A phenomenological study of the lived experiences of home-based caregivers of patients with chronic mental illness in Ga-Dikgale, Limpopo Province

BY

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DISSERTATION

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DECLARATION

I declare that **A phenomenological study of the lived experiences of home-based caregivers of patients with chronic mental illness in Ga-Dikgale, Limpopo Province** hereby submitted to the University of Limpopo as fulfillment for Master of Arts Degree in Psychology has not been previously submitted by me for a degree at any other university, that it is my own work in design and execution, and that all the material contained therein has been duly acknowledged.

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NOVELA MANDISA ISABELL (MS)   **DATE**

DEDICATION

I would like to dedicate this work to my late mother (Thandie Christabell Mkhabela Novela) who recently passed on. She groomed me well and directed me in the right paths. She has been my number one supporter throughout this study. I would not have had all the strength to complete it if it were not for her constant motivation, love, and emotional support. She will forever have a special place in my heart.

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- My sisters for their continuous support and love.
- My partner (T, N) for his continuous support and love throughout this study and for encouraging me when times were tough.
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Abstract

Previous studies have investigated caregiving within the family unit when a family member takes the role of the primary caregiver. These caregivers often experience many physical, emotional and psychological challenges such as anxiety, depression and stress. The present study sought to explore lived experiences of home-based caregivers of people living with chronic mental illness in Ga-Dikgale, Limpopo Province, South Africa. Eight caregivers of family members with chronic mental illness were sampled from Ga-Dikgale, Limpopo Province, South Africa, and requested to participate in the study. Data were collected through in-depth, semi-structured, individual face-to-face interviews, and analysed using Hycner's phenomenological explication process. The following themes were extracted from participants' narratives. The role of home-based caregivers and their understanding of mental illness; challenges that they encountered; their coping strategies; support systems available for them; their psychological well-being; and suggestions for improvement. The study is concluded by, among others, recommending a collaborative approach amongst the Department of Health, NGOs and community healthcare services to facilitate support for home-based caregivers.

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List of abbreviations and acronyms

AIDS: Acquired immuno-deficiency syndrome

HBC: Home-based care

HBCG: Home-based caregiver

HBCGs: Home-based caregivers

HIV: Human immuno-deficiency virus

NGOs: Non-governmental organisations

PHC: Primary health care

PLCMI: People living with chronic mental illness

PTSD: Post traumatic stress disorder

SASH: South African Stress and Health Study

SMI: Sever mental illness

WHO: World Health Organization

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CHAPTER 1

INTRODUCTION

1.1 Background to the study

Mental illnesses are widespread issues that place a heavy burden on populations, patients, and their families everywhere (Thornicroft, Semrau, Alem, Drake, Ito, Mari, McGeorge & Thara, 2011). Mental health has a major impact on health at both individual and community levels (Jacob, 2018). According to the World Health Organization, the suffering, hardship, and costs associated with mental illness for people, families, and societies are tremendous (World Health Organization, 2003). It was stated by Achaya (2017) that mental illness is the largest contributor to disabilities in mostly low- and middle-income countries globally. Vigo, Thornicroft and Atum (2016) supported the notion and added that mental illness does not only lead to disability, but is also the leading cause of mobility globally. This was also pointed out earlier by Kabir, Iliyasu, Abubakar, and Aliyu (2004) that mental disease is becoming more widely recognized as a major cause of morbidity around the world. Statistics in South Africa has shown that one in third people are likely to suffer from mental illness in their life time (Collin, Patel, March, Insel & Daar, 2011). There is no denying that mental illness places a heavy burden on South African society on both a social and economic level. Anxiety disorders, drug addiction disorders, mood disorders, and depression are the four most common mental illnesses in South Africa (Meyer, 2019). Despite the huge number of people suffering from mental illness, there is a lack of mental health experts, hence the implementation of home-based-caregivers (Burns, 2011).

Chronic mental illness does not only have a negative effect on the patient, but it also imposes a significant burden on home-based care givers (HBCGs). Studies have indicated that mental illness is frustrating not only for patients, but also for the affected family members. For instance, a study by Farshid (2015) found that family HBCGs of persons with severe mental illness suffer from significant stress and face different

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challenges. Research into the impact of caregiving by Farshid (2015) revealed that one-third to one-half of caregivers suffer serious psychological distress. They also reported to have experienced significant rates of mental illness than the overal population. Another study conducted in a rural area in Limpopo Province by Ntiseni (2014) found that voluntary home-based caregivers experienced challenges because of the shortfall of home-based care kits. They described how they frequently found themselves operating with the absence of mandatory kit such as facemasks and gloves. Evaracia (2017) argued that caregivers in Botswana reported not receiving adequate psychosocial counselling to help them cope with stress of care giving. As a result, this contributed to the poor quality of care they delivered. Home-based caregivers who provide nourishment to people with severe mental disorders are impacted in different ways. The interplay of caregiving consequences, poverty, discrimination, stigma, diminished social relationship, emotional trauma and depression are associated with the caregiving burden (Ngibese, Doku, Asante, Owusu & Agyei, 2015). Valjee (2014) emphasised how family home-based caregivers have a significant role to play in the management of patients with chronic mental illness. The wellbeing of family home-based caregivers is therefore crucial because the impairment of their physical or mental health could impact negatively on the management of their chronic mentally ill family member.

The obstacles and health risks associated with their profession as home-based caregivers for older persons with chronic diseases have an impact on their health, wellbeing, and quality of life. There is, however, little information about home-based caregivers and the caregiving profession. therefore, the aim of this study is to investigate on the experiences of caregivers with regards to caring for people with chronic mental illness. With all that has been said, it is evident that the impact of mental illness on home-based caregivers is multifaceted. Home-based carers are typically in charge of helping patients with their daily living tasks, such as bathing, eating, cooking, dressing, taking prescriptions, and attending hospital follow-up appointments. According to Imas and Wandee (2011), the longer a patient receives care, especially if they have schizophrenia, the more likely it is that the caregiver will feel a heavy load, which could have unfavorable effects. The burden of home-based caregivers is a multifaceted notion

that takes into account the physical, psychological, emotional, social, and economical effects of looking after a disabled family member. (Sahoo, 2010). The concept of home-based caregiver burden is referred to as a burden arising because of being close to a severely ill psychiatric family member (Sahoo, 2010). These studies suggest that family members generally have little prior knowledge of mental illness, and as a result, the impact of mental illness on home-based caregivers is multifaceted. It is these responses and other psychological problems that encouraged the investigator of this study to seek and explore more on home-based caregivers' experiences.

1.2 Problem statement

Growing awareness of the function of home-based carers in the long-term care of patients with chronic mental illness has been observed in recent years with a growing body of literature showing caregiver burdens, poor caregiver outcomes, and lack of caregiver support (Farshid, 2015). According to Jackson (2007), the implementation of home-based care on an informal basis dates back to many decades, and is progressively becoming common in nations globally (World Health Organization, 2000). Like many other evolving countries, South Africa also relies on home-based care as an alternative to address the crisis in health care, and in particular the rural areas (Ntsieni, 2014). The fundamental aim of home-based caregivers (HBCGs) is to make sure that customers remain self-sufficient, and the best quality of life is provided through appropriate care, and the provision of hope. The institution primarily draws the strength of families and societies, which serve as the service's cornerstone (De Wet, 2012). According to research by Farshid (2015) on the impacts of caregiving, between one-third and one-half of HBCGs experience much more psychological distress and mental health conditions than the general population. The term "caregiver" has a wide range of applications and a rich semantic value. Its significance and meaning frequently vary between societies, cultures, families, and individuals.

Chronic and traumatic stress have a significant negative impact on the quality of life for HBCGs. However, these encounters are not enough studied or acknowledged. HBCGs

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are acknowledged as a useful and necessary resource in society throughout a large portion of the industrialized globe. Research among home-based carers in those nations formed the basis for most of the recognition and supportive measures for HBCGs. It is unclear, however, how dependent on such care the population in South Africa is, who fills the role of an HBCG in families, and what the traits of those who carry this burden are.

According to a study by Matambela (2019) on caregivers for people with mental illnesses in the Limpopo vheme district, caregivers encounter psychological frustrations as a result of the hostility and physical and emotional violence their mentally ill children subject them to. By making them take medication and go to follow-up appointments with doctors, they also show that they are always at war. Being unprepared to face such circumstances, the parents claimed they were unable to handle this role adequately.

A study conducted by Valjee and Van (2014) disclosed that studies on home-based caregiving has received very little attention in South Africa. In the study on the experiences of caregivers of people living with critical mental illnesses, Ngibese, Doku, Asante, Owusu and Agyei (2015) suggested that HBCs experience different challenges related to the burden and the stress of caregiving. Some of the common challenges included social isolation, emotional stress and psychological problems that are associated with the burden of caring for people with chronic conditions, such as chronic mental illness (Ngibese et al., 2015). Another study conducted in the Western Cape by Zubair (2016**)** discovered that HBCGs were unable to deal with the emotional challenges, and stress that came with caring for older persons living with chronic sicknesses. HBCGs also added that providing care for older adults was strenuous and too much of a heavy load for them, as they had to struggle with different chores, including work and preparing food. Moreover, a few of the HBCGs regarded caregiving as an emotionally exhausting task that caused them to become frustrated, and emotional to a point where they would find solace in alcohol as a coping defence mechanism (Zubair, 2016). It is in this regard that there are calls for the implementation of programmes that will assist HBCGs by lessening the burden that comes with

providing care to mentally ill patients. Not much is known about home-based caregiving for persons with chronic mental illness in the South African perspective, particularly in the more rural settings. The present study seeks to address this gap by focusing on experiences of home-based caregivers of persons with chronic mental illness. Despite evidence from a few studies on the HBCGs' lived experiences, not much has been done on the caregiver challenges that come with the burden of looking after sick patients.

1.3 Aim of the study

The aim of the study was to explore lived experiences of home-based caregivers of people living with chronic mental illness in Ga-Dikgale, Limpopo Province, South Africa.

1.4 Objectives of the Study

The objectives of the study were:
- To assess the nature and types of care provided by home-based caregivers (HBCGs) in Ga-Dikgale to people with chronic mental illness.
- To identify challenges experienced by HBCGs in Ga-Dikgale.
- To determine coping strategies used by HBCGs taking care of People living with chronic mental illness (PLCMI).
  To determine types of support available to HBCGs taking care of PLCMI

1.5 Operational definitions of concepts

- **Lived experience:** This refers to a representation of encounters and decisions of a particular individual, and the awareness that they attain and learn from these encounters and choices. In phenomenological research, lived experiences are the central object of the study (Lisa, 2008). Similarly, lived experiences will be understood in the present study to mean experiences of home-based caregivers taking care of people with chronic mental illness.

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- **Home-based caregivers:** The World Health Organization (WHO, 2001) defines a home-based caregiver (HBCG) as someone rendering health services to people in their homes. In the context of the current study, a home-based caregiver will carry the same meaning. Home-based caregivers assist mentally ill people with daily life activities in their homes.

- **Patient**: This refers to any individual benefiting from healthcare services. The person is most often in need of medical attention and treatment. This refers to any sick or wounded person in need of medical assistance by a physician, nurse, physiotherapist, physician-assistant, psychologist, dentist or other healthcare providers (Stewart, 2001). For the purpose of the present study, a patient will be understood to mean any individual suffering from chronic mental illness, and who is looked after and provided with service by a home-based caregiver.

- **Chronic mental illness:** Chronic mental illness is a term used to describe a severe mental condition based on a diagnosis by a qualified medical professional, which reveals that the person has significant challenges at work and in their personal lives, as well as frequent changes in their mood or intellectual functioning. This includes chronic illnesses such as schizophrenia and dementia (Goldman, 2006). In the present study, chronic mental illness will carry the same meaning as the one above.

1.6 Organisation of the dissertation

Chapter one provided background to the study and the problem statement. Furthermore, it outlined the aim and objectives of the study. Chapter two presents the relevant and most recent literature of the subject matter. Theoretical framework is discussed in chapter three. Chapter four presents the methodology and outlines the research design. It also highlights data collection and data analysis methods that were followed. Furthermore, it presents the quality criteria and ethical considerations that were observed throughout the study. The results and findings are presented in chapter 5. Chapter six reflects the findings of the study while chapter seven concludes the study.

CHAPTER 2
LITERATURE REVIEW

2.1 Introduction

The first part of the chapter will centre on the prevalence and nature of chronic mental illness. The second part of the chapter will focus on home-based caregiving and the role of home-based caregivers, including their experiences.

2.2 Prevalence and nature of chronic mental illness

2.2.1 Prevalence of chronic mental illness

The frequency, chronicity, and morbidity of mental diseases are very high globally (Jorns, 2021). The most typical mental diseases are depression and anxiety. At any given time, each affects 3 to 4% of the world's population, and they are all together to blame for 8% of years lived with disability globally (James, 2018). The global prevalence of PTSD ranges from 4% to 41%; and major depression increased by 7% in the year 2019/20 (Mowbray, 2020). The estimated global prevalence for depression is 28.0%, anxiety is 26.9%, PTSD symptoms are 24.1%, stress is 36.5%, psychological discomfort is 50.0%, and sleep issues are 27.6% (Nochaiwong, Ruengorn, Thavorn, Hutton, Awiphan, Phosuya, Ruanta, & Wongpakaran, 2021). Emerging studies and surveys have shown an increasing rate of mental health globally. According to estimates, depression and anxiety disorders affect respectively 4.4% and 3.6% of the adult population worldwide (Sara, 2020). Psychologists have also reported children to be anxious, and an increase in cases of depression and anxiety have been recorded in several countries (Kate, 2020). In the past two years, it has been noted that there has been a rise in the global prevalence of serious mental illness (SMI) (Schizophrenia and other psychotic illnesses 0.9%, bipolar disorder 0.5%, and major depressive disorder

3.9%). (Huang, 2019). According to Tianchen (2021), worldwide prevalence rates for depression, anxiety, distress, and insomnia were 31,4%, 31,9%, 41.1%, and 37.9%, respectively, in 2020.

Anxiety disorders, drug addiction disorders, mood disorders, and depression are the four most common mental illnesses in South Africa (Meyer, 2019). According to research, 17% of children and adolescents in South Africa and 16.5% of adults have common mental disorders such anxiety and depression in the previous year (Meyer, 2019). Major depressive disorders were among the top 10 causes of mental illness in 2016, and there were an estimated 1.1 billion people living with these conditions in four nations, including South Africa (Vos, 2016). One in five high school students in South Africa has attempted or contemplated about suicide at some point, and 9% of young adult deaths are caused by suicide. These and other variables all contribute to the high chronic burden of mental illness in teenagers (Meyer, 2019). According to a recent study by Jorns, Napp, Dessauvagie, Stein, Jonker, and Breet (2021), one in seven children and adolescents (14.3%) in South Africa encounter substantial psychological difficulties, and one in ten (9.5%) are eligible for a psychiatric diagnosis. In a study that looked at the lifetime prevalence of depression in a household sample of 5631 South African teenagers (ages 15–17), the lifetime prevalence was found to be 2.6% (M: 3.1% vs. F: 2.0%) (Ward, 2018). Anxiety, depression, and substance use disorders affect one in six South Africans, according to a 2019 survey (Pillay, 2019).

2.2.2 Nature of chronic mental illness

Mental health disorders are more prevalent in those with chronic illnesses than in the general population, according to Adams (2021). Many people who suffer from chronic conditions including rheumatoid arthritis, systemic lupus erythematosus, cancer, and epilepsy, for instance, experience symptoms of despair and anxiety. Comorbid mental health disorders can arise coincidentally, but can also be related to direct effects of the chronic underlying disease, illness-related anxiety, stress and the use of certain medications. The World Health Organization (2021) states that there are numerous

distinct mental diseases, each with a range of manifestations. The combination of deviant thoughts, perceptions, emotions, behavior, and relationships with others most often characterizes these diseases. Major depressive disorder, bipolar disorder, schizophrenia and other psychoses, dementia, and developmental disorders, such as autism, are examples of chronic mental illnesses (WHO, 2021). WHO (2021) states that there are practical methods for preventing mental illnesses like depression. There are effective methods for treating mental illnesses, as well as strategies to lessen the suffering they cause.

Autism and other pervasive developmental diseases are included under the phrase "developmental mental disorder" (WHO, 2021). WHO (2021) states that developmental mental problems typically manifest in childhood but frequently continue into adulthood, impairing or delaying processes related to the maturation of the central nervous system. Unlike many mental disorders, which exhibit intervals of remission and recurrence, they often have a consistent course. The impairment of skills in numerous developmental domains, including cognitive functioning and adaptive behavior, is another characteristic of intellectual mental disability. The capacity to adjust to the demands of daily life is reduced by lower intelligence (WHO, 2021).

2.2.3 Mental health resources and services for people with chronic mental illness

For a multitude of reasons, one of the biggest obstacles to the reform of mental health systems is the provision of long-term mental health care for people with chronic mental illnesses. Caldas (2011) says that although chronic mental disorders such as schizophrenia and dementia despite their minimal occurrence, they have a profound impact on people, families, and societies. (Caldas, 2011). The core principle of providing for mental health is to make the greatest mental health care, treatment, and rehabilitation services available to the community in a fair, effective, and in the patients' best interests' manner within the constraints of available resources. The core principle of providing for mental health is to make the greatest mental health care, treatment, and rehabilitation services available to the community in a fair, effective, and in the patients' best interests' manner within the constraints of available resources. According to Caldas

(2011), emergency care, general hospital admissions, outpatient treatment, community centers, outreach programs, residential homes, respite care for families, HBCGs, occupational rehabilitation support, and basic necessities like food and clothing should all be provided as part of community mental health services. The provision of mental health services includes sheltered employment in the non-health sector, residential care, primary health care (PHC) specialists, mental health services in the PHC environment, and community-based mental health services (Mpanga, 2019). The funding and staffing levels for these healthcare services have also been reportedly been inadequate. As a result, the mental healthcare system is inadequate, which provides justification for addressing the underutilized mental healthcare management of mental disease at the primary health care (PHC) or community level. According to reports, community-based treatments, such as PHC, are thought to be the most successful method for managing mental illness and providing mental health care (Mpanga, 2019).

With the release of the White Paper for the Transformation of Health Services in 1997, the policy on the integration of mental health care was established in South Africa. According to the policy on the integration of mental health care into primary health care (PHC), patients who need mental health services must be integrated into general care at PHC and should receive their care at the clinic closest to where they live. South Africa also adopted the Mental Health Care Act of 2002, which is founded on the idea that PHC should incorporate mental health services and be available close to where people live. Nurses are in charge of overseeing, administering, and counseling patients in a PHC clinic. This necessitates that the clinic's trained nurses be able to evaluate every patient, recognize those who have mental illnesses, and administer the appropriate care (Hlongwa, 2019). The Mental Health Care Act 17 of 2002 establishes rules for the treatment and rehabilitation of mentally ill people in South Africa, as well as for the care and administration of their property. According to the Department of Health (2014), mental health treatments should be offered as part of primary, secondary, and tertiary health services because health is a condition of overall physical, mental, and social well-being (National Department of Health, 2016). The South African Mental Health Act 17 of 2002 further regulates the provision of any person needing mental

health care treatment and rehabilitation services with the appropriate level of mental health care treatment and rehabilitation services within its professional scope of practice, or refer such person according to established referral and admission routes, to a health facility that provides the appropriate level of mental care, treatment, and rehabilitation.

The Mental Health Care Act 17 of 2002 states that a health facility may not make a mental health care user take psychiatric medication for longer than six months without a doctor's note from a mental health professional who is authorized to administer medication and monitor psychiatric therapy. In South Africa, a wide range of mental health services are provided at the basic, secondary, and postsecondary levels. Primary, secondary, and tertiary prevention are the first three stages of mental health interventions, which can target both people and populations (Jacob, 2018).

2.3 Home-based caregiving

Studies contrasting HBCGs with other care models repeatedly demonstrate superior and appreciable results in terms of treatment compliance, clinical symptoms, quality of life, housing stability, and vocational rehabilitation (Braun, 1981; Conway, 1994; Bond, 2001). The research uses the phrase "home-based care," but it is understood that terminology may vary among nations, providers, and recipients of such care. In the literature, terms like "home-based care," "community home-based care," and "family care" were used, but their underlying meanings were largely interchangeable with the definition of "home-based care" that is given below. Although it is recognised that home-based care may be paired with (temporary) care in other settings, such as respite care in a formal care centre such as a hospice's in-patient unit or sporadic care delivered in a day care facility, this dissertation concentrates on care given in the home setting. The history, importance, and experiences of HBCGs in South Africa are briefly discussed below.

2.3.1 Role and history

A part of comprehensive PHC is HCBC (Russell, & Schneider, 2000). The idea of Community-Oriented Primary Care, conceived and pioneered by Sidney and Emily Klark at the Pholela Health Centre in the former Natal Province in 1940, is where PHC in South Africa first began. In South Africa, the National Party came to power in 1948. The growth and legalization of the apartheid system were caused by this change in leadership. Home-based Community-Oriented Primary Care struggled to survive and was no longer in operation by 1960 (Kautzky &Tollman, 2008). With the advent of South Africa's first democracy in 1994, a new era that promoted equality began. The African National Congress (ANC), which produced the National Health Plan before 1994 and was based on the earlier locally conceptualized Community-Oriented Primary Care and the worldwide Alma-Ata Declaration of 1978, laid the groundwork for the creation of new policies (Kautzky & Tollman 2008). Private health care services, which were almost primarily used by privileged minority racial groups and prospered, replaced institutionalized public health care.

Prior to these advancements in the HBC profession in the West, its application and guiding principles were already ingrained in Africa as an inherent part of being an African. In many southern African communities, the concept of sharing and caring for one another is encouraged by the African worldview known as ubuntu. It is an expression of love, empathy, and compassion for the enhancement of daily life and the preservation of community cohesion (Martson, 2015:424; Sarpongi, Amankwah, & Amoah, 2016:17; Makoae & Jubber, 2012:38). Thousands of years ago, Africa had its own customary methods of providing care, which were frequently combined with spiritual counseling and care (Sama & Nguyen, 2008:3).

Therefore, the development of HBC in Africa might be seen as an attempt to reinforce the African value of Ubuntu, which already existed. HBC also includes transportation, referrals to clinical health care services, functional restoration, palliative care, pain management, social support, livelihood support, legal support, nutritional support, empowerment, child protection, and health promotion and prevention (Aantjes, 2014). Home-based Population-Oriented Primary Care is the ongoing delivery of medical

attention to a clearly defined community in response to an evaluation of their medical requirements (Mullan & Epstein, 2002). A comprehensive community-based package that includes preventive, curative, rehabilitative, and palliative services is linked with health promotion and education. In order to supplement professional service providers' capabilities and support skill development, health, education, and household promotion initiatives, home-based community caregivers receive training as educators and health assistants (Kautzky & Tollman, 2008). Accessible, ongoing, and accountable health care services are the foundation of community-oriented primary care, with an interdisciplinary team's focus on prevention, promotion, and community involvement based on a community's health needs (Longlet, Kruse & Wesley, 2001).

2.3.2 The role of home-based caregivers to persons with mental illness

HBCGs have a variety of responsibilities in the treatment of people with mental illness, including providing daily care, monitoring hospital patients and their medicines, and taking care of their finances. The HBCG supervises treatment by ensuring that the patient takes their daily medication, and affords emotional provision to the patient (Chadda, 2014). The caregiver also has to bear with the behavioural disturbances in the patient. Thus, HBCG's experience considerable stress and burden, and hence they require assistance in coping with it (Chadda, 2014). He added that caregivers tend to the patient's daily needs by keeping an eye on their mental health, spotting early indications of illness, relapse, and deterioration, and assisting the patient in getting access to mental health treatments. Chadda (2014) further revealed that most caregivers of chronic mentally ill people without having much knowledge about the condition, assume the role of caregiver, and integrate the demands of the role into their regular family chores. Aishia, Taghrid, Hassa, Afia, and Billing (2021) stated that HBCGs are frequently a significant basis of care for people with severe mental illness (SMI). He added that they provide practical and personal support. Furthermore, people with SMI often depend heavily on their caregivers, and the status of their illness. For this reason, they frequently depend on the quality of care provided to them by their HBCGs (Aisha et al., 2021).

2.3.3 The experiences of home-based caregivers of persons with chronic mental illness

Given that mental illness tends to be a chronic and demanding condition, HBCGs who provide care for patients with it have expressed feeling overwhelmed, apprehensive, and depressed (Chadda, 2014). HBCGs are faced with adverse challenges that include burnout and impoverishment, vulnerability to diseases, emotional and physical challenges (Odgen, 2004). Research conducted from different research studies reveal that HBCGs suffer from significant psychosocial problems. In a study carried out in a rural area of South Africa's Limpopo Province, Mathye and Eksteen (2016) found that caregivers of children with mental disabilities reported emotional stress, and mentioned that accessing infrastructure, knowledge, skills and training for caring and supply is exhausting on them and their families. The difficulties faced comprised depression, anxiety, loneliness, anger, fear, stigmatisation and financial problems. The level of care giving in these studies included support with daily living activities, controlling of the sickness, medications, emotional and economic maintenance (Deventer, 2017). Another study in Botswana focusing on older HBCGs found that women of old age complained of tiredness because they were regularly looking after different family members (Deventer, 2017). Furthermore, the study revealed that older women looking after family relatives who are mentally ill experienced some decline in their own health, as they had to spend more time caring for family members.

2.3.3.1 Caregiver burden

HBCGs burden is a multifaceted notion that takes into account the physical, psychological, emotional, social, and financial effects of caring for a family member with a disability (Sahoo, 2010). According to Fujino (2009), caregiver burden is a psychological condition that manifests as a mix of the physical and emotional labor, social pressure, and financial constraints that are results of caring for a patient. Home-based caregivers who provided care for an elderly person with a chronic disease

described it as a taxing job that had an impact on their mental, physical, and emotional well-being (Zubair, 2016). The HBCGs claimed that juggling their many responsibilities—including work and cooking—while providing care for elderly people was difficult for them. Some of the HBCGs found providing care to be an unpleasant task that occasionally led them to cry and use alcohol. One caregiver was described in a research by Zubair (2016) as saying: "I have been caring for them for a while now, and it is quite draining, especially when you come home and you fatigued, you can't sit, you have to cook meals for the next day, and all that. I feel emotionally, physically, and cognitively exhausted."

The HBCGs consistently believed that lack of time was a barrier to providing care for an elderly person. Some of the family caregivers decided to give up their jobs in order to provide care for the older adult (Zubair, 2016**)**. Additionally, HBCGs mentioned that it was difficult for them to juggle caring for an elderly relative on top of their regular jobs, education, and extracurricular activities. They added that the demands of caring for the elderly person were "over their shoulder" and that they had no time to relax. HBCG is typically in charge of helping patients with their activities of daily living, such as bathing, eating, cooking, dressing, taking medications, and attending hospital follow-up appointments (Ajibade, 2016). Imas and Wandee (2011), however, noted that the possibility that the home-based caregiver will encounter severe load and that this can have negative effects, increases as the length of time spent providing care, particularly for patients with schizophrenia. The transition to home-based community care for patients with mental disorders has resulted in passing on to family members the daily care of patients, which has resulted in significant psychosocial, physical, and financial demands on patients' relatives (Abdulkareem, Folorunsho & Akinsola, 2009).

2.3.3.2 Stigmatisation

One stressor that has a negative effect on caregivers of people with chronic mental illnesses is mental health stigma (Kardof, 2016; Park & Seo, 2016). Mental health stigma is when people have negative perceptions towards an individual with mental

illness (Lebowitz & Ahn, 2016). Stigma around mental illness is a societal problem that can make people feel isolated, limit their social prospects, put obstacles in the way of receiving treatment, and cause emotional frustration in both the mentally ill person and the caregiver (Wong, Kong, Tu & Frasson, 2018). The stigma attached to mental illness creates emotions of dehumanisation that relates to preconception (Lebowitz & Ahn, 2016). Associative mental health stigma is something that caregivers of people with chronic mental illnesses are likely to feel (Crowe, Lyness, 2014; Park & Seo, 2016). Associative mental stigma, according to Park and Seo (2016), is the stigma that emerges from associating with a mentally ill individual. They continued by saying that while the caregiver internalizes the social stigma, it can also manifest as self-stigma. 87% of family members and caregivers report stigma as a result of having a mentally ill family member, according to Park and Seo (2016).

Associative mental health stigma can result in frustration for the caregiver of the chronic mentally ill person, adding more burdens for them, weakening their physical and mental health (Crowe & Lyness, 2014; Gelkopf & Roe, 2014). Kardof (2016) continued by stating that blame for the patient's mental health condition may be placed on the family members and caregivers of chronically mentally ill patients. In addition, he said that when they interact with the social group, they could feel avoided and rejected. Because of associative stigma, some family members and caregivers conceal their sick patient's mental health situation, and thus increasing the distance between the individual and other members of the community (Park & Seo, 2016). A study by Ntsayagae (2019) revealed that caregivers reported that they live in fear of being stigmatised because of negative perceptions and misconceptions towards their mentally ill family members, and as a result, they experience verbal abuse and outbursts from their relatives. One caregiver quoted "I'm hurt because of words of rejection and stigma that are uttered by their neighbour about our mentally ill person." Ntsayagae (2019) that stigma and discrimination against people who live with mental illness persist. Because of the stigma around mental illness, caregivers face many difficulties, while on the other side they are dealing with the challenge of having to handle an extremely uncommon odd behaviour that is mostly frightening to them (Ntsayagae, 2019).

2.3.3.3 Violence and physical aggression

Chronically mentally ill people frequently struggle with issues of violence and physical hostility (Venkatesh, 2015; Hanzawa, 2013). Psychiatric patients are reported to have aggressive behaviours, verbal aggression, self-aggression and mostly aggression towards others, including family members and caregivers. Such aggression might result in harm and increase the caregivers' emotional stress and strain (Hanzawa, 2013). Physical aggression leads to caregivers and other relatives of the family feeling powerless and helpless because they are ill-equipped to deal with the hostility, and they might not know who to ask for help. (Hsu & Tu, 2013).

2.3.3.4 Physical and emotional exhaustion

A study by Ntsayagae (2019) revealed that caregivers report experiencing overwhelming feelings of physical and emotional exhaustion that results from taking care of mentally ill individuals. Furthermore, the caregivers reported experiencing feeling very frustrated when the sick person refuses to take medication. Caregivers of chronic mentally ill persons experience negative emotions which include hopelessness, helplessness, powerlessness and feelings of distress. One caregiver quoted that they felt "powerless and helpless" when they were powerless to stop an ill family member's combative behaviour (Ntsayagae, 2019).

2.3.3.5 Burnout

Uys and Cameroon (2003:280) define burnout as the point in life when a person can no longer manage life's challenges and stressors. This person would start to intensify a negative element in whatever they did. The individual won't have as much energy to work as previously and will become disheartened in all they accomplish. According to Uys and Cameroon (2003:280), the psychological burdens and frustrations that come with caregiving can leave a caregiver feeling burnt out and hopeless.

2.3.4 Home and community-based care in South Africa

Many non-governmental organizations (NGOs) in South Africa offer a variety of home-based care models, including home visits, home-based palliative care, comprehensive treatment and care, and support programs (Western Cape Government Provincial Treasury, 2011:19). Most of these care programs in South Africa rely on community volunteers to do basic nursing and other caregiving tasks in patients' home. Typically, these volunteers get no compensation; but, in some cases, small transportation stipends may be provided. Home-based care has advantages for the person living with chronic mental illness (PLCMI), as well as for family members in the sense that it enables the ill person to be cared for in a comfortable setting and gives them the opportunity to plan for their death and die with dignity at home. The majority of family members lack the necessary training to provide care for those who are suffering from persistent mental illness (Department of Health, 2002). Thus, NGO initiatives have intervened to ameliorate the issue by establishing volunteer-based projects. The volunteers undergo training to provide care for persons in their homes and are typically locals and family members who are otherwise unemployed. The informal home-visiting activities started by religious groups or concerned citizens are the origin of volunteer-based home care projects. However, providing care at home, whether by family members, concerned neighbours, or volunteers, can be extremely stressful (Department of Health, 2002).

According to Mousa (2018), HBCGs of patients with chronic mental illnesses are crucial to the treatment of psychiatric patients and help to prevent readmission. These caregivers deal with various difficulties in many cultures, while the caregivers of the mentally ill patient try to manage and care for the patient. Moussa (2018) further stated that they suffer great pressure physically, mentally and socially during care and control of the sick members of the family. It is for this reason that there has been a need to utilise the services of home-based caregivers. The Mental Health Care Act 17 of 2002 is steady with global human rights principles, and is centred on a systematic consultation procedure with a variety of stakeholders (Department of Health, 2002). As a main tool of

improvement such as the progress of mental health care within general health services and the reinforcement of community-based care, the Act seems to be an applicable and significant innovation in the evolution of the mental health system in South Africa. The Act also makes primary healthcare the main contact of mental healthcare with the health system, and endorses the incorporation of mental healthcare into overall health provision and the improvement of home-based community-based facilities (Department of Health, 2002).

2.3.5 Scope, availability and importance of HBC in South Africa

The service should be provided to people with chronic mental illnesses, including HIV and AIDS, non-communicable diseases like hypertension and diabetes, people with disabilities, older people, people who need long-term care, and people who are recovering from illness, per the national guidelines on HBC in South Africa (National Department of Health, 2001). Non-communicable diseases, such as cancer, diabetes, cardiovascular disease, mental illness, and neurological disorders, accounted for 16% of South Africa's disability-adjusted life years in 2000. (Levitt, Steyn, Dave & Bradshaw, 2011). The greatest cause of adult disability in South Africa is a cerebrovascular accident or stroke, which is made more likely by cardiovascular conditions and diabetes (Wasserman, de Villiers & Bryer, 2009). People who live with disabilities and chronic illnesses depend on the work of community health workers (in the broadest sense of the word).

According to the Department of Health (2001), HBC is care that is assessed nearest to their home by the consumer, which inspires involvement, responds to people's needs, constructs accountability, and encourages traditional community. The primarily aim of HBC is to make sure that customers remain self-sufficient, and the top quality of life is delivered through appropriate care, and the provision of hope. The facility mainly attracts the power of families and societies who form the foundation of the service (De Wet, 2012). A study by Bohman (2010) suggested that HBC should also pay more attention on older adults, and try to meet the healthcare necessities of elder individuals

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to let them live in their homes preferably than institutions. Harrison (2012) pointed out that with getting old, some individuals encounter more activity restrictions as deficiencies associated to vision, hearing, intellectual function, and flexibility set in. He further added that the possibility for impairment illnesses such as stroke and dementia also rise (Harrison, 2012). In general, HBC comprises an extensive range of services comprising providing basic nursing care, clinical treatment, distributing medication, assisting with essential daily tasks, and providing health education and counseling (Aantjes, 2014; Tsolekile, 2014). HBCG also comprises promoting involvement in economic activities and the development of people with disabilities (Lorenzo, 2015).

2.3.5.1 Importance of home-based care-giving

There are benefits to HBC establishment, according to Uys and Cameroon (2003:5), and they are evident. First, by enabling the sick person and their loved ones to accept that death is inevitable. Additionally, studies contend that it is less expensive when the patient is cared for by family members at home because the expense of bringing the sick and incapacitated to the hospital is significantly lower. Another recommendation from the researchers is that caregivers should receive training in the field so they can also offer the necessary support in a professional manner (Uys, & Cameroon, 2003:5). HBC centers support and ensure that issues are dealt with early on before they balloon and intensify. For instance, the HBC intervention program will stop a sick HIV/AIDS patient from infecting other uninfected community members.

2.4 Concluding remarks

Reviewing this literature has shed insights into challenges of mental illness. It also shed light on the prevalence of mental illness and how it impairs daily on the individual, and as a result, affects negatively on family caregivers. Challenges of coping with caregiving could affect the caregiver's health. This chapter has revealed that caregivers of mental ill people suffer adverse consequences which include feeling distress as a result of the

burden that comes with the caregiving role. The next chapter focuses on the theoretical frame-work relevant to the study.

CHAPTER 3
ROLE OF THEORY IN THE STUDY

3.1 Introduction

In this chapter, pertinent theories related to caregiving are reviewed. Specifically, the researcher chose to review the following theories: Attachment theory, Systems Theory, Roy's Adaptation Model and Theory of Caregiver Stress. In the last part of the chapter, the researcher critically reviews Lazarus and Folkman's Stress and Coping Theory, which is the one underpinning the study and through which home-based caregiving for chronic mental illness will be understood.

In order to better understand the caregiving process, the researcher looks at three theories and one model. These theories include Lazarus and Folkman's Stress and Coping Theory as well as the attachment theory and systems theory. These theories are relevant to home- based care settings.

3.2 Attachment Theory

Attachment theory is a psychological theory that concerns relationships between humans. The theory was developed by John Bowlby in 1958 (McLeod, 2020). The most important tenet of the theory is that infants must establish a relationship with at least one major caregiver for normal social development. According to this view, the feeding interaction between the kid and the caregiver is what causes attachment. The theory

emphasizes that behavioral and motivational patterns define ties and attachments. Bowlby thought that the early connections made between children and their caretakers have a significant, long-lasting effect that endures throughout life. Since the caregiver gives the child food, security, and nourishment, the youngster develops a bond with them (McLeod, 2020). The researcher found this theory to be relevant to the current study. According to the notion of attachment, people have an innate need to develop a strong emotional connection with their primary caregivers. In the current study, the caregiver provides nourishment and a sense of security for the patient, which results in an attachment bond. This study seeks to explore experiences of caregivers, which look at the dynamic relationship formed between the caregiver and the patient.

The theory of attachment is pertinent to caregivers who frequently grieve both before and after the passing of terminally ill patients. Most caregivers form bonds with their patients over time, and it is sometimes very difficult for them to lose them through death. Through grief counseling, the caregiver may receive support as they work through their grief and prevent depression and breakdown. Home-based caregivers must successfully navigate the grief process without denial and embrace the truth of the unavoidable loss. (Eneh, 2010:5). According to Creswell (2009:85), the need for security and protection is just as important as certain biological needs in determining the development of attachment ties between people. These bonds develop early in life and are usually directed towards specific individuals who tend to endure throughout a larger part of the cycle. Situations that threaten an intimate bond bring loss and suffering if the attachment's main goal is to maintain it. When a person experiences a loss, they all experience grief. This grief can be either physical, emotional, or behavioral (Anderson cited in Payne, 2005:142).

3.3 Systems Theory

The work of Ludwig Von Bertalanffy in the 1940s served as the foundation for systems theory (Heylighen, 2000). According to Compton and Galaway (2005:28), the systems theory facilitates in problem solving by helping the client and the professional helper

grasp the issue at hand in the context of the person-in-situation. By refocusing on the individual and circumstance as an interconnected whole rather than on linear cause and effect interactions, systems theory meets one of these needs. The Theory is less concerned with whether a person's behavior is influenced by their surroundings or whether that behavior is influenced by them. The individual is frequently seen as an essential component of his or her overall life situation. The care of persons, patients, or clients is emphasized by systems theory in human-to-human interactions. According to Anderson, the systems theory "integrates the atomistic-holistic continuum" (2005:142). In any social context, there are social and personal components that interact with one another to form a cohesive whole. This theory was also found to be relevant to the current study. In this study, caregivers who work from home get to know patients who have chronic mental illnesses, engage with them, and participate in the system. In the event that they are impacted, the entire community will also be. Researchers and healthcare professionals can spot issues in the dynamics, procedures, and transactions of the system as a whole thanks to the application of systems theory. Health practitioners can find several areas of intervention and propose new transformation tactics for old problems with the help of systems perspectives.

3.4 Caregiver stress theory

The hypothesis of caregiver stress was built using the Roy adaption model, which was developed to help understand the connection between caregiver stress and caring for a chronically ill individual (Tsai, 2003). Walter Cannon developed the caregiver stress theory around the beginning of the 20th century (Cannon, 1932). According to Cannon (1932), stress is an acute flight or fight response state that prepares an organism to handle threats. The caregiver stress hypothesis is a middle-range theory that is used to predict how stress may manifest itself along with other potential negative effects (Dobratz, 2011). Demographic traits, the difficulty of caregiving, stressful life events, social support, and social roles all predict these severe impacts. The informal caregiving stress variables that could be harmful to the caregiver's health are evaluated using the caregiving stress process model. These stresses related to caregiving are classified as

primary (physical demands resulting from a disability) and secondary (demands resulting from the caregiver role) stressors, which might alter over time (Raina, 2004). In a socio-structural process, the idea connects the micro and macro levels of stresses, resources, and results. It emphasizes the three main sources of stress: the source, the stress intervention (i.e., support), and thirdly, the manifestation of stress (Pioli, 2010).

The researcher found this theory to be relevant in the present study. The caregiving stress process model, as described by Raina (2004), examines how unfavorable life situations can have an adverse impact on the caregiver's personal life as well as their work as a caregiver. The consequences of change may be positively influenced by social support and coping mechanisms, which can help and positively support the process of change (Raina et al., 2004).

3.5 Theoretical framework of the present study

3.5.1 Lazarus and Folkman's Stress and Coping Theory

The study has adopted the Stress and Coping Theory developed by Lazarus and Folkman (1984) as a theoretical framework. According to Lazarus and Folkman (1984), for a situation to be deemed stressful, it must be appraised as threatening. Lazarus and Folkman (1984) stressed that an interrelation linking the environment and the individual exists. This person-environment interrelation is connected by two significant procedures known as cognitive appraisal and coping. When a person's coping mechanisms are strained and their bodily and psychological well-being is in danger, stress results from their relationship with their environment. A person uses emotional appraisal to evaluate and interpret a situation, then formulates a reaction based on this evaluation. Thereafter, depending upon the outcome of the transaction, can generate measurable acute and chronic psychological and somatic distress (Hellhammer, Wüst & Kudielka, 2009). On the other hand, coping is a set of techniques that the person will use to handle a particular situation that is perceived as stressful. Coping may be emotion-focused or problem-focused. Cognitive evaluation and stress-related person-environment interactions are linked to coping (Lazarus & Folkman, 1981).

The Stress and Coping Theory was found to be appropriate for the present study and the researcher opted to use it, because various studies have suggested that home-based care giving results in emotional, psychological and physical stress on the home-based caregiver (Akintola, 2008; Jack, Kirton, Birakurataki & Merriman, 2011). By using this theoretical framework, the researcher was able to determine the home-based caregivers' experiences of caring for persons with chronic mental illness. Stress is defined by Lazarus and Folkman (1984) as interactions between people and their environments in which external demands exceed personal capacity, leading to a person's psychological and physiological dysregulation. Coping is the act of deliberately using behavioral and cognitive reactions to stressful situations that are occurring or that are anticipated in order to control both the stressful experience and any negative socio-emotional and physiological outcomes.

Ajibade (2016) defines a stressor as any event that occurs in the caregiver's surroundings and has the potential to breach both the flexible line of defense and the typical line of protection, with either a favorable or unfavorable outcome. Caregiver environments can be internal or external effects or elements that are present in their immediate surroundings. In contrast to external environment, internal environmental stressors are pressures acting on the caretakers' system. In this study, "environmental stressors" are any factors that put a strain on the family caregivers, whether they be psychological, social, economic, or physical. The caregivers' capacity to adjust is either threatened or strengthened by these environmental influences (Ajibade, 2016).

Using the concepts of thoughts and behaviors people utilized in stressful situations, Lazarus and Folkman (1981) explored coping. This was a shift from past theories in which coping was described in terms of personality types or ego-psychologically driven defense mechanisms. Two main coping categories were established by Lazarus and Folkman. The first is emotion-focused coping, which is the control of feelings brought on by the appraisal process, such as anger or sadness in response to a loss assessment, anxiety or dread in the case of a danger appraisal. When evaluating obstacles, emotion-

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focused coping techniques include anticipation and enthusiasm combined with a little worry. The second strategy is problem-focused coping, which is utilized to tackle the situation directly. In the current study, the researcher also explored coping mechanisms that are used by home-based caregivers from the stress as a result of the burden associated with caregiving to the chronic mental ill.

3.6 Conclusion remarks

This chapter reviewed four theories that were found to be relevant to this study. The researcher reviewed the attachment theory, systems theory, the caregiver stress theory, and lastly, the theory of stress and coping. However the researcher only opted to use one theory, which is the theory of stress and coping. Furthermore, all four theories were critically discussed in relation to caregivers' experiences. The following chapter will discuss the research methodology.

CHAPTER 4
METHODOLOGY

4.1 Introduction

In this chapter, the researcher will outline the research design and methods that have been followed to conduct the study. In this regard, different aspects of research such as sampling, data collection and data analysis will be covered. Other relevant methodological sections such as quality criteria and ethical considerations will also be covered.

4.2 Research design

This study was exploratory in nature. According to Rangarjan (2013), an exploratory research design refers to a research problem that has not been studied and researched previously. The qualitative research approach was used to carry out the investigation. In-depth knowledge of human behavior and the factors influencing it is the goal of qualitative research. As a result, a qualitative study's research approach is different from a study that begins with an understanding to be tested, where the hypothesis frequently determines the shape, volume, and breadth of the data that must be collected. Other approaches to the study issue are pre-empted by this type of design. To comprehend and investigate the lived experiences of home-based caregivers, a phenomenological method of inquiry was adopted. Phenomenology is concerned with investigating

experience from a personal standpoint. The purpose of the phenomenological approach is understood and describe phenomena from the perspective of the actors in a situation (Bless, 2006).

4.3 Sampling and setting

The methods utilized to choose participants were purposive sampling and snowball sampling. Purposive sampling, also known as judgment sampling, is the process of selecting participants specifically based on their personal characteristics Etikan (2016). According to Faugier and Sergeant (1997), snowball sampling is a non-probability sampling recruitment method where research participants are requested to assist researchers in locating other potential participants by helping them identify people who have similar traits of interest or who meet the requirements of the research. Non-probability sampling is a technique that collects samples without guaranteeing that each member of the population has an equal chance of being chosen.

The participants of the study were selected from the Dikgopheng community at GaDikgale using random sampling method and snowball. Using these two methods for sampling (that is snowball and purposive sampling), the researcher started by contacting a pastor of a local church who also happens to have started a home-based care centre for chronic mentally ill patients in Ga-Dikgale. After interviewing the pastor, he was asked to suggest the name of another mental health caregiver within the community of Ga-Dikgale known to him/her who also specialises in the study focus. This approach was used with all the other home-based caregivers interviewed up until data saturation, or the point at which further data analysis produced redundant results and yielded no new information (Morse, 1995). The study used both male and female home-based caregivers. According to Mufamadi and Sodi (2010), who cited Kruger (1988), suggested the following rules for conducting a phenomenological study should be kept in mind: Participants should be able to communicate in the same language as the researcher to prevent the potential loss of tiny semantic nuances brought on by translating text from one language to another, and participants should (a) have an

experience linked to the topic being studied. The study sample comprised 8 home-based caregivers who were drawn from Ga-Dikgale village. 6 of the participants were females and 2 were males. Initially I envisaged that at least 12 home-based caregivers will be interviewed. However it was a challenge to reach this number as it was uneasy to identify participants. And some that were identified refused to participate in the study, hence the sample only comprised 8 caregivers from the whole Di-kgale community. The village is situated roughly 50km north of Polokwane, the capital city of Limpopo Province.

4.4 Research instrument

To acquire comprehensive information, semi-structured one-on-one interviews were held with the caregivers who provided care at home. A semi-structured interview is a conversation in which the interviewer uses questions to try to elicit information from the subject. Semi-structured interviews take place in a conversational style despite the interviewer having prepared a list of planned questions, giving participants the chance to explore themes they believe are important (Longhust, 2010). Where there was a need for clarification, the researcher probed deeper.

4.5 Data collection

Interviews were completed in a place convenient to the home-based caregiver. Three interviews were conducted in English, and 5 were conducted in Sepedi, which was the participant's preferred language. For language barrier reasons between the researcher and participants, the researcher appointed a data field worker for data collection purpose and translation. Even though the researcher had an assistant for data collection, she was also present during the data collection process to observe and she did most of the probing for the interviews that were conducted in English. Each interview lasted anything from 35 minutes to an hour. To facilitate data collection, the interviews

were audiotaped. Later, to make sense of the narrative data, the transcripts and translations into English were completed.

4.6 Data analysis

Hycner's five stages of phenomenological analysis were adopted by the researcher. Edmund Husserl (1859–1938) created this school of thought, rejecting the ideas that things in the outside world exist independently and that information about them is trustworthy (Groenewald, 2004). Later, other phenomenologists emerged and made significant contributions to this strategy (Martin Heidegger, Alfred Schultz, Jean-Paul Sartre, and Maurice Merleau-Ponty, to mention a few) (Groenewald, 2004). To analyze participant replies, the researcher used Hycner's explicitation approach, which involves investigating a phenomena while maintaining the context of the whole. The explicitation process has five steps as outlined by Hycner (1999), as follows:

4.6.1 Bracketing and phenomenological reduction

By seeking to surface the interviewees' knowledge in this step, the researcher suspends or brackets his or her prior knowledge of the phenomenon (Hayes, 2000). This entails understanding the meaning of what a person is saying using their worldview's matrices rather than what the researcher anticipates a given individual to say (Makgahlela, 2016). prior to repeatedly playing each participant's interview to gain sense of the overall tone and caliber of the interviews conducted with each participant, the researcher in the current study made sure that her presumptions were bracketed. Additionally, this was done to develop a thorough grasp of the phenomenon under inquiry, particularly from the perspective of the participant's own personal experiences. After the audios had been transcribed, translated, and examined, any potential meaning loss that may have occurred during translation was noted. The researcher re-captured the genuine substance of the statements in cases where a loss of meaning was noted by listening to the original audio interviews one more time.

4.6.2 Delineating units of meaning

This step involves identifying and isolating units of meaning that have been determined to have importance for the phenomenon being investigated (Groenewald, 2004). In order to clarify the participant's meanings, the investigator in this study carefully read every word, phrase, sentence, and paragraph in the transcript and made note of any noteworthy nonverbal signal. Repeating meanings were coded to produce meaning units from all of the transcripts.

4.6.3 Clustering of units to form themes

The researcher here tried to distill the core meaning of each unit inside the holistic framework. Or, whether there seems to be a commonality that binds together multiple relevant meanings that are expressed in different ways. Clusters of themes are frequently produced by combining units of meaning that the researcher has chosen, which also known as important subjects are or units of significance (Creswell, 1998; King, 1994; Moustakas, 1994; Adorno and Sadala, 2002). In the current investigation, the researcher organized the pertinent meaning units into clusters according to the study's goals for each participant. Repetitive or unnecessary meaning units were dropped. The convergence of some meaning units became apparent at this point, supporting particular themes for each participant.

4.6.4 Summarising each interview, validating it and where necessary modifying it

Groenewald (2004) stated that, the researcher performs a validity check at this stage by speaking with the informant again to ascertain whether the key points of the interview have been accurately documented. Any necessary changes are then made. In the current study, each transcript was summarized by the researcher, who then followed up with each participant to confirm the details in order to maintain the essential elements of the initial interviews, which were performed with the intention that each participant should be able to relate to the interview summary. The participants agreed that each summary accurately captured their personal experiences.

4.6.5 Extracting general and unique themes from all the interviews and making a composite summary

During this phase, the researcher looks for both the distinctive themes that appear in the majority or all of the interviews and the individual variations. Additionally, the researcher make sure not to group related concepts together when there are extreme distinctions (Groenewald, 2004). The researcher created a comprehensive synopsis of all transcripts in this step. The broad and distinctive topics from the interviews were determined by the researcher. The coded relevant units of meaning from each participant were preserved for each theme in the form of quotations or extracts. Then, certain coded quotations from specific individuals were kept for.

4.7 Quality criteria

In order to guarantee quality of this study, four criteria as suggested by Guba (1981) were followed.

4.7.1 Credibility

The objective of this alternative to internal validity is to show that the investigation was carried out in a way that ensured the subject was correctly pointed and described (De Vos, Strydom, Fouche & Delport; 2005). Credibility was ensured in the current study by having continual discussions about the results with a peer who was not contractually involved in order to gain a comprehensive description of lived experiences of home-based caregivers.

4.7.2 Transferability

Lincoln and Guba (2000) propose transferability as an alternative to external validity or generalisability, where the burden of demonstrating the applicability of one set of findings to another environment falls more on the researcher making the transfer. By carefully choosing participants in the current study, that is, choosing those who are information-rich cases, transferability was ensured. Home-based caregivers of patients

with chronic mental illnesses were considered to be more able to articulate their experiences in this scenario, which was more crucial to the study's conclusion.

4.7.3 Dependability

As an alternative to reliability, this method tries to take into account the fact that the phenomenon chosen for the study may vary over time, as well as design modifications brought on by a deeper understanding of the context. These assumptions are different from those that define the reliability concept (De Vos, 2005). To verify dependability, many data kinds were gathered and various conclusions were drawn.

4.7.4 Confirmability

Confirmability is the extent to which other people can concur that a study's findings are accurate. This criterion serves to confirm that participants more strongly influence findings than researchers do (Statistic Solutions, 2017). Interpretations and conclusions were linked to people and contexts other than the researcher in order to ensure data confirmability.

4.8 Ethical considerations

The safety of research participants is of utmost importance. Therefore, it is essential that their rights be protected. In this study, informed consent, privacy, respect, anonymity, and withdrawal were all taken into account as ethical considerations. The University of Limpopo's ethics committee was consulted before the study was carried out in order to obtain ethical approval. The researcher started collecting data after receiving ethical approval.

4.8.1 Permission to conduct the study

The researcher received approval from the University of Limpopo ethical committee before commencing data gathering (see Appendix 2a & 2b for English and Northern Sotho versions of the letters requesting for permission).

4.8.2 Informed consent

The researcher informed participants about the reason, goals, and purpose of the investigation of their experiences as home-based caregivers of the chronically mentally ill, as well as what will be involved and what will happen to the data they generate. This was done to ensure the issue of informed consent. Additionally, the researcher asked individuals to assent by signing a document that explains everything above without using compulsion (see Appendices 2a & 2b and 3a & 3b informed letter and from-Sepedi version).

4.8.3 Anonymity and confidentiality

The investigator guaranteed participants that their responses were used exclusively for the purposes of this study. Additionally, it was clarified to them that they will remain unknown and that no names will be disclosed. For the researcher to be able to classify the participants, numbers instead of names were used. Individuals were treated as independent people. They were allowed to apply their rights to the fullest, comprising the right to confidentiality, and the right to have their personal information not disclosed.

4.8.4 Aftercare for participants

Referrals to mental health professionals were made for support for study participants who displayed emotional discomfort as a result of their involvement. To make sure they are adjusting well after being exposed to the research procedure, regular follow-up visits will be made.

4.9 Concluding remarks

This chapter clarified qualitative research, which served as the primary research methodology for this investigation. Qualitative research aimed to search for in-depth insight into lived experiences of home-based caregivers of chronic mental ill people as they experience them. This chapter also shed light on the data collection method that

was used and how data was analysed using the five phenomenological steps of Hycner's method. The outcomes of the study, which will be examined in terms of the literature reviewed in the study utilizing Hycner's explicitation method of data analysis, will be the main topic of the following chapter.

CHAPTER 5
RESULTS

5.1 Introduction

The study aimed to explore lived experiences of home-based caregivers of chronic mentally ill patients in Ga-Dikgale, Limpopo Province The raw data from the case of each research participant was analyzed using Hycner's explicitation method. The researcher used a method that entailed closely examining the data and drawing themes from it. Demographic data about the participants is given in this chapter. Also included are the profiles and a synopsis of the instances. Before delving deeper into the experiences of home-based caregivers of patients with chronic mental illnesses, these profiles seek to provide a little background information on them. To help the reader understand the content, the encounters are organized into topics.

5.2 Profile of participants

"In total, 8 participants were interviewed". The sample consisted of more females than males, two males and 6 females. Participants were all Africans over the age of 18

years, and resided in Ga-Dikgale in Limpopo Province. All participants were given pseudonyms to protect their identity and to maintain confidentiality. Participants' demographic information is laid out in Table 1 below.

	NAME	GENDER	AGE	LENGTH OF USING SERVICES	AREA of residence
1.	Happy	Male	35	4 years	Ga-Dikgale
2.	Meiki	Female	44	4 years	Ga-Dikgale
3.	Agnes	Female	40	3 year	Ga-Dikgale
4.	Mapule	Female	50	5years	Ga-Dikgale
5.	Given	Male	45	5 years	Ga-Dikgale
6.	Alina	Female	38	4 years	Ga-Dikgale
7.	Sophie	Female	42	4 years	Ga-Dikgale
8.	Thandie	Female	47	3 years	Ga-Dikgale

Table 1 - Demographic information

5.3 Emerging themes

To create a composite summary of the transcripts, general and specific themes from the interviews were extracted using the fifth and final step of Hycner's explication approach. The following table lists the general and particular themes that emerged from the interviews:

Themes	Sub-themes
1. The role of home-based caregivers and their understanding of mental illness by caregivers	a) Participant's attribution to the role of caregiving b) Conceptualization of mental illness by participants c) Nature of services they provide
2. Challenges encountered by home-based caregivers	a) Day to day challenges that come with the role of home-based- caregiving
3. Coping strategies used by home-based caregivers	a) Participants share how they deal with caregiving challenges
4. Support systems available for home-based caregivers	a) Forms of support that were available for participants

5. The psychological well-being of home-based caregivers	a) Participants share if they need any psychological interventions
6. Suggestions for improvement	a) Participants share their views and suggestions

Table 2 - Emerging themes

5.3.1 The role of home-based caregivers and their understanding of mental illness

5.3.1.1 What participant attribute to the role of caregiving

Participants described the role of caregiving as taking care of people who are unable to care for themselves in their homes as a result of chronic illnesses, providing support and care and referring them to appropriate service providers. However, while some participants were clear on their roles, not all participants understood their roles.

"When you take a mentally ill person, the first thing that you notice is the physical appearance, the dirty clothes and the smell. So you have to make sure that you bath them, give them clothes to wear, feed them and make sure they have a proper place to sleep" participant 1.35. Male.

"We work because we are required to, and often we have no idea what we are doing. There are no protocols or policies to help us understand what our roles are. This job is incredibly hectic.'" Participant 8. 47 Female.

"Being a caregiver means you are helping someone who's unable to help themselves because they are sick". Participant 7. 42 Female.

"Participant shared that this 'role' is something that he doesn't view as "just getting the job done" for the sake of it or getting paid, but it's doing a noble thing for someone who's incapable of helping themselves, the bible also quotes "do good unto others". Participant 1. 35 Male.

Based on the above extracts, it is clear that most participants understood their role, while some felt that the scope of practice and job descriptions are not clear. It is evident from the narratives that the caregivers have now accepted the psychological burden that comes with caregiving, and have chosen to dedicate most of their lives helping their patients and ensuring good psychological well-being for them.

5.3.1.2 How participants conceptualise mental illness

Participants were asked how they view mental illness and to define the concept. Some participants defined mental illness in a cultural perspective. Most commonly, mental illness has been defined as abnormal thought patterns and actions that indicate a person has lost their sense of reality. Each participant explained how they perceive mental illness in their own terms. The quotes from the interviews that follow lend credence to their positions.

"Mental illness is associated with ancestral sickness ad causes the person to behave abnormally". Participant 2. 40 Female.

"Mental illness is madness that is associated with witchcraft". Participant 4. 50 Female.

Mental illness is a sickness that affects the brain and causes a person to behave abnormal" participant 5. 45 Male.

"When a person is mentally ill they lose touch with their self, and reality. They become confused and unaware of their actions and thoughts". Participant 7.42 Female.

"A person who has mental impairment brought on by ancestry typically does not upset people; they can engage in all forms of irrationality without offending them."" participant 8. 47Female.

"Mental illness is abnormal behavior that can't be really understood as to what causes it" Participant 6 (Alina) female 38

Participants argued that symptoms shown by mentally ill patients were understood to be severely abnormal behaviour to moderately normal behaviour. They contended that patients differ in their behaviour. Some displayed severe symptoms while others showed moderate symptoms. Some disturbing antisocial behaviours that were reported include, shouting, screaming, crying, beating them when they try to calm them, singing and laughing uncontrollably. Some even wander in the streets and eat food from garbage bags.

"Mental ill people can sometimes be dangerous, and they are capable of self-harming and inflicting pain on those around them" I don't want to lie sometimes I become afraid for my own wellbeing" participants 6. 38Female.

A mentally ill person can be recognised through their behaviours; they usually wander around, collecting rubbish and appear messy most times" participant 8. 47Female.

"Mental illness has different ways and people show different behaviour. Mental illness impairs the psychological well-being of an individual which makes them act odd sometimes" Participant 1. 35 Male.

From the above narratives People obviously assign meanings and perspectives to particular circumstances based on how they feel and how they have experienced them. It is also evident that a mentally ill person can be dangerous and inflict injuries on themselves. Some participants believe that mental illness is caused by external factors such as ancestral beliefs and witchcraft. Even though psychological factors are attributed to mental illness as the core cause, some believe that psychological factors are not always the sole contribution to mental illness.

5.3.1.3 Nature of services they provide

Participants outlined the type of services that they render to chronic mental ill patients. They argued that they perform daily tasks such as cooking, cleaning and bathing those who are unable to bath themselves. They stated that they also ensure that patients do

not default on their medication and do not miss any doctor's appointment by also accompanying them. *"We ensure that their health needs are met at all times",* one participant said.

"It's my duty to make sure doctor's appointments are not missed for medication collection, so I make it a point to go along with" participant7. 42Female.

'Without the medication, she doesn't function well, so I make sure she drinks every day, same time after meals" Participant 3.40Female.

"People's needs differ, some are not that disabled, they can actually feed, bath and clothe themselves" it's not in all cases where I have to perform all these duties, sometimes I just monitor because it's my job to do so" participant 1. 35 Male.

I help him with daily needs such as ensuring he eats, and he looks presentable always and I ensure he takes medication Participant 6. 38 Female.

It is clear from the extracts above, that caregivers' role may differ based on the needs of the sick person cared for. Although these caregivers may not be professional mental health care providers, their psychological support is evident, such as offering emotional support to mentally ill people. It is evident that caregivers play a huge role on the psychological welfare of patients.

5.3.2 Challenges encountered by home-based caregivers

5.3.2.1 Day to day challenges that come with the role of home-based- caregiving

Participants highlighted how performing their daily jobs without proper training poses a challenge for them to work effectively. They argued that the government was not providing them with enough training. Participants also shared how patients can be physically aggressive towards them sometimes, and how uneasy it is to stabilise them

and bring them back to their right senses. They posited how the caregiving role is a challenge sometimes as it comes with an emotional burden. Some participants shared how stigmatisation and people's negative perceptions regarding mental illness has affected them and their social lives. Participants' narratives of their challenges include the following:

"My social life is affected as I'm always viewed as the person who stays with a mad person" Participants6. 38 Female.

"It would be wonderful to be given training and more information so that I may know what to do when we visit the patients and how to respond to their queries. When a patient has a question, it is upsetting when you are unsure of how to respond because they believe we are experts since we are their regular caregivers. We need training" Participant 5. 45 Male.

"It's not an easy thing to do I must be honest with you. They beat me, they literally beat me, they kick me, and they break windows. There are some things that they do that you cannot share with people, and you can't even chain them because it's not within the laws of government" Participant 1. 35 Male.

"I always have to beg him to take medication and eat food, and as a result he would get aggressive because I'm asking him to do something that irritates him at that time". Participant 6. 38 Female.

Participants showed a great desire for medical professionals to be interested in their work, recognize them and the difficulties they confront, and support and appreciate them. They complained that their relatives and the neighborhood had failed to acknowledge them. When caring for patients in their homes, they claimed that neither they nor the medical staff were treated with the respect they needed. Participants claimed that the medical staff at the clinics was unfriendly; as a result, some are discouraged from accompanying their patients to the clinics since the medical staff does

not view them as colleagues. They complained about the lack of understanding, assistance, and respect from medical experts.

"Despite the fact that our services are required, we are completely unrecognized by clinic health officials." participant 6. 38 Female.

"We require training and being acknowledged. We are not viewed as important or doing a professional job by the nurses. They view us as a cheap labor force. We don't see the medical staff coming to encourage us." participant 3. 40 Female.

5.3.2.2 Physical and psychological exhaustion

Participants complained about extreme fatigue and body aches sometimes. They shared how the caregiving role can be exhausting, especially the much older adults. They mentioned how very challenging it is physically and emotionally to deal with sick patients that do not always listen and cooperate. They mentioned that some patients do not make their job easy on them. They also shared how some patients make their caregiving role extremely difficult by refusing to take medication or eat; and some even get physically aggressive towards them. Participants share their experiences.

"Sometimes when you try to calm them down and assist, they get physically aggressive. It's physically tiring" Participant 4. 50 Female.

"I once found him on the street dirty and looking disoriented, I tried walk back with him, so that I can assist him bath and eat, but he wanted to physically attack me and started swearing at me. This job is very challenging" Participant 2. 40 Female.

"I mostly suffer from fatigue because I work long hours sometimes, the chores of cooking and cleaning after a sick person can be extremely exhausting" participant 7. 42 Female.

"What people don't know is that looking after a mental sick patient is actually frustrating and tiring. It's a full-time job, and it takes up a lot of your time and social life" Participant 8. 47 Female.

"it can be emotionally physically exhausting at times, but then again, I volunteered, no one forced me to take this role" participant 1. 35 Male.

"I get extremely physically exhausted and it's also draining emotionally too. Sometimes you feel overworked and burdened" Participant 6. 38 Female.

"He becomes aggressive when you reprimand him about something wrong that he does it's physically and emotionally challenging" participant. 50. Female.

5.3.2.3 Poor remuneration

Participants complained that the stipends that they receive are insufficient. They said that the stipend was insufficient to meet their basic necessities and the needs of their families. They noted that having to wait a month to receive the meager pay on occasion severely demotivated them. Participants share their views below.

"The fundamental issue here is a financial one. We feel discouraged because of this problem. R1000 is a pitiful amount of money to make a good living. I really enjoy my work, but to be quite honest, the pay is very low, and doing this job requires a lot of emotions sometimes so much that you need counseling." Participant 2. 40 Female.

"What can you buy with R1500? If you spend it on food, you won't have any money left over the next day to even visit the patients. They need us but pay us so little. There are moments when it seems preferable to simply stay home." Participant 8 .47Female.

"The money is not there I won't lie; I just do it because sometimes something is better than nothing" Participant 3. 40 Female.

From the above extracts, it is clear that caregivers suffer great consequences. The caregiving role is challenging as narrated by the caregiver participants. It is evident that this role can lead to adverse psychological consequences such as stress and depression as a result of the heavy burden that comes with it.

5.3.3 Coping strategies of home-based caregivers

5.3.3.1. Participants share how they deal with caregiving challenges

Participants argued that they can barely cope, and patients do not make this role easy on them. They mentioned how sometimes they feel powerless and helpless. It was also revealed that participants sometimes rely on group support, and when they gather as caregivers to discuss their mutual challenges, it is a way of coping for them. Participants shared how they sometimes get overwhelmed by the caregiving role, and that prayer works for them in such instances. They also shared that they reach out to family and friends to help them cope. Participants share their experience as follows:

"Sometimes I feel helpless and powerless because there's not much I can do especially when she gets aggressive" Participant 4. 50 Female.

"It's a way of life, sometimes I don't even see it a challenge anymore that makes me want to cope from, it's just a way of life, the way I have decided I'm going to help the people. It's not easy sometimes, I even pop out my own money and I'm not employed, but I use my own money to feed these guys. So it doesn't cost me anything, I don't have to cope it's a way of helping people and I voluntary chose to take in mentally challenged people in my own home" participant 1. 35 Male.

"Coping with a difficult patient, is hard especially when they become aggressive you just have to distance yourself and let them be until they calm down on their own" Participant 5. 45 Male.

"There's really not much you can do especially when dealing with a difficult patient, after all we are not professionally trained to deal with this kind of situation". Participant 3 .40 Female.

I'm a spiritual person so I pray a lot; I think that has helped me to cope". Participant 4. 50. Female.

"I don't cope with anything but prayer, what else we can do; we are not even taken seriously from a professional level". Participant 6. 38 Female.

"I pray and tell myself all will be well" Participant 2. 40 Female.

I create a comfortable relationship with the patient so she can feel secure and comfortable around me. This makes my role so much easier " Participant 8. 47 Female.

It is evident from the above extracts that caregivers sometimes struggle to cope with the burden and distress that stems from the role of caregiving. It is clear that as overwhelming as this role can be on the caregiver, it is how they perceive and choose to deal with the circumstances that makes them able to cope, which supports Lazarus's theory of coping appraisal. This suggests that how caregivers respond to and interpret stressors in their life is determined by their coping appraisals.

5.3.4 Support systems available for home-based caregivers
5.3.4.1 types of support available for participants

Participants argued that they do not really have sufficient support systems from the government and family members; and that there is no adequate professional health system. Others argued that they do receive support from family members. They indicated how family members are absent physically and emotionally from patients' lives, and shared how this is also a contributing factor in making the caregiving role very challenging. One participant shared how he does not need any support from family

members. He always rejects their financial assistance because he voluntary took this role as a church leader to help those who cannot help themselves.

Participants share their experiences below.

"Some family members are fully supportive and very much involved. It actually makes it easier and less burdening when the caregiving responsibility are shared with members of the family for the wellbeing of the patient". Participant 8. 47Female.

"There's no support system at all, it's actually very sad the things we see in other families because of SASSA grant money the patient receives. Members of the family will actually completely forget about their sick family members and their needs, just to satisfy their own greed, People are greedy and only care about the SASSA grant. What happens to the sick individual, and how they survive is actually none of their concern? In most cases you find that the patient can't even speak for themselves, and who are you to say anything on their behalf? Next thing you'll be accused that the only reason you are assisting this person is because you are also after the SASSA grant while that's not true. Some of us actually have a good heart and empathy for others" Participant 6.38 Female.

"I volunteer to help and take in mentally challenged patients in my home. So I don't receive anything from the family members. At some point one family wanted to buy food and give me the SASSA grant money, but I stopped them because I volunteer to assist the people and I don't want people's money, it has got nothing to do with whether the family is getting SASSA grant at home for that particular individual and this particular individual I'm talking about has been living in the street for over 20 years and now the family thinks we are helping him because we want his SASSA grant money but the truth is we don't. I use my own money, my own personal budget to maintain these guys" Participant 1. 35Male.

"There's not much support, one thing I have realised in my years of caregiving, is that most families are afraid of the caregiving role. They are afraid to take on any family

member that's not well and can't look after themselves because they are afraid of the burden that comes with being a home-based caregiver and I don't blame them, because it's a full-time challenging job that requires most of your time and energy" Participant 7 42. Female.

"Yes, there is support from families; and the SASSA grants are helping" Participant 3. 40 Female.

"No there's no support from family members. It's sad how some families forget about their mentally ill relatives" while some are even using their SASSA grant for their own personal needs and forget those of the patient". Participant 5. 45 Male.

"I think I can say there's assistance from government through the SASSA grants. It assists because that's the money we use to feed, and buy basic necessities for patient". Participant4.50 Female.

"I don't think there's sufficient support at all even the grant we receive it's not enough to cover all monthly basic needs, especially food. This person requires more than 3 meals a day" Participant 3.40 Female.

From the above extracts, it is evident that lack of support is likely to result in a psychological relapse for a mentally ill person. It is clear also that the caregiver's mental well-being is also affected at some point while trying to manage the person's health and give them full support. It is also revealed that families contribute a lot to the patient's mental well-being by being present.

5.3.5 The psychological well-being of home-based caregivers
5.3.5.1 Participants share if they need any psychological intervention

Participants provided feedback that certainly demonstrated there were negative psychological consequences stemming from the work that they do with patients. Five participants out of 8 pointed out the need for psychological intervention for caregivers, and pointed out that they are feeling psychologically exhausted, frustrated and have feelings of giving up as a result of this role. However, some participants did not express any need for psychological interventions. The discussions and narratives were expressed in the following:

"The emotional experience that I once experienced was after I have tried to help the patient by bathing him, feeding him and hours later he died. I was emotionally disturbed, even though death is part of us and it's inevitable, but truth is no one can truly prepare for it" Participant 2. Female 40.

"For us to be able to share our emotions and receive professional help, we need group therapy. Furthermore, we do not use counsellors to provide counselling as part of our caring obligations." Participant 7. Female 42.

"We do not see the medical professionals who are supposed to be encouraging us. We don't often receive counselling. Given how difficult the work we do is, debriefing meetings where we can discuss our issues would be tremendously helpful." Participant 8. Female 47.

"No, I don't really need psychological help, I am normal. I don't have psychological issues. Yes, everybody needs psychological assistant at some point, even psychologist is not normal, we all need help at some point but not concerning this for me" Participant 1. 35 Male.

"I think at some point I did feel like I needed some kind of assistant. I was a caregiver for a very close family member that literally died on my watch, in my hands. It was a very painful experience that would psychologically disturb anyone who finds themselves in that predicament" Participant 5. 45Male.

"I don't really understand those things. I think the truth is that in our black communities we are not much familiar with psychological concept. We pray and face each day as it comes" Participants 3. 40 Female.

"No, I don't think I do need any psychological intervention" Participant 4. 50 Female.

"Yes, I think I do need psychological intervention "Participant 6. Female 38.

The above extracts reveal that the psychological strain that comes as a result of caregiving is overwhelming and unavoidable. It is clear that the impact of mental illness not only affects the patient, but also the people close to them, including family members, close friends and caregivers. It has been revealed that caregivers suffer serious psychological consequences. For this reason, psychological support is needed.

5.3.6 **Suggestions for improvement**

5.3.6.1 Participants share their views and suggestions

Participants suggested the need for recognition by health workers and government. They mentioned how being a home-based caregiver is almost the same to being a professional nurse, because you basically do the same job nurses do in hospitals, which is to take care of sick people. Participants argued for the need for psychological support, and emphasised how they want the government and healthcare professionals to take home-based caregivers seriously and acknowledge their contributions to the community, by providing proper and well-equipped facilities for them. Some participants strongly felt that there are no sufficient healthcare services and trained professionals in the community. They revealed that they have to wait long hours to be assisted in healthcare facilities and how frustrating this is.

5.3.6.2 The need for financial gains

Participants come from backgrounds that are similar to those of their clients in terms of financial instability. They reported that they are not coping financially and do not benefit much as home-based caregivers. They felt that the efforts are not rewarded appropriately. They noted that they receive no benefits and that the stipend is insufficient.

"I would like more financial assistance to assist with monthly needs" Participant 2. Female 40.

"It would be much better if they paid us the same way government employees get paid, with benefits" Participant 8. 47 Female.

5.3.6.3 Psychosocial support

Some study participants mentioned various psychosocial support needs for patients, families, and caregivers. These findings are in line with prior research on caregivers of patients with chronic illnesses, which showed that these individuals were at risk of feeling burdened and that this risk was linked to high levels of psychological distress and anxiety.

"This is draining us psychologically, maybe if we can get advice on how to cope with this role" Participant 7. 42 female.

5.4 Summary of results

The sample comprised eight (8) participants aged between 35 and 50 years, who are family home-based caregivers residing at Ga-Dikgale in Limpopo Province, and were working in this role for roughly 3 years and above. All participants were drawn from Ga-

Dikgale trust and were Sepedi- speaking. Three participants were English-speaking. Two participants were interviewed together because they were working closely together, while the rest were interviewed separately for the researcher to have a comprehensive knowledge of their lived experiences and perspectives from each home-based caregiver. Results of this study showed that participants have a range of lived experiences on the caregiving role. While most participants revealed being overwhelmed by the role, a few felt it was not overwhelming for them. The study definitely did reveal a pattern in terms of home-based caregivers' experiences and challenges from participants. The conceptualisation of mental illness revealed how most participants are not ignorant when it comes to understanding underlying issues faced by their patients. This revealed to the researcher that mental health awareness programmes are undoubtedly reaching out to disadvantage communities also, and adults are getting informed about challenges of mental illness. However, their conceptualisation overlaps considerably and seems to be culturally defined by some.

Participants stated that they feel competent to a certain level, but emphasised that they are inadequately trained. Suggestions about training skills, attending workshops and at least weekly classes will enhance their knowledge and skills. However, they encounter numerous challenges that they attribute to a lack of collaboration between home-based caregivers and departments to which they refer their patients. The care-givers reported that their patients do not always receive the assistance they require, with some waiting years without any progress. This makes home-based caregivers appear incompetent and of no value to the community; hence it becomes more difficult for them to carry out their work because community members and health professionals do not take them seriously, and give them the respect they need. The study also revealed the issue of SASSA grant not being used for the benefit and wellbeing of patients. However, this is not new information, and is quite common in South Africa. Participants stated how they wish there could be a proper allocation of funds towards the families of caregivers, patients and caregivers. As much as some expressed the importance of the SASSA grant, they still feel that it is not enough and because it is not always used for its rightful purpose, which is to help sick patients. This study revealed the need for collaboration

between professional health workers and non-professional home based caregivers to understand the needs and wellbeing of patients, and to help enhance the skills of home-based caregivers. The study therefore assists in identifying best practices and identifies factors that have a negative impact on home-based caregivers' service delivery.

CHAPTER 6
DISCUSSION OF RESULTS

6.1 Introduction

In this chapter, the results are discussed and related to existing literature on the subject under investigation. Each of the themes that were presented in the results chapter is presented and discussed in relation to previous studies.

6.2 Discussion of experiences of caregivers based on emerging themes

6.2.1 The role of home-based caregivers and their understanding of mental illness

6.2.1.1 What participants attribute to the role of caregiving

The findings of this study revealed that participants are well aware of what being a home-based caregiver is. They explained that being a home-based caregiver involves helping the sick by providing accessible care, support and meeting their health needs at the residence of patients, which supports the definition by the World Health Organization (2015). Home-based care (HBC) is a term used in South Africa to describe the delivery of medical services by formal and informal cares within the home with the goal of promoting, restoring, and maintaining a person's optimal level of comfort, function, and health, including care for a dignified death. Participants also reported having little knowledge of and training in regards to the definition of roles and training necessities, which had a detrimental effect on the quality of the services provided.

6.2.1.2 How participants conceptualise mental illness

Mental illness was understood to present in terms of behavioural indications and disrupted thoughts. Mental illness was commonly defined as when a person loses touch with reality and behaves strangely due to aberrations in their thoughts, routines, and behaviour. Presenting antisocial behaviours, saying meaningless things and confusion were pointed out as factors indicating mental illness. Participants' views are also

consistent with the view by Butcher et al. (2010) who pointed out that Abnormalities in thought, feeling, or behavior are hallmarks of mental disorders. According to Butcher et al. (2010), mental illness is viewed as a clinically relevant behavior or psychological syndrome linked to suffering or impairment. Participants also suggested that witchcraft and ancestors' beliefs can result in mental illnesses, and that a person who is mentally ill can be easily identified through their odd behaviours. The participant's views of mental illness being a result of ancestral calling, are consistent with the view by Nyowe (2015), who asserted that ancestors are members of the family who have died away and are thought to be active in the spiritual world. They serve as the family's protectors and spiritual leaders. According to Nyowe (2015), African epistemology is predicated on the idea that the visible and invisible worlds are interconnected and have an impact on one another. The odd behaviours of someone with mental illness are the first indications that the ancestors have selected that person. The study further revealed that a mentally disturbed person can harm himself or herself and be dangerous towards others.

6.2.2 Challenges encountered by home-based caregivers

6.2.2.1 Day to day challenges that come with the role of home-based-caregiving

The study found that HBC has grown in importance as a component of the community healthcare system as South Africa continues to struggle with chronic non-communicable diseases, which are exacerbated by a lack of resources. The provision of HBC is not without difficulties, though. Some of the challenges revealed in the study included lack of training, dealing with difficult patients and the issue of their services not being recognised by community members and health professionals in the clinic. A few participants shared how the issue of stigmatisation affects them and how the society views them as "people who live with a mad individual". Participants shared how this negatively impacts on them. Based on these findings, it is evident that Participants demonstrated emotion-focused coping in the appraisal of challenges as suggested by Folkaman and Lazarus. The participants have made suggestions that reveal that they have tried to gain control over their emotions by altering the meaning of a stressful

situation. The findings also support Seo and Park's (2016) argument that family caregivers of chronic mental ill people suffer a lot of stigma as a result of a mental ill family member. Also, the findings revealed that the issue of insufficient funding and poor remuneration poses a challenge on their work and   demotivates them.

6.2.2.2 Physical and psychological exhaustion

Participants revealed that the psychological and physical exhaustion mostly stems from aggressive and difficult patients. The study also revealed that being a home-based caregiver for a mentally ill patient can render you to high risk as a result of patients who are physically aggressive towards you. According to Hanzawa (2013), violence and aggressive behaviour is a common problem among chronic mental ill patients. He further revealed that these patients are not only physically aggressive, but can also be verbally aggressive and self-aggressive (Hanzawa, 2013). Participants also revealed that this job is not easy and has a lot of emotional and psychological effects as a result of the burden that comes with the role. This supports AE-Ngibese (2015) and Zubair's (2016) contention that home-based caregivers experience psychological problems that are a result of the burden of caring for people with chronic conditions. The findings of this study are consistent with previous studies. For example, a study conducted by Zubair (2016**)** in the Western Cape discovered that home-based caregivers were unable to deal with the emotional challenges and stress that came with caring for older persons living with chronic sicknesses. Similar studies were arrived at by Farshid (2015), who discovered that the effects of caregiving reveal that one-third to one-half of HBC suffer extreme amount of psychological distress.

6.2.3 Coping strategies of home-based caregivers

6.2.3.1 Participants share how they deal with caregiving challenges

Participants   argued that they mostly need to cope with the burden that comes with caregiving, which includes dealing with difficult patients, an issue of not being well

trained for the job. What stood out the most was that some participants shared how they mostly rely on prayer to cope when the job gets too overwhelming for them. They also have their own support groups whereby they share their experiences, and this somehow helps them cope as they motivate each other. This is supported by a study by Moahi (2007), where caregiver participants shared how they rely on God for coping with their role. However, this did not apply to all participants. This is supported by Thapa, Sung and Klingbeil (2015) that various cultural practices, such as coping mechanisms, familial bonds, and religious convictions, affect people's readiness to seek assistance and capacity to respond to mental health services. The researcher noted that participants did not share any specific coping methods. They just indicated that there is not really much that they can do to deal with challenges because this is the only way they can make a little income for themselves and be able to feed their families. A female participant did share that creating a comfortable relationship with the patient makes them feel secure and comfortable, and seemed to work for them when coping with difficult patients. This is supported by the theory of stress and coping by Lazarus and Folkman (1984) which states that coping is determined in terms of personality styles or defence mechanisms derived from ego psychology. How a person perceives a difficult situation will determine how they will decide to deal with it. Lazarus and Folkman (1984) identified two main categories of coping strategies: (1) emotion-focused coping, which refers to the regulation of emotions generated by the appraisal process, such as anger or sadness in response to the appraisal of loss, anxiety or fear in the case of the appraisal of threat, and eagerness and excitement, mixed with some worry, in the case of the appraisal of challenge. Based on the two coping mechanism noted by Lazarus and Folkman, it is evident that participants relied on both problem-focus coping mechanism and emotion-focused coping mechanism. Participants' resort to prayers is an emotional response to a stressful situation that helps them to cope. Furthermore, participants building a safe and secure relationship with the patient to help ease the tension and manage the challenge is regarded as problem focus mechanism by attempting to modify the circumstances as suggested by Lazarus and Folkman (1984). The theory's relevance's was proven in this study because it was revealed that a person's daily environment can determine their psychological well-being; and cognitive

appraisal plays a huge role on how an individual decides to cope with complex stressful situations.

6.2.4 Support systems available for home-based caregivers

6.2.4.1 Forms of support available to participants

According to Ntsayagae (2019), the act of providing care might make a person feel alone and alone. A protective element against psychiatric problems is social support. According to research, the stress that family caregivers felt was due to a lack of crucial assistance.. The study revealed that not all participants receive enough support in their caregiving role. The majority of participants felt that there is not enough support. They shared how family members are emotionally absent from the patient's life. Participants felt that some family members only cared about the patients' SASSA grants and did not care about their well-being. The study revealed that some families do not have any interest in their sick family members, but only care about money that they receive though their terminal illnesses. Banyini (2012) revealed that on many instances, due to their lack of understanding of the condition, family members reported they were unable to support their loved ones who were caring for a sick family member. However, some participants shared that family members are supportive and felt that the SASSA grant received from government monthly is support enough, which makes their role less of a burden. Participants felt that the support they receive lessens their burden in this caregiving role, and improves the wellbeing of patients and caregivers. This has been revealed to be consistent with Musunga's (2016) suggestion that for the sake of the mental illness-affected family's wellness, social assistance is crucial. The study also revealed that there is not enough support from healthcare professionals.

6.2.5 The psychological well-being of home-based caregivers

6.2.5.1 Participants share if they need any psychological interventions

Studies by Schulz and Sherwood (2008) and Shah, Wadoo, and Latoo (2010) found that taking care of others may put a strain on the caregivers' mental and physical health. Participants revealed that there are consequential psychological effects stemming from the work that they do as caregivers. Five participants out of 8 pointed out the need for psychological intervention, stating that they were psychologically exhausted, frustrated, and had feelings of giving up. These findings collaborates Lazarus and Folkamn's theory which stipulates that cognitive appraisal plays a huge role on how an individual chooses to cope with emotional threatening situations. Caregivers experiencing feelings of giving up suggests that at times they are unable to adopt the two coping mechanism suggested by the theory and as a result they experience feelings of frustration. Findings revealed that most participants need psychological intervention to express their feelings and receive therapy for their frustrations as a result of this role. They felt that they need to receive counselling as a result of traumatic experiences they encountered previously, such as the death of a patient in their care. However, some participants did not express any need for psychological interventions and felt that they were coping well.

6.3 Suggestion for improvement

Participants suggested the need for recognition by health workers and government. They mentioned how being a home-based caregiver is almost as equivalent to being a professional nurse, because you basically do the same job nurses do in hospitals, which is to take care of sick people. Participants shared the need for psychological support. They emphasised how they want the government and healthcare professionals to take home-based caregivers seriously and acknowledge their contributions to the community, and provide proper and well-equipped facilities for them. Some participants strongly felt that there are no sufficient healthcare services in the community, and that there is a lack of trained professionals. They revealed that they have to wait long hours to be assisted in health care facilities, and how frustrating this is. The study also revealed that participants need more financial gain from this role as they felt that they

receive insufficient remuneration. The study also revealed that participants need psychosocial support for both patients and caregivers. These findings are in line with those of past research on those who care for people who have chronic illnesses, which showed that they were vulnerable to feeling burdened by their patients and that this emotion is linked to high levels of psychological distress and anxiety. According to Imas and Wandee (2011), a home-based caregiver is more likely to endure severe load and psychological discomfort the longer they provide care, especially for patients with schizophrenia, and this can lead to adverse consequences.

CHAPTER 7
SUMMARY AND CONCLUSION

7.1 Introduction

The aim of the study was to explore lived experiences of home-based caregivers of people living with chronic mental illness. The objectives of the study were: to assess the nature and types of care provided by home-based caregivers (HBCGs) for people with chronic mental illness; to identify challenges experienced by HBCGs; to determine coping strategies used by HBCGs; and to determine types of support available to HBCGs taking care of PLCMI.

7.2 Summary

Firstly, the role of caregiving was understood to be providing patients with high-quality, appropriate, and accessible care at home in order to support their independence and maximize their quality of life. The study revealed that even though not all caregivers' experiences were the same, there is, however, a consistent pattern in their challenges, which are consistent with previous findings (Motswasele-Sikwane, Madumo, Moipone, Tlapu & Govender, 2020). Mental illness was understood to be distortions in behaviour and thoughts. Some participants defined it as a result of psychological issues, while others believed it was traditionally related. It was also revealed that almost all HBCs in the study experience psychological challenges at some point relating to the HBC role. Despite the diligent work of HBCGs in the community, the study also revealed a lack of cooperation between HBC programs and the government. Participants lamented the lack of assistance and respect they received from the community, patients, and healthcare workers. Patients and other healthcare professionals generally don't respect or support HBCGs. Their frustration grows as a result. Participants said they needed psychological support to handle the difficulties faced by HBCGs. According to a study conducted in South Africa by Ramathuba, Mashau, and Tugli (2015), psychotherapy is necessary for the HBCs to have a laser-like concentration. The study also showed that HBCGs were able to explore their perspectives on difficulties they faced while doing

home visits thanks to effective psychotherapy. HBCGs can communicate their anxieties and worries in individual psychotherapy, which is a helpful approach for crisis management.

7.3. Implications of the study

The results of this study show different areas of practice related with the employment of home-based caregivers. Home-based caregivers appear to have insufficient resources and assistance. To help with the caring challenges that they experience working in private South African homes, support is crucial for caregivers. Caregivers of chronic mentally ill people face different challenges regarding their lived experiences. Caregivers' responses to challenges are guided by their culture, friends and family support. People have various beliefs, attitudes and knowledge about mental illness and its causes. The lived experiences of caregivers of chronic mentally ill people are sometimes affected by community perceptions and cultural factors. The study's key finding is that there is a pressing need to raise awareness of mental illness and its causes. The first step should be to lessen stigma inside the family, and to lessen societal stigma and ostracizing behavior toward those with mental illnesses and their families. There is also a need to train, register and recognise health caregivers as professional health care providers.

7.3.1 Implications for theory

The findings of this study revealed that the adverse psychological challenges that come with caregiving may lead caregivers to stress that they will eventually need to cope in order to make this role less challenging, and for the betterment of their psychological and physical wellbeing. This correlates to the Lazarus and Folkman (1984) stress and coping model, which was discussed in chapter three and was helpful in understanding and analyzing several parts of the research study on the impact of context and caregiver stress and coping on caregivers' experience. The model emphasises the environment one is exposed to as the reason for stressors in life; and coping is

determined in terms of personality styles or defence mechanisms derived from ego psychology. How a person perceives a difficult situation will determine how they will decide to deal with it. It was evident with the findings of this study that as stressful as the caregiving role is, caregivers' perceptions and their emotional responses to the stressful situation determines how they choose to cope with the role.

7.3.2 Implications for policy

This study offers healthcare professionals insight into the difficulties caregivers confront in their social environments and the coping mechanisms that patients employ. The results of the current study can aid in the development and use of well-informed interventions and help policymakers gain a deeper knowledge of the experiences of home-based caregivers. The results of the study can also be used to make decisions, take action, and carry out community psychosocial mental health education programs. This can be done by educating people about psychological challenges that are faced by chronic mentally ill people, family members and caregivers. The study also questions whether enough policies and working guidelines are available for employed mental health caregivers. The findings do indicate that this caregiving population needs new policies and procedures to be developed. The results of this study show that organizations and unions provide home-based caregivers a voice in society, which, in their opinion, is currently lacking. If current unions and policies are improper for employed caregivers, it is recommended that this study leads to the implementation of unions, policies and working guidelines that clearly stipulate job description, role clarifications and acts that will serve, guide and protect the rights of informal mental health-care workers in South Africa. If there are previously established unions available to such persons, then greater awareness of their existence may encourage both caregivers and employers to adhere to prior set norms and laws within the workplace.

7.3.3. Implications for practice

The proposed intervention strategies on policy implementations for a South African context based on the findings of this study will enhance a better working environment for caregivers in South Africa. This will create a platform where grievances will be shared and solutions provided. It will give caregivers a voice as the current study suggested they do not have one. This will lead caregivers to do better in their work.

7.3.4 Implications for further research

This study suggests that exploratory research designs be applied in qualitative ways in further investigations. In-depth and descriptive information about each participant's experiences playing the caregiver role was gathered through the use of semi-structured one-on-one interviews and focus groups. As a result of this study's focus on caregivers who support patients with persistent mental illnesses, it is recommended that further research be done on these populations as well as other caring groups who might have an underrepresented voice. Investigating whether other caregivers providing care in South African homes for individuals with various chronic illnesses would have comparable perspectives on and experiences with caregiving might be valuable. Possible research suggestions for further studies within this topic include working towards implementing a successful collaboration model\policy between informal mental health caregivers and professional mental healthcare providers.

7.4 Limitations of the study

Firstly, the Sepedi to English translation of the interview data may have resulted in the omission or incorrect replacement of the rich data originally provided by participants. Secondly, the study was limited to Ga-Dikgale in Limpopo Province; therefore, findings reveal only significant and limited lived experiences of home-based caregivers in this area. However, based on literature and observation, HBCs' actual experiences are comparable in other provinces and regions. Thirdly, this study relied only home-based caregivers' personal lived experiences, and other people, Patients, for instance, were not interviewed. As a result, the current study's interpretation of the phenomenon was

biased. Lastly, as the objective was to understand home-based caregivers' experiences in depth, the number of participants was small, thereby affecting the generalisability of the study.

7.5 Recommendations

Despite the shortcomings mentioned above, this study has advanced our knowledge of South African caregivers for patients with chronic mental illness. The study also deepens our comprehension of the requirements and difficulties faced by carers who provide care at home. It looked into the experiences of HBC and the psychological effects of their labor. It also looked at coping mechanisms used by HBCs in the workplace. As a result, the study helps identify optimal practices for HBCs and elements that have a detrimental effect on HBCs' service delivery. Many difficulties were revealed by the HBCs' lived experiences, and suggestions were provided. There is a request for policymakers to address the needs articulated through regulation to control the training of HBCs that will guarantee their distinct roles and job descriptions. It is suggested that the state takes action by increasing the payment of HBCGs who deliver a crucial service to the healthcare system. The report also suggests that in order to facilitate support for HBCs, the Department of Health, NGOs, and community healthcare services work together. To maintain the HBCGs, policies and support systems must be improved or enhanced to deliver comprehensive and incorporated care.

7.6 Conclusion

According to the study's conclusions, HBCs have requirements and issues that can be resolved by various stakeholder responses. These answers include regular, encouraging supervision, mentoring, efficient coordination amongst healthcare workers, and community participation in patient and family care. Any home-based palliative care service should include a well-designed caregiver program to train carers because the tasks and responsibilities assumed by HBCGs are not recognized and are undervalued in South Africa. In order to manage the stress of caring for patients in households, HBCGs will benefit from psychological support.

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APPENDICES
APPENDIX 1 (a) SEMI-STRUCTURED INTERVIEW GUIDE (ENGLISH VERSION)

OBJECTIVES	INTERVIEW GUIDE
1. To understand the nature and type of care provided by home-based caregivers (HBCGs) in Ga-Dikgale to people with chronic mental illness	a. What do you understand as your role in the kind of work that you do? b. outline the nature and type of work that you do as a home-based caregiver
2. To investigate the challenges experienced by HBCGs in Ga-Dikgale	c. What are some of the challenges you encounter on a daily basis?
3. To determine the coping strategies used by HBCGs taking care of PLCMI.	d. How do you cope or make this job or male it less challenging?
4.To establish the types of support available to HBCGs taking care of PLCMI	e. Are you receiving any form of support from the family members and government? f. Do you need any psychological intervention for your wellbeing?

APPENDIX 1(b): SEMI-STRUCTURED INTERVIEW GUIDE (SEPEDI VERSION)

DIPHIHLELELO	HLAHLO YA DIPOTŠIŠO
1. Go kwesisahlago le muhutawahlokomelo yeo bahlokomedibakagaeba e fagobalwetsibamonagano	a. Kedife tšatšedingwedihlotlotšeo o kopanagonatšotšatši ka tšatši? b. Naa o dirabjang gore mošomo o se keWAba le dihlotlotšedintši go wena?
2. Go nyakišišodihlotlotšeomaHBCGbakopanagonatšomo Ga-Dikgale	c. Kemekgwaefegare ga ye mengwe yeo o e šomišang go kgona go kgotlelelaseemo? d. Keengseo se felago se go

	šitiša go kgona go kgotlelaseemo ka makga a mangwe?
3. Go sekasekamekgwa yeo maHBCGba e šomišang go kgonago kgotlelela go hlokomela PLCMI 4. hwetšamehutayathekgo yeo e begogona go maHBCG bao bahlokomelagoma PLCMI	e. Naa e ka bagona le thekgo yeo o e hwetšago go tšwa go maloko a lapa, bammušogobamekgahloya go se be yammušo? f. Naa e ka ba o hlokathušoyatšalephelo la monagano go kgontšha go phelagabotse?

Appendix2 (a)

 Participants' Letter of Consent (English Version)

Department of Psychology

University of Limpopo

Private X1106

Sovenga

0727

Date__/__/____

Dear Participant

I would like to thank you for agreeing to participate in this study about the lived experiences of home based care givers taking care of the mentally ill in Ga-Dikgale Please take note that your participation in this study is voluntary and you are free to withdraw from participating at any time during the study should you wish to do so. Your replies will stay confidential; you are therefore free to answer all questions as reliably as possible.

Your responses are very much appreciated and valued and would be of great help to the researcher.

Kind regards

_____   Date__/__/____

Novela MI (Student)

_____   Date__/__/____

Prof T Sodi (Supervisor)

_____   Date__/__/____

Dr MB Setwaba (Co-Supervisor

Appendix 2(b)

Lengwalo la tumelelanola Motšeakarolo (Sepedi Version

Lefapha la Thutoyamenagano

Yunibesithiya Limpopo

MokotlawaPhoraebete X1106

Sovenga

 0727

Tšatšikgwedi__/__/____

Motšeakarolowahlomphegago

Ke rata go leboga go dumela ga gago go tšeakarolomodinyakišišongtšathuto ye e bolela ka tsebahlokomedibamomagaengbaitemogela go tone gebahlokomela bao baitekanetjegomogopolongkua Ga-Dikgale. Ke rata lemoga gore go tšeakarolo ga gagomonyakišišongyathutoke ga boithaopogommewalokologa go ikgogelamoragomonakongefegobaefemagareng ga thutoge o rata. Dikarabotšagago di tlaswarwa ka sephiring, gommelokologa go araba dipotšišokamoka ka botshepegi ka mokgwa woo o kakgonago.

Dikarabotšagago di bohlokwa kudu gomme di tlathušamonyakišiši. Ke a leboga.

Madume a borutho.

_____   Tšatšikgwedi: __/___/____

Novela MI (Moithuti)

_____   Tšatšikgwedi: __/___/____

Prof T Sodi (Mohlahli)

_____   Tšatšikgwedi: __/___/____

DR MB Setwaba (Mothuša- Mohlahli)

Appendix 3: Ethical clearance

University of Limpopo
Department of Research Administration and Development
Private Bag X1106, Sovenga, 0727, South Africa
Tel: (015) 268 3935, Fax: (015) 268 2306, Email: anastasia.ngobe@ul.ac.za

TURFLOOP RESEARCH ETHICS COMMITTEE
ETHICS CLEARANCE CERTIFICATE

MEETING: 16 September 2020

PROJECT NUMBER: TREC/342/2019: PG - Amended

PROJECT:

Title:	A phenomenological study of the lived experiences of home-based caregivers of patients with chronic mental illness in Ga-Dikgale, Limpopo Province
Researcher:	MI Novela
Supervisor:	Prof T Sodi
Co-Supervisor/s:	Dr M Setwaba
School:	Social Science
Degree:	Master of Arts in Psychology

PROF P MASOKO
CHAIRPERSON: TURFLOOP RESEARCH ETHICS COMMITTEE

The Turfloop Research Ethics Committee (TREC) is registered with the National Health Research Ethics Council, Registration Number: **REC-0310111-031**

Note:	
i)	This Ethics Clearance Certificate will be valid for one (1) year, as from the abovementioned date. Application for annual renewal (or annual review) need to be received by TREC one month before lapse of this period.
ii)	Should any departure be contemplated from the research procedure as approved, the researcher(s) must re-submit the protocol to the committee, together with the Application for Amendment form.
iii)	PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES.

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Appendix 4: Editorial letter

507 Caledon Village, Cell +27794848449, Email: kubayij@yahoo.com

06 March 2022

Dear Sir/Madam

SUBJECT: EDITING OF DISSERTATION

This is to certify that the dissertation entitled 'A phenomenological study of the lived experiences of home-based caregivers of patients with chronic mental illness in Ga-Dikgale, Limpopo Province' by Mandisa Isabell Novela has been copy-edited, and that unless further tampered with, I am content with the quality of the dissertation in terms of its adherence to editorial principles of consistency, cohesion, clarity of thought and precision.

Kind regards

Prof. SJ Kubayi (DLitt et Phil)