown and Biegel (2007) likewise highlighted some of the pitfalls encountered by mental health professionals while caring for those who are emotionally stressed or distressed. They include occupationally related psychological problems such as stress and anxiety, depression, emotional exhaustion, anxiety, psychosocial isolation, decreased job satisfaction, reduced self-esteem, disrupted personal relationships and loneliness. Stress may also negatively impact professional effectiveness by reducing attention and concentration and impinge on decision-making skills. Furthermore, stress can increase the likelihood of occupational burnout (a syndrome that involves depersonalisation, emotional exhaustion, and a sense of low personal accomplishment). Women religious are also prone to the above occupationally-related health problems at both the physiological and psychological levels. This is because their ministries expose them to working in high-demand settings.

4.5.2 Impoverished Intra and Inter Relationships and Professional Output

With the diminished overall well-being and quality of life resulting from the poor holistic health recorded above, one could hardly be expected to be performing one's responsibilities at one's optimal level. The participants voiced the following observations in connection with this. Participant 5 commented that:

> The individual religious will be stressed, tired, not finding joy in the apostolate, not finding joy in religious life. And with regard to prayer life, she will pray with tiredness and also not enjoy the flavour of the prayer. Relationships will not be free-flowing because the person will be feeling that she needs time for herself, but again, she is forced by the situation to either be working or be helping others. Then the relationship will be stressful as well (March 29, 2017).

Participant 4's response manifested a commendable level of self-awareness:

> It really has a lot of consequences, and with experience, I notice that when I don't take time for myself or self-care, I become angry or harsh. And sometimes I feel I am obliged to do what I am doing. So it's a problem for me (April 10, 2017).

Participant 9's terse response equally revealed the incidence of poor job performance, poor social life, being unhealthy and frustrated (March 27, 2017).

Even so-called common sense demonstrates that mechanical devices such as vehicles, for example, cannot run without fuelling. How then can a human being expect, or be expected to function without the necessary maintenance that self-care provides? Nwagwu (2008) in the study's literature review posited that this could be due to the insistence on emptying of self, forgetfulness of self, submission or surrender of oneself often heard within the circles of the religious life. She noted that this has led to some confusion with various religious persons maintaining a form of dualism between the body, spirit and soul, as though not part of the human person.

4.5.3 Deviance and Development of a Toxic Personality

This consequence is one that displays the manifestation of its presence through the entire spectrum of human relationships, the personal, communal and the global. It shows the active disarray generated by the neglect of self-care on the intra-personal health of the individual. From there the pandemonium spreads to the interpersonal level, and finally, it becomes resident at the general or macro level.

As shared by Participant 6,

> One of the consequences of the neglect of self-care on women religious is deviance, a deviation from the norms, the principles of religious life. Secondly, the person starts suffering from psychosomatic illnesses like ulcers. Another consequence is that the person becomes sad all the time. And she manifests this sadness by always complaining. And she will carry this complaint from the community to the apostolate, and will be attacking anybody she sees in the area of apostolate. But then, to quit the religious life is problematic, because of what people will say (April 5, 2017).

Participant 7 lamented that:

> And today people get engaged in all kinds of funny things because they don't have the provisions for taking care of themselves. They do extra work, to go to people to beg for support. They find out ways to sneakily

> care for themselves, at times, in very immoral ways. It becomes a very serious problem (April 1, 2017).

Participant 8 shared his experience of disillusionment at the reality of the disappearance of moral rectitude in some women religious when they are confronted with material want:

> Formerly, I used to believe that no matter what the female religious go through, they are disciplined in terms of maintaining their self-dignity and pride. But I have seen sisters who are openly dating lay people, politicians and married men. These men even rent apartments for them especially while they are university students. All this is because she cannot access care from the right quarters (April 5, 2017).

The above example is, regretfully, really a form of prostitution and a counter-witness to the Gospel values. But do women religious have to get to that level before their basic needs are met? And who is qualified to judge the women religious or the structures that drove them that far? An international organisation, the Soroptimist International of the Americas, captured the issues at stake here rather aptly. In its White Paper titled *Prostitution is not a choice,* the Soroptimist International of the Americas (2014), asserted that although prostitution has been called the world's oldest "profession" it is, in reality, the world's oldest "oppression" and continues to be one of the most overlooked human rights abuses of women in the world today. It is a particularly lethal form of violence against women and a violation of a woman's most basic human rights. Contrary to the claims in some quarters, prostitution is not a choice, but rather the choice made by those who have no choice. Common reasons which force women into prostitution include gender discrimination, race discrimination, poverty, abandonment, debilitating sexual and verbal abuse, lack of formal education, or a job that does not pay a living wage. Should these words apply to women religious?

Participant 8 further shared that there are other women religious who may not resort to compromises with their bodies, but may take to the misappropriation of funds entrusted to them. He, euphemistically perhaps, reflected:

> When somebody is looking for some money to augment what is required to meet a need, they might decide to take money from the community to assist. That may be sinful, but they do not call it stealing. They rather term it "taking part of what belongs to them without permission" (April 5, 2017).

This kind of development amounts to using the wrong tools to solve one's problems and calls into question the quality of the spiritual vitality, the moral convictions and the level of the spiritual intelligence of a religious who indulges in such an action. All these were expected to have been developed during the years of formation and further sharpened in the living out of the religious life, whose rigour is described in terms of the radical nature of the following of Christ (Vita Consecrata 84, 1996).

Zohar and Marshall (as cited in Ronel and Israel, 2008) defined spiritual intelligence as the core intelligence that comprises the ability to solve problems that relate to values, vision, and meaning. It is characterised by the ability to see the best in seemingly painful circumstances, as well as to see the Divine beyond the gains of the secular world. Again, Zohar and Marshall (as cited in Safara and Bhatia, 2013), saw spirituality as the ability to reframe issues through standing back from a situation or problem, and seeing the bigger picture or wider context. If women religious are found to be lacking in this important ingredient for a meaningful life, renewal programmes at given intervals might be appropriate to help remind such needy religious of the need of a stronger effort at cultivating and faithfully adhering to a healthy spiritual vision.

In a related development, McGhee and Grant (2017) carried out a study on using spiritual intelligence to transform organisational cultures. The paper explored how professionals, in a variety of organisations, used their spiritual intelligence to cope with and solve challenging ethical dilemmas. Emmons (as cited in McGhee and Grant, 2017), observed that adaptive problem solving and goal attainment, using a set of specific competencies, are central to many definitions of intelligence. If spirituality is the search for

meaning then SI is a set of tools that utilises such expertise to achieve a more meaningful life. The conclusion from the study was that there is a general consensus between academics, practitioners and managers in the literature for the need to embrace increased spirituality in organisations. Ongoing training can further encourage the development of spiritual skills and capabilities. Such behaviour, spread through a critical mass of authentically spiritual people, is likely to transform organisational cultures for the better as individuals realise their spirituality in their organisations by seeing the sacred in their everyday living, and finding meaning by experiencing their Ultimate Concern through what they do.

4.5.4 The Perpetuation of an Abusive or Exploitative System

Participant 7 took a sober and objective look at the entire set up and expressed his views on the effects of the neglect of self-care on the lives of the women religious and the need for a reappraisal of the structures on which the religious life operates, as follows:

> If you look at the time table of the Sisters, (for the Priests, it's a bit different), you find that every minute is occupied. You are never given time for yourself. You know, if you reflect on your time schedule, it's very oppressive, and very inhuman actually. Of course, you're just meant to work for the system, sustain the system, but your personal sustenance? Even the time for you to think about your retirement, about your social relationships with others, about your family, your apostolate, your vows, you don't have, because you have to maintain the structure; you have to maintain the institution. And you know you have been brought up to think that this is the right way, the Divine way. So you remain there. Anybody who says the contrary is like a heretic. We have a big problem. If you want to look at the consequences, look at the sick bay, and talk to some of the people who are there. We crash land. Our retirement time becomes a time for regrets. So we need to expand our meaning of self-care (April 1, 2017).

The above account reveals a family system in distress and atrophy. One of the basic assumptions of the Structural Family Theory, the theoretical framework used for this study, is that families pass through developmental and non-developmental changes that produce varying amounts of stress affecting all members (Allen, Cornelius & Lopez, 2011). The family systems of women's religious congregations and the general Roman Catholic Church

are no exception to this phenomenon. This state of affairs clearly calls for the prompt interruption and prevention of the vicious cycle of repetition of the observed dysfunctional sequences and the promotion of structural change within the system by modifying the transactional patterns of these families (Corey, 2009).

4.5.5 Lifelessness, Misplaced Priorities and Stagnation

The following dispassionate account from Participant 8 is one which resulted from his experience of working closely with individual women religious and their respective congregations over several years. His comments appear to be holistically evaluative of the effects of neglecting self-care among women religious. He summed up the effects as:

> Disunity. Disruption in the lifestyle. Lifelessness. It goes against what we believe in the religious life. Once the self-care is not there, it is a cankerworm to the system. We might think that everything is there by virtue of the structures, but the greatest structure is the human person, and if the human person is not taken care of, then all these structures make no sense. They are dead. And if the human person is properly trained and taken care of, and the dignity of the person appreciated, then the person relaxes in confidence. So the consequences are great. They militate against the growth of that institute. Without a provision for self-care, you don't get the best out of your people. People just do the barest minimum. They design other ways of life for themselves that you know nothing about, planning for the rainy day (April 5, 2017).

The above accounts paint a dismal picture of the state of women's religious congregations indeed. It would appear from the accounts that the women's religious congregations are at an impasse and have not yet figured out how to resolve this crisis within their ranks. They depict situations of intra-family violence and neglect. The effects of exposure to intra-family violence may impact the psychological, social and occupational functioning of members, including the development of mental disorders and complex trauma. In a study on the use of lifeline technique in cognitive behavioral-systemic family therapy, Poletto, Kristensen, Grassi-Oliveira, and Boeckel (2015) reported on their therapeutic sessions with a family of seven (comprising father, mother, two sons and three daughters), exposed to multiple situations of intra-family violence with the use of this approach. This

new psychotherapy approach integrates systemic comprehension of family functioning and the use of therapeutic interventions during sessions. In the study, the use of this technique facilitated the trauma's narrative in a non-invasive way, allowing questions about the abuse and violence trans-generational patterns right from the beginning of the psychotherapeutic process. It facilitated the reporting of multiple traumatic events suffered by perpetrators within the family in a safe environment, validated their emotions, and reframed the life history of this family, which had been marked by a continuous exposure to physical, sexual and emotional abuse and neglect by parental figures. Empathy among family members was developed through listening to the reports related to traumatic experiences, and through the strengthening of linkages. The study concluded that this technique is an excellent therapeutic tool in psychotherapy and can be used both with individual clients and with families in situation of violence. The structural family therapeutic model on which this study is anchored can be combined with other treatment modalities to maximise its effectiveness (Corey, 2009).

4.6 Analysis of Research Question Four

The fourth research question of this study was: What are the suggested solutions to the challenges of self-care among women religious in Karen-Nairobi? Evidence obtained from the interview data indicated that there was a significant degree of what might be called an instinctual awareness of the need for self-care among the African Catholic women religious in Karen, Nairobi. This was expressed in the vivid ways a good number of the participants described their personal experiences of living as self-caring persons or shared the self-care experiences of some women religious which were known to them. They, however, reported that women religious, the target group of this study, were prevented from self-caring regularly and beneficially for various reasons, such as the demands of their lifestyle, and poverty, and their readiness to grant even unreasonable demands in the name of service, for example. This stimulated the proposal of the remedial measures presented below under such

themes as awareness-creation, sensitisation and access to education, designing of self-care programme, regular supervision by superiors, systemic reorganisation as well as individual and collective revision of life.

4.6.1 Awareness-creation, Sensitisation and Access to Education

As indicated in the independent variable of the conceptual framework of this study, the notion of awareness has to do with consciousness, perception and knowledge about a given matter or issue. It refers in this instance to the subject of this study, namely, self-care among African Catholic women religious. As awareness signifies the starting point in any journey towards a desired goal, so it has been pin-pointed as the basis for the implementation of an enduring edifice to self-care among African women religious. In response to the question about suggesting possible ways of remedying the lack of self-care among women religious, Participant 4 insisted that they should be taught awareness. They should be taught from the basics, from the formation houses to be aware, and in this way, they would be more effective on the field. Their minds should also be opened through education, as education enables people to discover reality (April 10, 2017).

In response to the same question, Participant 5 suggested:

> The most important strategy will be education, letting the women religious know that time taken to care for oneself is not selfishness. If it is understood like this, it will help them to put it into practice. So when someone sees one Sister alone somewhere, they will not raise their eyebrows or make suspicion-laden comments. Reactions like this can prevent a Sister from benefitting from such self-care (March 29, 2017).

Participant 7 was of the opinion that education was very important, as also the need to convince people about the importance of self-care, especially by emphasising the consequences of not practising it (April 1 2017). For Participant 8, in the quest for the achievement of the goal of remedying the lack of self-care among African women religious, it was vital to:

> Educate everyone and create equality. Equality must be seen and felt and not just talked about. Equality is different from sameness, we cannot be the same. Equality in the sense that A is as valued as D, and D is as valued as C and C is as valued as T. If you don't create such equality, there's nothing you can do (April 5, 2017).

The above calls for education and equality are very significant. The study itself proposes to provide a psycho-educational intervention on the issue of self-care among women religious. One of the specific ways of achieving the goal of education as indicated in the literature review is through self-management education. Omisakin and Ncama (2011) in the literature review recognised in this tool a means of effective goal setting, decision making, focussing, planning, scheduling, task tracking, self-evaluation, self-intervention and self-development as well as coping with adversity through self-help, self-reliance, and family and community reliance.

4.6.2 Self-Care Programme

Self-care is a comprehensive package targeting human holistic well-being at all levels of being: physically, mentally, emotionally, socially, psychologically and spiritually. The study invited the participants' views on what they would include in a programme of self-care for women religious and the responses which follow were received. Participant 3 enthused about including leisure time, holidays, retreat, renewal courses, games and time for work (March 23, 2017). Participant 9 submitted a verbally economical, but weighty counsel advocating formation and information (March 27, 2017) while participant 8's proposal surfaced some forms of recreation which are largely overlooked in the modern digital age. He opted for the inclusion of vacation, as he noted that some sisters never went for vacations. He further advised that women religious should go out and recreate. He meant proper recreation, where people could just sit and chat and everybody was listened to, and that opportunities should be created to ensure this (April 5, 2017). Participant 10, on her part suggested a holistic, bio-psycho-socio-spiritual package:

> Go for retreats, go for seminars, go for recollections. So the spiritual aspect is taken care of. You may not also be able to socialise outside there. But in your community, you should have time for leisure. You can play games, do other activities. You can also change the work station so that you are not bored or burnt out through overstaying in one area. Sometimes you also can have a change of activity, because you might get tired of, maybe, doing something manual. But if you sit down, you can do something mental. And avoid stress because stress will always bring burnout and other complications to your health (April 2, 2017).

The above interventions confirm what the literature review for this study already glimpsed at, namely, the incorporation of preventive self-care practices into the lifestyle of women religious. The earlier two stages of action to pave the way for this would be the prior inclusion of self-care guidelines in all formation programmes and manuals and the organisation of multi-component, psycho-educational workshops around the variables of this study to create an awareness of the need for this. Details can be obtained from already designed plans such as the one by McDermott (2013) titled, *Creating Your Holistic Self-Care Plan*. It incorporates little practices for each of the levels of one's being-body, mind and spirit. In consonance with the foregoing, Dorociak (2015), in her study on the development of the personal and professional self-care scale, advocated the meaningful conceptualisation of self-care activities into the following five areas: life balance, professional development, cognitive strategies, daily balance and professional support. These would, however, need to incorporate the basic and indispensable necessities of adequate exercise, diet, and sleep.

4.6.3 Regular Supervision by Superiors and Systemic Reorganisation

The regular life schedule of the religious life already incorporates the practice of major Superiors visiting the houses of their respective congregations at stipulated intervals to check on the general progress of their members. The following input from Participant 6 appears to seek to reinforce this practice. He proposed that in order to ensure that women religious were well cared for, there be a:

> Regular interview of the Sisters by the Superiors. Know their strengths, know the areas they need to improve on in their lives. Know what

> they're struggling with, and help them. Some persons have a lot of baggage. For example, when you are a religious, you still have some family obligations. You will not run away from your family ties. If, for example, a sister's mother is sick, and nobody in her home is handy to take care of her, can her community help her to treat her mother? If her community does that, she becomes a happier sister. So the superiors should maintain a constant contact with the Sisters on their personal affairs (April 5, 2017).

In the same vein, in an article by Lenz and Smith (2010), the need for a model of supervision that features wellness concepts was identified. This prompted the discussion of some relevant concepts of wellness in the helping profession, and how they could be integrated within a model of clinical supervision. In addition to proposing a model for integrating wellness as a central construct into a clinical supervision, case examples are utilised to illustrate the implementation of this model. The study affirmed that a well-organised, strategic, developmental plan is an important tool during the evaluation of supervisees, and offered guidelines as to how this might be accomplished. If these ideas were transposed to the religious life, they could work just as effectively.

4.6.4 Individual and Collective Revision of Life

The revision of life is a familiar concept to most religious. It is here recommended by Participant 2 as the means of ensuring self-care through

> Ongoing formation, internalising spiritual values like Gospel values, to be humble and to accept our limitations also so as to be balanced in our lives. We also need Sacred Scripture in order to transform our lives, to retain the originality of our religious lives, the measure of our relationship with God and to observe our norms (March 23, 2017).

Similarly, Participant 6 advised that:

> Sisters themselves in the community need to be content with what they have because when there is negative competition in the community over personal effects like items of clothing and shoes, it could prove detrimental to their overall well-being. Also, there is a need for one to be open about the type of life one is living, and for contentment with what the community can provide for her. Doing otherwise could endanger one's life and vocation. It is also important to share one's apostolic life with the members of one's community because this allows one to get some input on how to go about any challenges one might have. Ensure,

> moreover, that strict confidentiality is maintained in this regard to ensure that none of it gets leaked outside the community. Finally, there is the need to sleep well. Leave all your challenges in the hands of God and sleep (April 5, 2017).

The appropriate renewal of the religious life was given adequate attention during the Second Vatican Council (1962-1965). It gave rise to a document which dealt quite exhaustively on that subject. It directed, among other things, that the manner of life, of prayer, and of work should be in harmony with the present-day physical and psychological condition of the members (Perfectae Caritatis 3, 1965). The call by the universal Church for the renewal of the religious life is now over fifty years old. More than enough time to begin the practice of renewing the religious life as it is lived among African women religious, surely?

4.7 Summary of the Findings

This study explored the degree of self-care awareness among African women religious in Karen-Nairobi, Kenya. The study revealed that the participants were quite conversant with the subject of self-care. They manifested a concrete awareness of it and were able to define it and offer meaningful examples of how they personally engaged in it mainly at the physical and spiritual levels. According to their expressed opinions in this study, therefore, there exists an awareness of the need for self-care among the African women religious in Karen-Nairobi, Kenya. However, the fervent commitment to the service-oriented lifestyle of African women religious and a systemically induced financial poverty placed intolerable burdens on them. They further compromised their ability to live in a dignified manner, or attain to a reasonable quality or standard of living as well as access to self-care.

The study further ascertained the causes of the neglect of self-care among women religious in Karen-Nairobi. The findings on this were summarily negative in nature, content and effect, life-diminishing and dignity-depriving. They included overwork, negligence, wrong concept of religious life, lack of balance in the life of women religious,

misunderstanding of the meaning of self-care, lack of control over one's life, poor remuneration and gender bias.

In the same vein, neglect of self-care resulted in colossal damage to the individual woman religious and her immediate community as well as the wider human community. The damage spanned such areas as health, intra and interpersonal relationships, deviance and the development of a toxic personality. Others were wholesale individual and organisational lifelessness, misplaced priorities and stagnation. The study therefore recommended some strategies for remedying these identified deficiencies. They included greater self-care awareness through sensitisation programmes, access to education for women religious and the designing of a self-care programme. Furthermore, regular supervision of self-care by superiors and the systemic reorganisation of the unhealthy structures of the religious life and the Church, as well as individual and collective revision of life were recommended.

CHAPTER FIVE

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

This chapter presents the summary, implications and outcomes of the study. It also includes the conclusion of the study, and discusses its limitations, suggestions for future research, as well as the essence of the study and its inspiration for the researcher (Creswell, 2013).

5.2 Summary of the Study

The study explored the influence of self-care awareness on the physical well-being of African women religious in Karen-Nairobi, Kenya. It had in view the proposal of a psycho-educational intervention for the purpose of integrating self-care into their lifestyle for optimal well-being and ministerial effectiveness. Ten participants comprising four women religious, two religious brothers, two priests and two lay persons took part in the study. The study was organised in five chapters. Four research questions probed the level of the awareness of, the type of self-care practices among women religious, the causes of its neglect among them, the results of its neglect and the means of correcting these. The study was further hinged on the structural family therapy of the family systems theory developed by Salvador Minuchin in the 1960s. A conceptual framework was constructed to showcase the essential nature of the study. The review of relevant literature in chapter two which was structured on the study's research questions revealed the pivotal role of self-awareness in the practice of self-care among African women religious. It further established the various causes and consequences of the neglect of self-care among the study population and concluded by proposing some remedial interventions for these. The study adopted a qualitative paradigm and used phenomenology design. An in-depth face-to-face interview was used to collect data from the ten participants who were of diverse African nationalities.

The objectives of the study were achieved. There was indeed a significant level of an awareness of the need for self-care among African women religious. As a result, they were able to pinpoint the causes of its deficits, categorise its consequences and propose some remedial measures to facilitate the actualisation of self-care among the target group.

This study differs from the ones presented in the literature review in four major ways. The first major difference is the nature of its target group: African women religious. While its subject matter, self-care awareness, is not exclusive to the target group, its uniqueness is that the level of its awareness and practice is being examined among this group of people who have a vocation or recognised state of life within the Roman Catholic Church while the target groups of the studies in the literature review basically belonged to diverse helping professions or another state of life like the Catholic ordained priesthood. In the second place, the identity of the target group was also specified: African. In addition, it is gender-specific: female only.

5.3 Conclusions

Self-care can be defined as a process in which mature persons are able to identify needs and make decisions to meet them. Self-care embraces the fulfilment of the needs of the different levels of the human person: physical, spiritual, psychological, socio-economic and professional. And that creates a vital and mutually reinforcing link between this study and psycho-spiritual counselling. The focus of this study is the necessity of being aware of the need for self-care so as to facilitate the incorporation of appropriate, life-enhancing practices into the lifestyle of the target group.

The study findings pointed to the need for a multidimensional and multifaceted intervention in order to make the implementation of self-care among African women religious a reality. There would be the need to build the capacity of the African women religious through appropriate educational measures to enable them see and accept self-care for what it really is, and not some excuse for narcissistic self-indulgence. It would also be

necessary to introduce some amount of balance into their lifestyle as it is lived at present and empower them with some assertiveness training. Further, the institutional Church would need to begin to tackle the obstacles of poverty and gender role against women religious. Finally, the superiors of the various women's religious congregations would need to spearhead some needed modifications to the structures of their respective congregations so as to make the actualisation of self-care among their members a well-planned, systematic, permanent and life-enhancing experience.

5.4 Limitations of the Study

The study was titled Influence of Self-care Awareness on the Physical Well-Being of Women Religious in Karen, Nairobi-Kenya: A Psycho - educational Intervention. A very conspicuous limitation of the study is its sample size. It was limited to the target group indicated, with a sample size of only ten participants and situated only within the geographical enclave of Karen in Nairobi, Kenya. Another identified limitation of the study is linked to the research method used - the qualitative method – which did not allow for the generalisation of results to the population but to the theory. Further, since only the qualitative research method and phenomenological design were used in the study; it was not possible to know whether different or better results would have been obtained if the quantitative and mixed methods, case study design, larger sample size to enable the generalisation of findings, etc. were employed.

In addition, the study was limited to only African women religious. It was not possible to extend it to male religious or priests as they too are among the consecrated persons in the Catholic Church. Owing to time constraints, it was not also possible to do an in-depth exploration of the African dimensions to the study.

Moreover, the age range of the participants in this study was inadvertently 42-65 years, and so did not include any temporary professed woman religious or novices. The study

also did not look at other areas of self-care but focussed on only the physical well-being of the women religious. The self has been identified as an indivisible, integrated whole. So dwelling on only its physical aspect to the exclusion of, for example, its psychological and spiritual dimensions, would appear to be splitting it into compartments.

5.5 Recommendations

This study aimed at exploring the influence of self-care awareness on the physical well-being of African women religious in Karen, Nairobi, Kenya, with a view to offering a psycho-educational intervention on it that will be integrated into the lifestyle of the target group. In keeping with this target, the following proposals, culled from the research findings, are proposed for implementation at various levels:

The Incorporation of Self-care Practices into the Lifestyle of Women Religious

A self-care sensitisation and implementation plan, comprising a comprehensive and well-articulated multi-dimensional package, to cover the provision of their physical, spiritual, economic and psychological needs will need to be formally introduced in each congregation. The leadership teams of the various congregations are to see to its establishment, but it will require a coordinated effort from top to bottom for it to succeed. It will help create awareness of the importance of self-care, and reduce, or altogether prevent, in the long run, the incidence of scandalous and life-threatening health and psychological crises and emergencies. Finally, it should also be accompanied by regular supervision sessions by the local and higher superiors, the latter by adding it to their canonical visitation schedules.

Education and Ongoing Formation

Access to higher education, ongoing formation and sabbatical leave should be treated as undeniable rights for women religious. This is to be facilitated by the leadership teams of the various women religious. Education will help build up the capacity of the women

religious and empower them to fit into and engage the contemporary world with greater ease and competence. An institutionalised policy on these will help guarantee this.

Economic Restructuring

The leadership teams of the women religious congregations, assisted by their finance committees are to see to it that terms of contracts with ecclesiastical and other bodies are respected, ethical investments are made, and congregational projects should be founded on viability and vitality. This is because skilful planning and management at the economic level are crucial to the success of the implementation of any self-care ventures for the African woman religious. Economic restructuring will also enable women religious live respectable and dignified lives without resorting to begging or to any shady deals. It will also help take care of the members' immediate needs as well as their future retirement needs.

Establishment of Congregational and Inter-Congregational Support Systems

Since the various women's religious congregations face identical challenges on the provision of self-care, it is therefore advisable that they work as a team to ensure the success of the permanent integration of self-care into their lifestyle. The implementation of this cooperation plan will primarily rest with the leadership teams of the various congregations. They will achieve this by meeting at stipulated intervals to compare notes and exchange best practices. Besides introducing a congregational self-care plan, they will also need to establish inter-congregational support systems for women religious at various levels. The nature of the cooperation will incorporate such practices as the establishment of an inter-congregational network for regular counselling and spiritual direction support. The establishment of emergency lines or life lines at the congregational and inter-congregational levels would also help ensure the availability of instant and safe telephone counselling aid to a needy or traumatised woman religious. By so doing, an improved quality of life can be guaranteed for their members.

Proactive Collaboration with the Ecclesiastical Authorities

The need for a proactive collaboration of the various women's religious superiors with the ecclesiastical authorities is also important to the success of this undertaking. This is because they are the chief shepherds and the spiritual leaders of the dioceses where women religious live and work. A cooperation of this nature is particularly important for the actualisation of a much needed cultural shift for the eradication of gender-based partiality against women religious and adherence to the terms of engagement in ministerial endeavours. The major superiors of the various congregations are to see to this in conjunction with the local ordinaries. Whenever necessary, the collaboration also extends to the episcopal conferences. The endorsement of any project or plan by the joint meeting of major superiors and bishops provides an assurance that the followership will also endorse and execute it.

5.6 Suggestions for Future Research

The present study was carried out on the influence of self-care awareness on the physical well-being of African women religious in Karen, Nairobi, Kenya. Future studies could consider other target groups such as religious brothers or priests or specific age-groups among these or those in other locations (specific dioceses, congregations and countries or continents). The present study was conducted using only the qualitative paradigm and phenomenological design. It would be interesting to compare the findings of this study with those that could be obtained from employing other methods and research instruments.

This study endeavoured to focus on the physical well-being of the target group. Future studies could explore other dimensions of well-being such as the psychological, spiritual, social and cultural self-care, for example. Liberating self-care from the shackles of misconception could also provide an interesting subject for future studies. Finally, the nature of the Church's response to the eradication of gender bias from the lives of women religious could also be examined at greater depth.

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APPENDICES

APPENDIX 1: INTERVIEW GUIDE

Preamble:

Good day, and how are you today? Thank you for agreeing to participate in this interview. You were chosen for the study because you are a Catholic, living in Karen, and have been recognised as someone who has a great deal to share about Self-care among African women religious in Karen, Nairobi. The purpose of this interview is to get your perceptions and experiences on self-care as understood and practised by African women religious. There are no right or wrong or desirable or undesirable answers. I would like you to feel comfortable with saying what you really think and how you really feel.

If it is okay with you, I will be tape-recording our conversation. The purpose of this is so that I can get all the details but at the same time be able to carry on an attentive conversation with you. I assure you that all your comments will remain confidential. I will be compiling a report which will contain all the participants' comments without any reference to individuals.

We will begin with by collecting your consent to participate in this interview. After that you will proceed to complete the demographic questionnaire. Thank you again for your willingness to participate in my thesis research by granting me this interview. Please feel free to stop me at any point. And now, to the questions...

Part 1: Participants' Demographic Profile

1. **Please state your age:**
2. **Nationality**:
3. **Year of Profession:**
4. **Status:** Temporary Professed [ ] Perpetually Professed [ ] (Tick √ as appropriate)
5. **What is the highest degree of formal education that you have achieved?** (Please tick your current **level):** Secondary School [ ] Certificate [ ] Diploma [ ] College [ ] BA / BSc. [ ] MA / MSc [ ] PhD [ ]
6. **What field or apostolate do you work in at present? (Tick as appropriate):** Leadership [ ] Education [ ] Health [ ] Pastoral [ ] Social [ ] Vocational [ ] Domestic [ ] Formation [ ] Any other…….
7. **What is your current position?** _____

PART 2

Section A: Awareness of the Need for Preventive Self-Care Among Women Religious

8. Tell me what you understand by self-care.

9. Would you mind mentioning some aspects of self-care you know / practice?

10. Please tell me about some of the things that often result in your being tired or stressed.

11. Please explain the benefits of self-care that you know. Have you experienced them?

12. How would you describe your self-care experiences?

13. What are the issues you think are affecting the practice of self-care among women religious?

Section B: Causes of the Perceived Neglect of Preventive Self-Care by Women Religious

14. What factors prevent you from taking as much care of yourself as you should?

15. In your opinion, why do women religious fail to take care of themselves?

16. Would you think that gender role or educational status have anything to do with this?

17. Do you know any woman religious who:

a) experienced burnout as a result of her involvement with the apostolate?

b) became sick while on active ministry?

c) is aged after years of active life?

18. How were their conditions treated?

Section C: Effects of the Perceived Neglect of Preventive Self-Care on Women Religious

19. What are the consequences of neglecting self-care?

20. In your opinion, do you think it is necessary for women religious to personally integrate preventive self-care into their lifestyle? Give reasons for your answer.

21. Do you think it is necessary for African women's religious Congregations to integrate preventive self-care into the formation process and post-formation lifestyle of women religious?

22. How would you suggest that this be done?

23. What would you think are the consequences of the neglect of self-care on women religious?

Section D: Solutions to the Perceived Lack of Preventive Self-Care Among Women Religious

24. Suggest possible ways of remedying the lack of self-care among women religious.

25. If you were given the opportunity to design a programme of self-care for women religious, what would you include?

Section E: Miscellaneous

26. Please feel free to add any other comments you may wish to share with the researcher.

Conclusion:

Thank you for your participation. It has been interesting, informative and helpful. And thank you also for your time. I really appreciate your availability. God bless you.