AN INVESTIGATIVE STUDY OF THE CAREGIVERS EXPERIENCES IN CARING FOR THE ELDERLY

PORTIA NTOKOZO NGUBENI

December 2011

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PORTIA NTOKOZO NGUBENI

Submitted in partial fulfillment of the requirement for the degree of

MASTERS IN CLINICAL PSYCHOLOGY

in the

Department of Psychology

in the

Faculty of Arts

at the

UNIVERSITY OF ZULULAND

Supervisor:

PROF J. D. THWALA

December 2011

DECLARATION

I, Portia Ntokozo Ngubeni, declare that this dissertation , “An investigative study of the caregivers experiences in caring for the elderly”, is my own work and that all sources used or quoted have been indicated and acknowledged by means of complete references.

P. N. Ngubeni

DEDICATION

I dedicate this study to all the caregivers, caring for the elderly. It is also dedicated to all the special people in my life, my parents, my daughter, and my siblings.

ACKNOWLEDGEMENTS

First and foremost I would like to extend my deepest appreciation and gratitude to the Almighty God, who was with me throughout this challenging and demanding academic pursuit.

My supervisor Professor J. D. Thwala for his deep understanding, insightful and constructive guidance.

La Gratitude's Chief Executive Officer, Ms J. A. Batista and the research participants, the caregivers at La Gratitude for making the study possible.

A dear friend Mr. B.B. Mdletshe who offered his time, sublime patience, dedication and insightful guidance.

My loving family for their love and support as from day one, I extend the highest form of gratitude for their patience and persistent prayers throughout this challenging and demanding year.

I would also like to thank my daughter Simphiwe Mabanga for having been my motivation and driving force behind this academic pursuit.

NRF: the financial assistance of the National Research Foundation (NRF) towards this research is hereby acknowledged. Opinions expressed and conclusions arrived at, are those of the author and are not necessarily to be attributed to the NRF.

ABSTRACT

While caregiving is a common topic, very few studies have been done on the experiences of caregivers in caring for the elderly in South Africa. This study focused on the subjective experiences of the caregivers caring for the elderly in one of the old age homes called La Gratitude in KwaZulu-Natal in a town called Newcastle, just under Km 400 north of the University of Zululand. This research study adopted qualitative research methods, although it also integrated elements of a quantitative approach. The study used non-random sampling techniques, in particular purposive sampling. The purposive sample of eight caregivers was selected from the old age home caregiver population. These caregivers' ages ranged from age 28 to 39 years. The General Health Questionnaire and structured interviews were the tools used for the purpose of collecting the data. Content analysis was used for analyzing data in the present study. The research finding of this study indicated that even though there are challenges in the caregiving job; however the majority of the caregivers experienced the job of caring for the elderly as rewarding and enjoyable.

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CHAPTER ONE

GENERAL INTRODUCTION

1.1 INTRODUCTION

The study focuses on the experiences of the caregivers in caring for the elderly. In this chapter the researcher introduced the theoretical background relating to the core issues of the experiences of caregivers. This was then followed by the statement of the problem, which highlighted what motivated the research questions. The aims, objectives and the value of the study including the outline of all the forthcoming chapters are also discussed in this chapter.

1.2 THEORETICAL BACKGROUND OF THE STUDY

Many studies define caregiving as an act of providing assistance to another individual especially when the other individual is unable to self provide such assistance, owing to physical, psychological or mental disability (Adamson & Donovan, 2005; Lopez, Lopez-Arrieta, & Crespo, 2005; Lovell, 2006; Kong, 2008; Losada, Perez-Panaranda, Rodriguez-Sanchez, Comez-Marcos, Ballesteros-Rois, Ramos-Carrera, Campo-de la Torre & Garcia-Ortiz, 2010). This study focuses on the experiences of caregivers in caring for the elderly, as the demand for such care proves to be increasing worldwide. Schulz and Sherwood (2008) and Abdulraheem, (2005) affirm that caregivers are a critical national health care resource, especially where caring for the elderly is concerned.

Dellasega (1991), states that as the number of older persons in the population increases and so does the demand for health care. The 2001 population census of South Africa found that 7.3 % of the total population were 60 years or older, and this percentage is projected to increase over the next two decades (Joubert & Bradshaw, 2005; Westaway, 2010). According to the workshop report of the community Law centre of (2011), the number of older persons (aged 60 and above) represented about 7.6 % of South Africa's total population by the year 2010. This percentage was estimated to be 3.9 million of the total population and this percentage is expected to rise to 13 % by the year 2015.

The above mentioned South African census of 2001, in Joubert and Bradshaw (2005) and also in the workshop report of the community Law centre of (2011), indicates that the number of older persons in South Africa continues to grow year after year. This vast increase in the older population suggests that more and more old people will require increased assistance with care. Kong (2008) supports the statement above when he states that "as the condition of frail older relatives' deteriorates over time, they require more care, assistance, and time". The increase in the elderly with functional deterioration has led to an increase in informal caregivers (family caregivers) and institutional care for older people by formal caregivers (paid caregivers).

According to Joubert and Bradshaw (2005), there is limited information about geriatric services provision and utilization in South Africa. There is also a limited number of studies done on caregivers caring for the elderly in South Africa. The workshop report of the Community Law centre (2011) reported that there are fewer than 10 registered

geriatricians for the 3.9 million older persons in South Africa. This further shows that there has not been much focus on geriatrics. In 2005 the estimated percentage for older people living in nursing homes in the United States of America was about 1.5 million. According to Kong (2008), the proportion of institutionalized older people increases with age.

Twining (1988), points out that, the natural process of physical growth automatically predestines aging. According to Rue (1992), aging is the process of change, which over time lowers the probability of survival and reduces the physiological capacity for self regulation which demands hospitalization or taking care of the elderly in an old age facility. Many studies suggest that a person is considered old or an elderly person when aged over 65 years (Twining, 1988; Lovell, 2006; Rincon, Muzumdar & Barzilai, 2006).

Sloan (1997), points out that old people are known to experience function deteriorations owing to normal aging, disease, and disuse, in roughly equal proportions and that only one-third of the elderly population is preventable by some sort of conditioning. This statement clearly highlights the extent to which aging affects the normal state of functioning of an individual, in essence the old people become prone to a vast range of physical and psychological illnesses, and it becomes difficult for them to achieve even the slightest day to day activities, thereby becoming dependent on others.

Many old men and women unfortunately go through all these struggles of old age in the care of caregivers in the homes of the elderly or rehabilitation of the elderly. Many

studies indicate the increase in the number of families resorting to placing their elderly members of the family in a nursing home, after the realization that the job of caring for them is very strenuous and burdening (Mohide, Torrance, Streiner, & Gibert, 1988; Eliopoulos, 1990; Grunfeld, Glossop, McDowell, & Danbrook, 1997; Cavanaugh, 1990; Durant & Christian, 2006). This responsibility of caring is then shifted to those considered as formal caregivers. Formal caregivers are long term care providers known as paraprofessionals- the certified nursing assistants, home health aides, and home care or personal care worker (Stone, 2000). The caregivers are faced with daily challenges of caring and providing support to the elderly. The job of caregiving is not an easy one, the duties of caregivers can range from helping with Activities of daily living (ADL) and/or instrumental activities of daily living (IADL). As a result the caregivers themselves become prone to physical and emotional strains and stressors due to the amount of burden exerted on them. The present study aimed at investigating the personal experiences of caregivers in caring for the elderly. It further investigated whether the caregivers experience any signs of distress or burnout, and to evaluate effective ways which can help assist the caregivers of the elderly with all their physical and emotional burdens and stress inherent in their job, as caregivers in the homes of the elderly.

1.3 MOTIVATION OF THE STUDY

The focus of this study is the experiences of caregivers in caring for the elderly. Caregivers have been termed the cornerstone of the formal long-term care system, they are the persons most involved in the hands-on care of increasing numbers of elderly and disabled people (Ball, Lepare, Perkins, Hollingsworth & Sweatman, 2009:37). The motivation behind the proposed study is based on the notion that care giving is recognized strain or burden that has become a living reality for many people, as stated by Burke and Laramie (2004), more especially those who are obligated to give care to the elderly with their varying degrees of dependencies, physical and psychological illnesses.

1.4 STATEMENT OF THE PROBLEM

The identified problem is that caregivers have long been recognized as a group characterized by high levels of poor health, depression, burden and stress, Chappell and Reid (2000), as cited by Burke and Laramie (2004). This is due to the fact that caregivers' burdens are known to include physical, psychological and social problems.

1.5 AIMS AND PURPOSE OF THE STUDY

This study investigated the subjective experiences of the caregivers while caring for the elderly. The study was done in New Castle, north of Kwa-Zulu Natal province.

The study further aimed:

i To investigate whether caregivers experience job burnout, due to the demands inherent in their job.

ii To investigate whether the job of caregiving makes caregivers susceptible to developing psychological problems.

iii To determine whether caregivers in old age homes were satisfied with their work roles in the workplace.

iv To establish whether caregivers in old age homes were coping with the work challenges.

v To recommend effective ways to assist the caregivers of the elderly to improve their well-being.

1.6 VALUE OF THE STUDY

This study would bring to light the strains and stressors inherent in the job description of the caregivers of the elderly. An added value would be to establish whether their struggles were in any way addressed or not. While the study makes new discoveries about the job of being a caregiver, it also explores effective ways in which a job of being a caregiver can be improved in order to minimize the stressors inherent in the job. This study would therefore, benefit the caregivers of the elderly, by helping them cope better with the demands and challenges that come with being a caregiver of the elderly.

1.7 RESUME`

This chapter was an introduction of the study. The basic foundations of the study were explored (i.e. motivation of the study, statement of the problem, aims and value of the study). The next chapter will focus on the relevant literature and how it impacts or relates to the present study.

CHAPTER TWO

LITERATURE REVIEW

2.1 INTRODUCTION

The chapter focuses on literature review. According to Hart (2007), literature review is the selection of available documents (both published and unpublished) on the topic, which contains information, ideas, data, and evidence written from a particular standpoint to fulfill certain aims or express certain views on the nature of the topic and how it is to be investigated, and the effective evaluation of these documents in relation to the research being proposed.

2.2 CAREGIVING FOR THE ELDERLY

Generally caregiving is a process whereby one person provides care assistance to another individual especially when the other individual is unable to self-provide such assistance (Lovell, 2006). The caregiving job is central in this study especially in terms of the experiences of the caregivers as major role players in the whole process of caregiving for the elderly. Often caregiving is claimed to be a challenging job, as it requires one to have a lot of physical, emotional and mental strength, Abdulraheem (2005), adds that caregivers need to have certain skills and knowledge to deal with problems that are common in the elderly, but even that is not sufficient enough at time.

Many studies bring forth the view that becoming a frail elderly person makes one require more assistance from family members (informal caregivers) or from caregivers found in

formal settings such as old age homes (formal caregivers) (Kong, 2008; Lopez, Lopez-Arrieta & Crespo, 2005; Losada, Perez-Panaranda, Rodriguez-Sanchez, Comez-Marcos, Ballesteros-Rois, Ramos-Carrera, Campo-de la Torre & Garcia-Ortiz, 2010). As mentioned earlier that the decision by the caregivers to provide care often means a reorganization of priorities, lifestyle, and time. This is due to the responsibilities that come with caring for the elderly as their livelihood becomes more demanding. Although caregiving can be, and often is rewarding, it can also come with physical and emotional costs to the caregiver (Anderson & Turner, 2010).

2.3 THEORIES OF CAREGIVING

The concept of caregiving has long been postulated by a wide range of theories as having an important barring upon psychological functioning. The following section will be looking at two conceptual interpretations about caregiving, namely the Exchange and Modernization theories of caregiving. These perspectives try to explain caring and its implications.

2.3.1 The Exchange Theory and caregiving

According to Durant and Christian (2006), the Exchange Theory is proposed to be useful when explaining the relationship between the caregiver and the care recipient. Exchange theory, which originated with the work of Homans (1961), attempts to explain how certain factors influence patterns of interaction and relationships between two actors. Based on the tenets of exchange theory, relationships between the caregiver and care recipient depend on the capacity of the actors to mutually reward one another with

something of value Homans (1961:31). Wang (2004) and Zafirovski (2005), also points out that Social exchange theory analyzes interactions between two parties by examining the costs and benefits to each. Durant and Christian (2006), further state that, in an exchange relationship, resources that may be used to reward others may include assistance with personal grooming, housework, money, information, affection, approval, labour, compliance, or various types of material support. If one actor has a lower capacity to reward the other person in the relationship, then the actor with less exchange resources is assumed to be more dependent in the relationship (Durant & Christian, 2006).

Durant and Christian (2006) state that Dowd (1975, 1980), was among the first to use the exchange theory in social gerontology, Dowd, as quoted in Durant and Christian (2006) advanced the argument that aging affects exchange relationships in the sense that generally people desire to profit from social interaction with others and that profit consists of a perception that the reward coming from the interchange outweighs the costs (Durant & Christian, 2006:3). In the case of the present study, it should be emphasized, that the caregivers obtain the reward in the form of emotional satisfaction thorough the love of their job. According to Durant and Christian (2006), one of the most common patterns of exchange relationships occurs within the context of the family, where adult children are the caregivers for aging parents. This is often the case in certain Black families in the South African context.

Again, Durant and Christian (2006) point out that the role of caregivers in the contemporary world has evolved immensely into becoming a job, where caregivers may

devout some of their resources for the major resource in exchange, which is money. In that regard it is obvious that from the side of caregivers, they would have fewer resources to contribute into the relationship between them and the caregiving recipients. According to the Exchange theory when one actor has fewer resources to exchange, the opportunity of gaining from the relationship is restricted (Durant & Christian, 2006). Therefore, if caregivers would see caregiving as only the means of getting monetary gains only, there is a possibility that their relationship with caregiving recipients will be unstable. In terms of Exchange theory unstable relationship has negative consequences such as stress, role strain, feelings of guilt, and feelings of dependency. Although caregivers may also devout more resources more than the caregiving recipients, but the consequences remain the same (Durant & Christian, 2006).

According to Zafirovski (2005) the basic assumption of exchange theory is that individuals establish and continue social relations on the basis of their expectations that such relations will be mutually advantageous. The initial impetus for social interaction is provided by the exchange of benefits, intrinsic and extrinsic, independently of normative obligations. Zafirovski (2005) further states that since the processes of social exchange are assumed to be governed by reciprocal relations. Exchange is therefore defined as social interaction characterized by reciprocal stimuli—they would not continue in the long-run if reciprocity were violated. Whilst the reasons for caregivers may differ as to why they decided to do the job of caring; it is, however, evident that they do benefit in their interactions with the elderly. Whether by getting monetary rewards or a sense of fulfilment for meeting a duty and enjoyment derived from caregiving itself or from

companionship with the care recipient, as pointed out by (Cohen, Colantonio & Vernish , 2002).

2.3.2 Modernization Theory and caregiving

The modernization theory is a macro-level theory which deals with the influence of societal changes on social roles, relationships, and resources, which may directly or indirectly influence caregiving. Durant and Christian (2006) put forth the view that the Modernization Theory causes society to change from a traditional social system to a modern industrial social system which may change the status that older people occupy in society and the esteem afforded to them individually as members of a social category (Durant & Christian, 2006).

Societal changes may have positive and negative consequences for individuals and groups in society. Simmons (1945) added that in relatively stable agrarian societies, elders usually occupy positions of honor, favor, and power, mainly due to the norms of seniority rights. However, when the rate of change increases, older people lose their advantaged status. From a sociological perspective, Cottrell (1960) saw modernization as creating conditions that lead to more complex forms of organization, including the family. In such families, older members lose many of their dominant roles in making family decisions and performing family functions. Accordingly, family roles shift from ascribed to achieved roles and statuses, which influence the distribution of power and resources and pattern of relationships among family members. The lower status of older people in the family tends to limit their roles and choices, reduce their authority, and thus,

make them more dependent on other family members. In this way, modernization may influence caregiving exchange relationships between adult children and their aging parents.

Durant and Christian (2006) state that other critiques argue that the modernization theory is a continuing and uneven process, thus, making it difficult to determine the degree or direct source of the societal influences. Moreover, changes in values, attitudes, beliefs, knowledge, and practices comprise a complex process that may precede modernization at the initial point, which raises the age-old question of "did the chicken come before the egg?" However, we do know that at some point, advanced technology does change the ways in which we live and make decisions that influence family life and functioning, including caregiving relationships between adult children and their elderly parents. Accordingly, the modernization theory can be useful in explaining how aging and treatment of older persons as a social category have changed within a given period of time. This theory may also be useful in explaining why and how certain societal changes influence the structure and dynamics of caregiving to the elderly population.

2.4 THE CAREGIVING JOB

2.4.1 Elderly care

Varner and Drago (2000), define elderly care as an act of assisting persons aged 65 and older who have functional impairments. Assistance is provided through informal and/or formal arrangement by family, friends and service providers. Smith (2005) highlights that elderly people will present with different needs and depending on the specific needs of the elderly persons, caregiving responsibility may include different types of help, such as around the clock supervision, shopping, transportation, lifting, bathing, dressing and feeding. It may also include Financial and legal management and advice, supervision of medication, arranging for health care, telephone reassurance, listening, talking and providing emotional support. These needs or activities of daily living needed by the frail elderly were also pointed out by many other studies (Chang, 2009, Lopez, Lopez-Arrieta & Crespo, 2005; Eliopoulos, 1990; Stone, 2000).

2.4.2 Aging and health challenges leading to the need for care

Crome (2003) notes that almost all human physiological systems show evidence of deterioration in structure and function with age. Kahya, Zorlu, Ozgen, Sari, Sen, and Sagsoz (2009) supports this view in stating physiological aging are losses in nervous, muscle, immunity and brain systems. Furthermore, Lovell (2006) has highlighted the changes that take place in people as they age. These changes include decreased taste and smell, tooth and oral bone loss, decreased gastrointestinal function, decreased vision and hearing, increased body fat percentage, loss of bone mass and its associated minerals,

reduced mental capacity, increased predominance of cardiovascular-related diseases, hypertension, diabetes, myocardial infarction, and cerebrovascular accident, loss of muscle control, strength, and endurance, decreased liver and kidney functions, decreased heart and lung fitness. Cognitive impairment is also very common in old age and they usually comorbide many other physical illnesses. These cognitive problems impair the social skills and may lead to disruptive behavior or changes in personality (Grunfeld et al., 1997).

According to Rue (1992) a significant number of people over the age of 65 years have at least one chronic medical illness, and many have multiple conditions such as heart disease, cancer, and stroke, which are the primary causes of mortality and morbidity in the elderly. Gignac and Cott (1998) coincide with the view that the development of a chronic physical illness and disability in adulthood is often considered synonymous with deterioration, reduced competence, increased needs, and physical and emotional pain, ultimately resulting in a loss of independence and increased dependence on others. Gignac and Cott (1998), further put forth the view that there are individual elements of dependency that include physical, psychological, behavioral and social dependency; although emotional, economic, and environmental dependencies also have been identified.

Many other studies concur that old age is synonymous with functional deterioration (Chang, 2009; Aguero-Torres, Thomas, Winblad & Fratiglioni, 2002; Crome, 2003;

Grunfeld et al., 1997; Schuit, 2006). These studies further reveal the increased need for care that arises in old age.

2.4.3 The experiences of the caregiving job

The demands inherent in the caregiving job often result in many caregivers experiencing strain, strain which in turn can lead to burn out, depression, or other physical or psychological problems (Anderson & Turner, 2010). Evidently both Informal and professional caregivers are most likely to experience emotional or physical strain from the job of caregiving, especially because the nature of the job is common in many aspects.

Many studies have demonstrated that caregiver's depression and other health challenges were associated with heavy burden (Okamoto & Harasawa, 2009; Chang, 2009; Chenier, 1997; Grunfeld et al., 1997; Anderson and Turner, 2010). Caregivers vary in the degree of caregiver burden that they experience when caring for a frail elder. It has not been clear which specific aspects or characteristics of the caregiving situation lead to burden or affect caregiver burden. It has also been unclear which areas of caregiving are hardest for individual caregivers and most affect their health or well-being (Chenier, 1997).

Koerner, Kenyon and Shirai (2009) highlight an association between caregiving and heightened emotional and mental health problems. In support of this notion, Eliopoulos (1990) stated that caregivers are at increased risk for symptoms of depression, elevated levels of hostility and anxiety, as well as concerns over insufficient time, loss of self, and

missed social opportunities when compared with population norms and demographically matched non-caregivers.

Chenier (1997) asserts that caregiver burden includes the number of tasks performed, restricted social contact, deteriorating physical or mental health, and the subjective feeling of stress or strain caused by the caregiving situation. The physical demands or stress of caregiving can lead to or exacerbate physical illness. Caregiving can also lead to high levels of anxiety or depression in the caregiver. Sometimes caregivers are so involved in the caregiving that they neglect their own physical and mental well-being.

Chenier (1997) agreed that the level of impairment of activities of daily living (ADL) and instrumental activities of daily living (IADL) was significantly correlated with the development of caregiver burden. Caregiving also had a negative effect on the health of the caregivers.

Care of the elderly is one of the most important aspects of primary health care. Caregivers need to have certain skills and knowledge to deal with problems that are common in the elderly (Abdulraheem, 2005). The research literature supports the concept that caregiving is burdensome (Chenier, 1997).

Evidence from literature demonstrates that caregivers' health can be compromised, in their quest for assisting (Chang, 2009; Chenier, 1997; Grunfeld et al., 1997; Anderson and Turner, 2010). Although negative outcomes (for example, depression, feeling

burdened, health risks) remain an important focus of caregiving research; a growing body of literature acknowledges the potential rewarding and positive outcomes of the caregiving experience. Caregiving benefits, according to Baronet (2003), include feeling more useful, feeling needed, learning new skills, and adding meaning to one's sense of self. As noted by Cohen et al. (2002), caregiving benefits include gaining a sense of fulfilment for meeting a duty and enjoyment derived from caregiving itself or from companionship with the care recipient.

Lund (2005), states that becoming a caregiver is a time of transition that requires a restructuring of one's goals, behaviors, and responsibilities. He further points out that no one comes to the job prepared for the task, regardless of the circumstances that brought one to the caregiver role. Caregiving can be both rewarding and challenging, it can also be just rewarding or just challenging for individual caregivers.

2.4.4 The family caregivers

The increased rate of elderly people indicates that more and more families have to assume the responsibility of caring for their elderly member of the family. This is common mostly among many South African families. Many times members of the family will feel obligated to care for their elderly member (Ozawa & Tseng, 1999). Research indicates that older individuals of colour are less likely to utilize formal services than are white elderly (Toseland & McCallion, 1997). Chang (2009) notes that families usually provide the bulk of long-term care for their disabled elderly relatives, and most of the time by providing care, they have to withstand physical and psychological burdens.

Financial and social stresses are also unavoidable. He continues to say as the provision of care continues; their careers also suffer, ending most likely with termination. In many cases, caregiver burden may be prolonged and may intensify and worsen and may end up resulting in more serious conditions such as physical and psychological distress or depressive mood (Chang, 2009).

Mbanaso (2006:5) adds that *time conflicts in caregiving often prevent caregivers from participating in their customary social and leisure activities and this is often strongly related to a feeling of burden and stress. This stress is exacerbated as a result of poor public support for caregiving to family members who provide care for their elderly relatives.*

Most home health services for older people with functional and health care needs are provided by the informal health care system, particularly family members, as it has been highlighted above. Most of the dependent elderly populations dwell at their own or at a family home. The relatives, known as informal caregivers, provide most of the assistance for the necessary activities of daily living, such as: feeding, bathing, dressing, toileting, among other things (Lopez, Lopez-Arrieta & Crespo, 2005). Results from the study conducted by Mohide et al. (1988) indicated that a large proportion of these caregivers experience physical, emotional and social burden as a result of meeting this responsibility. According to Lopez et al. (2005), only a small proportion of the dependent elderly is in nursing homes or is attended by professional formal caregivers. Nevertheless the job of caregiving has been identified to be common amongst caregivers caring for the

elderly. This then suggests that caregivers, regardless of whether formal or informal all experience similar challenges or rewards.

2.4.4.1 Women assuming their traditional role of caring

The bulk of the job of caregiving is performed by the women in the families and most often by daughters. Karner (1998), notes that the general caregiving tasks are seen as compatible with the traditional female role. It is estimated that more than 10 million people are involved in parent care, approximately half of whom provide care on a regular basis. Baldwin (1990) asserts that more than half of the elderly caregivers are wives; the next largest group of caregivers is daughters and daughters-in-law. Indeed, today the average woman will spend more time providing care for her parents than for her children. Eliopoulos (1990) makes reference that one in sixty full-time workers is a caregiver, and one in twelve is a potential caregiver. Families provide many types of assistance to their elderly members. Eliopoulos (1990) continues to say that the provision of assistance is often a subtle, gradual process. For example, a daughter may begin by telephoning her mother after the mother has returned from a physician's visit and inquiring about medication changes. As time progresses, the daughter may accompany her mother to the physician's office, discuss the medication directly with the physician, and telephone her mother to monitor the response to the drug. Eventually, the daughter may need to lift her mother in and out of the car, push her into the physician's office in a wheelchair, undress her for the examination, and administer the medications to her on a regular basis (Eliopoulos, 1990).

Baldwin (1990) estimates that about 5 million (18%) of all elderly live with an adult child. Family caregiving can carry with it numerous stresses, accumulated strain, and, for some, a sense of burden, as it has been pointed out by many studies above. As the dependency (both physical and psychological) of an aging adult increases, conflicts may arise, placing stress on various individuals and the family system as a whole (Eliopoulos, 1990). According to Eliopoulos (1990), unresolved family issues or conflicts may be heightened by the physical, emotional and, often financial strain of caregiving. With the increasing number of women in the work force today, the added responsibility of giving care to a parent can create tremendous pressures for the adult daughter and her spouse and children. Adult children often report feeling reluctant and resentful in assuming a parenting role in the care of their own parent. Increasing dependency of the frail elderly raises many concerns related to role reversal between parents and adult children. This role reversal situation may become especially difficult for middle-aged women who care for an adult parent in addition to their own spouse, children, and sometimes grandchildren (Eliopoulos, 1990). This is where the modernization theory comes in, as it deals with the influence of societal changes on social roles, relationships, and resources, which may directly or indirectly influence caregiving (Durant & Christian, 2006).

Grunfeld et al. (1997) adds that family caregivers of terminally ill elders experience significant psychosocial, physical and economic burden, which negatively affect their quality of life. Grunfeld et al. (1997) continues to point out that family caregivers report substantial financial losses associated with the role of caregiving. These include direct

out-of-pocket expenses and lost wages because of time taken off work. The widely held view that home-based care is more cost-effective than institutional care does not take into account the indirect costs (opportunity costs, lost wages and family labour costs) borne by elders and their families. In fact, when family costs are included in the analysis, caring for an elder with a terminal illness at home is no less expensive than caring for the same elder in an old age home (Grunfeld et al., 1997).

2.4.4.2 The challenges of caring for a frail parent

Many studies have revealed that caring for a frail parent is not without cost. Besides the obvious monetary expense, caring for a parent exacts a high psychological cost. Cavanaugh (1990) states that even the most devoted child has feelings of depression, resentment, anger and guilt at times. Many middle-aged adults have just come through the financial expenses associated with child rearing and may need to plan for their own retirement. The additional burden of a frail parent puts considerable pressure on resources that were earmarked for other uses. These difficulties are especially acute for the children of victims of chronic conditions (Cavanaugh, 1990). Overwhelmingly, research shows how caregiving for dependent elderly subjects generates emotional and physical distress on relatives (Durant & Christian, 2006; Rabin, Bressler & Prager, 1993; Oura, 2006). Thus, as noted by Lopez, Lopez-Arrieta and Crespo (2005), caregivers get ill more often than those who are not caregivers; their immune response is reduced and they feel, on many occasions, overwhelmed by the burden of the care, as well as by anxiety, anger and depression.

In support of this notion, Grunfeld et al. (1997) also agree with the fact that caring for an elderly family member with dementia at home may create a situation of chronic stress, which may adversely affect the caregiver's emotional and physical health. Although there are rewarding aspects of caregiving, virtually many of the studies reported increased symptoms of depression and anxiety among caregivers (Durant & Christian, 2006; Rabin, Bressler & Prager, 1993; Oura, 2006). Many spouses and children give dedicated care to their dementing family member for several years, but sooner or later some family caregivers struggle with the decision to move their relative to a nursing home (Spruytte, 2001; Dauenhauer, 2006)

It is unanimously agreed that home care is regarded as potentially burdensome. However; according to Grasel (1995), it is necessary to distinguish between contributing factors to the burden that can be measured objectively (for example, the extent to which the care is needed, the degree of financial privation involved) and the assessment of the situation through the eyes of the caregiver concerned.

Evidently the job of caregiving is not an easy one for family caregivers caring for an elderly person at home. Hence the challenges inherent in this job become much to bear or manage for some families and thus they eventually seek alternative care for their elder, in a retirement home, nursing homes, out of home placement or old age homes.

2.5 OLD AGE HOMES

An old age home is a place for people who are old and frail, ill or disabled and can no longer care for themselves. Placing an elderly in an old age home/nursing home is not always an easy decision to make. Regardless of the burdensome nature of caregiving, nursing home placement is a difficult decision for both the caregiver and the care receiver (Chenier, 1997). The decision is mostly taken after no other alternative is available for the old person. As the number of elderly people with functional impairment increases, and as more families decide to place their elderly members' in old age homes for rehabilitation increases, this then leads to more work for caregivers working in old age homes. The caregivers caring for the elderly in old age homes are increasingly faced by more challenges of caring for a large varied numbers of elderly people.

Dauenhauer (2006); Matsumoto and Inoue (2007) make reference to the things that determine placement of an elderly to an old age home and they call them "risk factors for institutional placement", apart from age and sex, they mention dementia, functional and physical disabilities, chronic medical conditions, living alone and social isolation and incontinence, which is involuntary loss of control of either urine or feces that interferes with hygiene and health.

2.5.1 Rehabilitation of the elderly

Eliopoulos (1990), states that rehabilitation is the practice of making capable of living again. The focus is upon function rather than cure. Rehabilitation specialists strive to teach a person how to function at his or her maximal level within the limits imposed by

an injury or a physical or mental impairment. Old age homes can function as rehabilitation centres that focus on rehabilitating old people. It is evident that family members of the frail elderly suffer too much burden as primary caregivers, and the quantity and quality of the resources and support system are not always sufficient for nursing care at home (Okamoto & Harasawa, 2007). As the condition of frail older relatives' deteriorates over time, they require more care, assistance, and time (Kong, 2008). Many family caregivers are obliged to place their older relatives in an old age home, as the condition of the old person worsens.

When the burden becomes such that the family caregiver can no longer cope, and the decision to place a loved one in a home is taken, it was found that family caregivers showed signs of depression, feelings of relief, satisfaction, sadness, loss, and guilt after the institutionalization of their frail older relatives (Kong, 2008; Sijuwade, 1996).

Dauenhauer (2006) also highlights that families also struggle with deciding to place an older relative in a nursing home as it symbolizes their failure as caregivers and often goes against their older relative's wishes.

After nursing home placement, there were significant decreases, in the five domains of caregivers' strain (i.e. physical strain, social constraints, time constraints, interpersonal strain, and elderly strain demands) except one domain, the financial domain (Coon, 2009; Grunfeld et al., 1997).

2.5.2 Elderly care in South Africa

Varner and Drago (2000) define elderly care as “assistance to persons aged 65 and older with functional impairments, provided through informal and/or formal arrangements by family, friends and service providers”.

The global population is ageing and many governments have made the care of older people a policy priority. There is a pressing need therefore for nurses and carers to work in health services for older people (Schofield, 2005). Ageing is becoming a concern in South Africa. Since the 1980s the provision of housing for the elderly in South Africa has been regarded as a joint venture of the public and private sector. However, the new social welfare policy introduced by the Department of Welfare and Population Development in 1997 proposed the phasing out of all state-funded homes for the aged by the year 2000 (Kotze, 2006). Even though the issue of the aging population has been overlooked in South Africa, as it has been pointed out by Kinsella and Ferreir (1997), many old people still use old age homes.

South Africa is one of the countries with a vast number of old age homes. Nevertheless, it is generally thought that being old and black (and poor) compounds the likelihood of placement into particular types of institutions. Kart (2001) noted the relationship between the type of facility in which an elderly person may be institutionalized and the status attributes of that elderly individual. The legacy of Apartheid has an influence in most aspects of South African culture and geriatrics care environment is not exception to this (Makoni, 2002).

Kart (2001), states that the poorest elderly are most likely to be placed in public facilities that generally provide an inferior form of care. Not all elderly persons have access to a range of available institutional settings. Concern has been expressed about the differential availability of institutional settings for elderly blacks and whites (Kart, 2001). Available data shows blacks to be grossly underrepresented in selected types of old age institutions (Kart, 2001).

2.5.3 Caregivers in nursing homes

As it has been mentioned above that when the human aging process begins, a lot of daily tasks are becoming more difficult to perform, until the individuals realize that they already depend on others. In this context, a new segment of population is highlighted: those who are responsible for elderly people and those who provide assistance to them (Rezende, Coimbra, Costallat & Coimba, 2010). Caregivers fall into two broad categories: caregivers working for pay who are part of the formal health care sector (e.g., homecare workers) and unpaid "informal" caregivers (usually family members) (Grunfeld et al., 1997). Formal homecare workers are often those that fill that gap between family support and elder need (Karner, 1998). Takahashi, Iwakiri, Sotoyama, Higuchi, Kiguchi, Hirata, Hisanaga, Kitahara, Taoda, and Nishiyama (2008) add that caregivers at nursing homes have received much less attention despite them being at risk. Varner and Drago (2000) further state that employed caregivers experience more stress-related medical conditions, when compared to employees without caregiving responsibility.

Some of the reasons why caregivers working in nursing homes are receiving such little attention is due to “caring” being perceived as an occupation, and also being widely regarded as something that comes naturally (particularly for woman), and therefore not valued as a skill. And yet if we are to understand and evaluate how caring is carried out in various contexts and its effects on such carers, it becomes clear that the concept of caregiving is not a straightforward one (Makoni, 2002). Weman, Kihlegren, and Fagerburg (2004) add that little attention has been paid to the nursing conditions in nursing facilities or in the private homes of older people and how they themselves experience their working situation as caregivers.

Ball, Lepore and Perkins (2009), describe Paraprofessional workers as the cornerstone of the formal long-term care system. They further suggest that, these workers are the persons most involved in the hands-on care of increasing numbers of elderly and disabled people. These direct care workers (DCWs) as further pointed out Ball et al. (2009), are predominantly female and increasingly non-white and their work typically described as onerous and physically and emotionally draining. It is not surprising that, the supply of these workers does not meet the growing demand for their services.

Many caregivers found in old age homes are paraprofessional caregivers, and despite their insufficient training as health workers they take on full responsibilities of trained health workers and are responsible for assisting the elderly with all sorts of demanding activities of daily living, Stone (2000), also supports this view. They are never fully prepared for the amount of work inherent in the job of caring for the elderly. Many para-

professional caregivers in South Africa take on the job of caregiving because it is available to them, not being fully prepared emotionally or physically for the demands of the job.

Koerner, Kenyon and Shirai (2009), state that many researchers have investigated the link between caregiving for the elderly and the mental and physical health of caregivers. Koerner et al. (2009) further state that these studies have repeatedly found a significant association between caregiving and heightened emotional or mental health problems. Many studies also provide evidence that caregiving is burdensome and that caregivers' physical and mental health can be compromised (Koerner et al., 2009; Mohide et al., 1988; Eliopoulos, 1990; Grunfeld et al., Glossop, McDowell, & Danbrook, 1997; Cavanaugh, 1990; Durant & Christian, 2006).

It is evident that a number of studies done on caregiving only reflect on the negative consequences of caregiving, recent research tried not to only examine the negative consequences of caregiving but also those seen as positive consequences of caregiving, experienced by the caregivers themselves (Cohen, Colantonio & Vernich, 2002). Although negative outcomes such as depression, burden, and health risks remain an important focus of caregiving research, Koerner et al. (2009: 238) note that a growing body of literature acknowledges the potential rewarding and positive outcomes of the caregiving experience—what we will refer to as caregiving benefits/gains. Caregiving benefits/gains include feeling more useful, feeling needed, learning new skills, and adding meaning to one's sense of self (e.g. they also may include gaining a sense of

fulfillment for meeting a duty/obligation and enjoyment) derived from caregiving itself or from companionship with the care recipient. Lopez et al. (2005) conducted a mixed-methods study of caregivers that revealed that the vast majority of caregivers could describe one or more positive aspects of caregiving.

Caregiving satisfaction represents the perceived subjective gains and rewards, and the experience of personal growth that occurs as a result of providing care (Lopez et al, 2005). It has been further highlighted by Koerner et al. (2009) that negative and positive outcomes often co-exist within the same caregiver. For example, it was found that a large majority of caregiving events evoked both positive and negative appraisals by caregivers. Other researchers have found that a large proportion of caregivers (70 – 80%) experience both positive and negative emotions as a result of their caregiving role (Koerner et al., 2009:238).

Koerner et al. (2009) states further that the experience of benefits/gains may help buffer against the common negative outcomes of caregiving.

Lopez et al. (2005) have highlighted five categories of predictors for how caregivers appraise their experiences' of caregiving. These have been classified in terms of the characteristics of the caregiver (caregiving role) and care recipient, stressors, appraisal, caregiver's resources and caregiver's problems.

Lopez et al. (2005) further elaborate on the predictors for caregiving experience in the points below.

i Characteristics of the caregivers included age, sex, marital status, educational level.

ii Stressors included the duration of caregiving (the months as caregiver), the daily schedule as caregiver, the type of caregiver, the number of people to care for, the groups who help the caregiver, the care recipient's level of dependence, and the amount of behavioral and memory problems.

iii Appraisal included levels of burden,

iv The caregiver resources included levels of self-esteem, social support, subject satisfaction with the amount of perceived support, and coping strategies.

v The caregiver problems included levels of depression, anxiety, trait anger, anger expression, psychotropic drug consumption, and changes in healthy behavior (such as sleeping, fitness, leisure, visits to doctors, and tobacco consumption).

vi Also working shifts has a considerable impact on health, safety and well being (Takahashi et al., 2008).

vii Makoni (2002) points out that the descriptions of the quality of everyday interactions can expose regimes of "care" which might undermine the personal integrity of the recipients of care, placing unrealistic interactive burden on the caregivers.

In a study conducted by Weman, Kihlegren and Fagerburg (2004) Registered nurses working with old people reasoned about their experiences and stated that providing old people with a sense of trust and commitment was at the core of caring.

2.6 RESUME`

This chapter focused on exploring relevant literature and previous work done on the topic. Exploring literature enables the reader to better understand the purpose of the study. The next chapter deals with methodological underpinnings of the study.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 INTRODUCTION

In this chapter research design, target population, sampling and sampling size, research tool, and ethical consideration will be discussed. The goal of this research study was to explore the experiences of the caregivers of the Newcastle home of the elderly (La Gratitude), in order to determine their experiences pertaining to their daily occupation.

3.2 RESEARCH DESIGN

The research study adopted qualitative research methods, although there are integrated elements of a quantitative approach. This was done particularly to achieve a holistic view on the experiences of the caregivers. Qualitative research methods were used to gain insight into people's attitudes, behavior, values systems, concerns, motivations or aspirations. Quantitative research methods were used to collect data through the use of a structured interview, with an aim to establish participants' feelings and behaviour.

3.2.1. Rationale for qualitative research methods

In qualitative research methods, researchers collect the data in the field at the site where participants experience the issue or problem under study. In this study the researcher collected the data in the field where respondents were invited to partake in the research process. Usually in qualitative research approach the information is gathered by actually talking to people and seeing the behaviour and act within their context, it also regulates face to face interaction over time (Creswell, 2003). This can be possible in the case whereby the researcher actually goes to the place where respondents are focused.

In addition qualitative research is fundamentally interpretive. This means that the researcher makes an interpretation of the data. This includes developing a description of an individual or setting, analyzing data for themes and categories, and finally making an interpretation or drawing conclusions about its meaning personally and theoretically (Creswell, 2003).

3.2.2. Advantages of Qualitative methods

One advantage of qualitative research method is that it uses of open-ended questions and probing gives participants the opportunity to respond in their own words, rather than forcing them to choose from fixed responses. Open-ended questions have the ability to evoke responses that are meaningful and culturally salient to the participant, unanticipated by the researcher, and rich and explanatory in nature.

Qualitative method is helpful not only in giving rich explanations of complex phenomena, but in creating or evolving theories or conceptual bases, and in proposing hypotheses to clarify the phenomena. Besides, value of the qualitative research consists in validity of the information received; people are minutely interviewed so as the obtained data would be taken as correct and believable reports of their opinions and experiences. Qualitative method allows the researcher the flexibility to probe initial participant responses, that is, to ask why or how. The researcher must listen carefully to what participants say, engage with them according to their individual personalities and styles, and use “probes” to encourage them to elaborate on their answers.

3.2.3. Disadvantages of Qualitative methods

Qualitative research method scope is limited due to the in-depth, comprehensive data gathering approaches required. The very subjectivity of the inquiry leads to difficulties in establishing the reliability and validity of the approaches and information. It is very difficult to prevent or detect researcher induced bias and the major disadvantage of qualitative research is that small group of interviewed individuals cannot be taken as representative.

Qualitative research is not understood well by classical researchers. Since it demands the researcher to listen carefully to what participants say, engage with them according to their individual personalities and styles, and use “probes” to encourage them to elaborate on their answers. Qualitative research can be difficult and expensive and require a lot of time to perform. It must be carefully planned to ensure that there is complete selection of

sample and correct designation of control groups. Qualitative researches do not always underpin the understanding of multi-dimensional pictures of the research study conducted.

3.2.4. Rationale for quantitative research methods

Quantitative research methods were used to develop and employ mathematical models, theories and hypotheses pertaining to established phenomena (Creswell, 2003). When conducting quantitative research the variables studied must be measured. The measurement of the variables tend to be undertaken through the use of questionnaires and some form of structured observations.

The process of measurement is central to quantitative research because it provides the fundamental connection between empirical observation and mathematical expression of quantitative relationships (Welman, Kruger & Mitchell, 2005).

Individual's responses are required. The individual's responses then aggregated to form overall measures for the sample. There is no requirement that individuals should know each other, only that their responses can be analysed. The individualistic element in quantitative research has to do with its techniques of investigation which use the individual as a source of data, largely independent from other individuals.

3.2.5. Advantages of Quantitative methods

Quantitative research methods are fairly inflexible. With quantitative methods such as surveys and questionnaires, for example, researchers ask all participants identical questions in the same order. The response categories from which participants may choose are fixed. The advantage of this inflexibility is that it allows for meaningful comparison of responses across participants and study sites. Quantitative research allows for a broader study greater objectivity and accuracy of the results, involving a greater number of subjects, and enhancing the generalization of the results.

Quantitative research design is an excellent way of finalizing results and proving or disproving a hypothesis. The structure has not changed for centuries, so is standard across many scientific fields and disciplines. After statistical analysis of the results, a comprehensive answer is reached, and the results can be legitimately discussed and published. Quantitative experiments also filter out external factors, if properly designed, and so the results gained can be seen as real and unbiased.

3.2.6. Disadvantages of Quantitative methods

One disadvantage is that quantitative methods collect a much narrower and sometimes superficial data. The results are limited as they provide numerical descriptions rather than detailed narrative and generally provide less elaborate accounts of human perception. The research is often carried out in an unnatural, artificial environment so that a level of control can be applied to the exercise. This level of control might not normally be in place in the real world yielding laboratory results as opposed to real world results.

The development of standard questions by researchers can lead to 'structural' bias and false representation, where the data actually reflects the view of them instead of the participating subject. Quantitative studies usually require extensive statistical analysis, which can be difficult, due to most scientists not being statisticians. The field of statistical study is a whole scientific discipline and can be difficult for non-mathematicians. In addition, the requirements for the successful statistical confirmation of results are very stringent, with very few experiments comprehensively proving a hypothesis; there is usually some ambiguity, which requires retesting and refinement to the design. This means another investment of time and resources must be committed to fine-tune the results. The quantitative research design also tends to generate only proved or unproven results, with there being very little room for grey areas and uncertainty. For the social sciences, education, anthropology and psychology, human nature is a lot more complex than just a simple yes or no response.

3.3 POPULATION OF THE STUDY

According to Neuman (2007) a population is the concretely specified large group from which the researcher draws a sample and to which results from a sample are generalised. The population for this study was the caregivers in old age homes, in particular the caregivers of La Gratitude home of the aged. This population was targeted to provide the study with relevant responses regarding the normal experience in the work of being a caregiver in an old age home.

3.4 DATA COLLECTION PROCEDURE

3.4.1 Sampling procedure

The study used non-random sampling technique, in particular purposive sampling. Coolican (2004) states that in purposive sampling the selection choice is made by the researcher on the basis of those who are most representative for the issues involved in the research and who have appropriate expertise in the matter. In this study caregivers were appropriate and representative for the issue involved as the study intended to establish the occupational experiences of the caregivers. For the purpose of this study occupational experiences include among other things both positive and negative experiences that are encountered by caregivers.

The sample of this study consisted of caregivers in one of the old age homes situated in KwaZulu-Natal namely La Gratitude home of the aged. The sample of the study consisted of 8 female caregivers, all of whom were trained and experienced caregivers.

3.4.2. Instruments for data collection

The General Health Questionnaire (GHQ) was adopted for the study including the use of interviews for the purpose of collecting primary data from the participants. These instruments used for data collection were created in the English language. Initially, the researcher was supposed to administer the questionnaire among ten caregivers found at the La gratitude home of the elderly. However, because of the unavailability of 2 participants, the questionnaire was administered to only eight caregivers.

Interviews were also used in this study; in particular a structured interview was adopted. In an attempt to reduce looseness and inconsistency which comes with responses, a structured but open-ended interview was appropriated for this study. Coolican (2004) states that in order to avoid the looseness and inconsistency that accompany informally gathered interview data, the interview session can use a standardized procedure.

3.4.3. The General Health Questionnaire

The General Health Questionnaire (GHQ) is a widely used measure for psychological well-being with demonstrable validity and reliability. It asks respondents about their recent experiences of symptoms known to be indicative of anxiety and depression, social dysfunction, and loss of confidence and self-esteem.

GHQ covers a wide range of symptoms, it is considered more appropriate for measuring the mental health of cares than instruments for detecting depression alone. The GHQ can be used be used to represent the severity of distress by counting the number of symptoms; however, the symptoms scale (range 0-12) was dichotomized to measure the proportion of respondents presenting high distress scores. It was designed to detect long-standing disorders as well as undifferentiated distress and transient variations; however, recurrent episodes of distress may be associated with significant clinical impairment, which can disrupt personal and social functioning (Hirst, 2005).

3.4.4. The structured interview

Structured interviews otherwise known as standardized interviews comprise a set of formally structured questions that are based on theory, and/or the experience of the interviewer. The questions are formally structured in that the wording is not altered from one participate to the next. The interviewer should be neutral and not engage in a conversation on the topic with the participants. This technique assumes that the questions cover much of the information required, and that the participants would understand the questions. It also enables comparisons to be made between participants (Struwing & Stead, 2007).

According Coolican (2004) in the structured interview but open-ended, the interviewer gives pre-set questions in a predetermined order to every interviewee. This keeps the multiplicity of interpersonal variables in a two-way conversation to a minimum and ensures greater consistency in the data collected. Coolican (2004) further state that in this type of an interview a respondent is free to answer in anyway chosen by him or her.

3.4.5. Data analysis

Struwing and Stead (2007) assert that data analysis methods enable the researcher to organize and bring meaning to the large amount of data. Content analysis was used for analyzing data in the present study.

In content analysis themes are extracted from the data. Themes can be extracted through coding of data, elaborating on the data, interpreting then checking of the data (Terre

Blanche, Durrheim, & Painter, 2007). In this study content analysis is suitable because structured but open-ended interviews were used; in those interviews respondents were given an opportunity to express their experience as well as their feeling over the occupational experiences.

3.5. ETHICAL CONSIDERATION

Participants were informed that the data collected from them will be treated with the highest level of confidentiality; they were informed about their right to withdraw from participation, should they feel uncomfortable at any time. The participants had to sign an informed consent form, before participating in the study. The researcher ensured that Confidentiality and anonymity were maintained throughout. Permission to conduct the research study was obtained from the University of Zululand's ethical committee and from the department of Psychology. A formal letter was written to the Newcastle home of the elderly, which requested consent to undertake the study.

3.6 RESUME`

This chapter has dealt with the research methodology used in the study. The study required purposive sampling procedure. The following chapter will focus on data analysis.

CHAPTER FOUR

DATA ANALYSIS AND PRESENTATION

4.1 INTRODUCTION

This chapter contains the analysis and discussions of the data collected from the respondents. The responses to questions in section (A) of the questionnaire, a Likert scale was used to assess the levels of distress as to quantify it into a particular meaning associated to the respondents. Even though section (A) of the questionnaire provides quantitative data, it was only used as a screening tool for the experiences of caregivers for the purpose of this study. As a result a descriptive data analysis is done for Section (A) of the questionnaire. Narrative and thematic analysis is applied for section (B) of the questionnaire; due to qualitative data. This data was mainly solicited from the respondents to determine the respondent's personal experiences of being a caregiver in an old age home.

4.2 FINDINGS AND DISCUSSION

4.2.1 Section A: Quantitative part of the questionnaire

4.2.1.1 Themes elicited from the respondents

The tables below display the respondents' scores and percentages obtained on the GHQ.

A1. Have you been able to concentrate on what you are doing?

Table: 1

Responses	**Scale score**	**Number of respondents**
Better than usual	0	2
Same as usual	1	3
Less than usual	2	1
Much less than usual	3	2
Total response		**8 =100%**

Table 1 above shows the level of concentration amongst the caregivers. Twenty five percent (25%) of the respondents indicated that their level of concentration into their work is better than usual, while (37.5%) of the caregivers indicated that their level of concentration into their work is the same as usual. Twelve and half percent (12.5%) indicated that their level of concentration is less than usual and (25%) indicated that their level of concentration is much less than usual. In terms of caregiver's concentration on what they do, respondents indicated that their level of concentration is on the same level. This means that the job of being a caregiver does not necessarily contribute to loss of concentration.

A 2. Have you lost much sleep over worry?

Table: 2

Responses	**Scale score**	**Number of respondents**
Not at all	0	4
Not more than usual	1	2
Rather more than usual	2	1
Much more than usual	3	1
Total response		**8 =100%**

Table 2 above reflects on levels of losing much sleep over worry, amongst the caregivers. Fifty percent (50%) of the respondents indicated not at all, (25%) of the respondents indicated not more than usual, (12.5%) of the respondents indicated rather more than usual and another (12.5%) indicated much more than usual. In terms of being worried to an extent of losing sleep over worries, more respondents indicated that they do not experience worries that could cause them to lose sleep. This means that more caregivers in the La Gratitude do not experience worries, while few of them still face some worries that caused them to lose sleep. The worries that can cause sleepless nights among caregivers could be work related.

A 3. Have you felt that you are playing a useful part in things?

Table: 3

Responses	**Scale score**	**Number of respondents**
More so than usual	0	5
Same as usual	1	3
Less so than usual	2	Nil
Much less than usual	3	Nil
Total response		**8 =100%**

Table 3 reflects responses regarding feeling that you are playing a useful part in things, amongst the caregivers. Sixty two and half percent (62.5%) of respondents indicated that they felt More so than usual, (37.5%) indicated that they felt same as usual, and none indicated feeling less so than usual or feeling much less than usual. In terms of playing a useful part in things within the organization, most of the respondents indicated that they feel like they are playing a part in things. Playing a useful part in things refers to the things the caregivers may be required to do the home (La Gratitude) that contribute to the well-being of the elderly.

A 4. Have you felt capable of making decisions about things?

Table: 4

Responses	**Scale score**	**Number of respondents**
More so than usual	0	5
Same as usual	1	2
Less than usual	2	Nil
Much less than usual	3	1
Total response		**8 =100%**

Table 4 reflects responses regarding the capability of making decisions about things amongst the caregivers. Sixty five percent (65%) of the respondents indicated that they were capable of making decisions more so than usual, (25%) of the respondents indicated that they felt the same as usual, none of the respondents indicated less than usual and (12.5%) of the respondents indicated that they felt much less than usual. In terms of the feeling of being capable to make decisions about things, more respondents indicated that they feel more so than usual. This means that most of the caregivers at La Gratitude home are able to make decisions about things in their lives. The implication of being able to

make decisions about things is that the person is functioning normally and hardly experiences stressors.

A 5. Have you felt constantly under strain?

Table: 5

Responses	**Scale score**	**Number of respondents**
Not at all	0	6
No more than usual	1	Nil
Rather more than usual	2	Nil
Much more than usual	3	2
Total response		**8 =100%**

Table 5 reflects responses regarding constantly feeling under strain amongst the caregivers. Seventy five percent (75%) of the respondents indicated Not at all to feeling under strain, none indicated No more than usual or Rather more than usual and (25%) indicated Much more than usual. In terms of feeling under strain constantly, more respondents indicated that they do not have that feeling at all. Not feeling under strain means that the job done by the caregivers at La Gratitude and other old age homes could not be strenuous to the caregivers.

A 6. Have you felt you could not overcome your difficulties?

Table: 6

Responses	**Scale score**	**Number of respondents**
Not at all	0	3
No more than usual	1	3
Rather more than usual	2	Nil
Much more than usual	3	2
Total response		**8 =100%**

Table 6 reflects responses regarding not being able to overcome one's difficulties amongst the caregivers. Thirty seven percent (37.5%) indicated not at all, another (37.5%) indicated no more than usual, none indicated rather more than usual and (25%) indicated much more than usual. In terms of overcoming difficulties, more respondents indicated that they have not felt like they could not overcome their difficulties at all or no more than usual. This means that the caregivers at La gratitude can very well manage their difficulties.

A 7. Have you been able to enjoy your normal day-to-day activities?

Table 7

Responses	**scale scores**	**Number of respondents**
More so than usual	0	4
Same as usual	1	3
Less so than usual	2	1
Much less than usual	3	2
Total response		**8 =100%**

Table 7 reflects responses regarding being able to enjoy one's normal day to day activities amongst the caregivers. Fifty percent (50%) of the respondents indicated that they have been able to enjoy their day to day activities more so than usual, (37.5%) indicated same as usual, (12.5%) indicated less so than usual and (25%) indicated much less than usual. In terms the enjoying one's day to day activities more caregivers indicated that they enjoy their day to day activities more so than usual. This then denotes that the caregivers at La gratitude home for the aged and other old age homes enjoy their job of caregiving.

A 8. Have you been able to face up to your problems?

Table 8

Responses	**scale scores**	**Number of respondents**
More so than usual	0	5
Same as usual	1	2
Less than usual	2	Nil
Much less than usual	3	1
Total response		**8 =100%**

Table 8 reflects responses regarding being able to face up to one's problems amongst the caregivers. (65%) indicated that they could face up to their problems more so than usual, (25%) indicated same as usual, none indicated less so than usual and (12.5%) indicated much less than usual. In terms of being able to face up to problems, more caregivers indicated that they could face up to their problems more so than usual. This means that the caregiving job does not stand in the ways of facing up to one's problems.

A 9. Have you been feeling unhappy or depressed?

Table 9

Responses	**scale scores**	**Number of respondents**
Not at all	0	5
Not more than usual	1	2
Rather more than usual	2	Nil
Much more than usual	3	1
Total response		**8 =100%**

Table 9 reflects responses regarding feeling unhappy or depressed amongst caregivers. (65%) indicated not at all to feeling unhappy or depressed, (25%) indicated not more than usual, none indicated rather more than usual and (12.5%) indicated much more than usual. In terms of feeling unhappy and depressed more respondents indicated that they didn't feel unhappy or depressed. This denotes that the caregiving job does not always result in unhappiness or depression.

A 10. Have you been losing confidence in yourself?

Table 10

Responses	**scale scores**	**Number of respondents**
Not at all	0	5
No more than usual	1	2
Rather more than usual	2	1
Much more than usual	3	Nil
Total response		**8 =100%**

Table 10 reflects responses regarding losing confidence in one's self amongst the caregivers. (65%) indicated not at all, (25%) indicated 'no more than usual', (12.5%) indicated 'rather more than usual' and none indicated much more than usual. In terms of losing confidence in one's self more respondents indicated that they did not lose confidence in themselves at all. This means that the caregiving job does not cause any loss of self confidence.

A 11. Have you been thinking of yourself as a worthless person?

Table 11

Responses	**scale scores**	**Number of respondents**
Not at all	0	7
No more than usual	1	1
Rather more than usual	2	Nil
Much more than usual	3	Nil
Total response		**8 =100%**

Table 11 reflects responses regarding thinking of one‘s self as a worthless person amongst the caregivers. Eighty seven percent (87%) of the respondents indicated ‘not at all’, (12.5%) indicated ‘no more than usual’ and none indicated ‘rather more than usual’ or ‘much more than usual’. In terms of thinking of one’s self as worthless person more respondents indicated that they didn’t think of themselves as worthless. This means that the caregiving job might be contributing more to persons thinking of themselves as worthwhile.

A 12. Have you been feeling reasonably happy, all things considered?

Table 12

Responses	**scale scores**	**Number of respondents**
More so than usual	0	1
Same as usual	1	5
Less so than usual	2	1
Much less than usual	3	1
Total response		**8 =100%**

Table 12 reflects responses regarding feeling reasonably happy, all things considered amongst the caregivers. Twelve percent (12.5%) indicated that they felt 'more so than usual', (65%) indicated 'same as usual', another (12.5%) indicated 'less so than usual' and yet another (12.5%) indicated 'much more than usual'. In terms of feeling happy all things considered more respondents indicated that they felt happy all things considered. This indicates that caregivers are happy with their job all things considered.

4.2.1.2 Respondents' scores

According to the General Health Questionnaire (GHQ) individuals are scored according to their overall responses. The first responses have a score of 0, second responses have a score of 1, third responses have a score of 2, and the last responses have a score of 3. After all 12 responses have been given scores a total score has to be worked out for each respondent. Score range from 0 to 36. Scores also vary by study population.

Scores about 11-12 typical

Score >15 evidence of distress

Score > 20 suggests severe problems and psychological distress

Respondent 1 obtained a score of **5** after all 12 responses have been added together.

Respondent 2 obtained a score of **2** after all 12 responses have been added together.

Respondent 3 obtained a score of **26** after all 12 responses have been added together.

Respondent 4 obtained a score of **4** after all 12 responses have been added together.

Respondent 5 obtained a score of **18** after all 12 responses have been added together.

Respondent 6 obtained a score of **5** after all 12 responses have been added together.

Respondent 7 obtained a score of **7** after all 12 responses have been added together.

Respondent 8 obtained a score of **4** after all 12 responses have been added together.

The results of the respondents obtained from the GHQ 12 reflect that 75 % of the respondents are typical, meaning that they show no signs of distress or severe problems

and psychological distress as a result of the job of caregiving. Respondent 5 obtained a score of 18 and this is indicative of distress. Respondent 3 obtained a score of 26 and this is indicative of severe problems and psychological distress.

4.2.2 Section B: Qualitative part of the questionnaire

4.2.2.1 Themes elicited from the respondents

Below are descriptions of each respondent's subjective experiences, followed by the table that displays the themes found in the participants' responses. The main themes are bolded, and are considered to be those found in most of the stories.

Kindly describe your experiences as a caregiver in this institution. Please feel free to related both good and challenging experiences.

Respondent one: "Being a caregiver is something that needs love, dedication so I am enjoying it because everybody young or old needs love and needs to be taken care of. Sometimes it is hard because you work with sick a person that means you can also catch some of their disease".

Respondent two: "My good experiences as a caregiver is to give the old people care, especially those who are ill. I become glad when I have helped someone who is ill, from the bottom of my heart. So when you are a caregiver you must be patient, you must give

your time with love and you must give them care until they recover from their illness. My bad experiences are that if you are not patient with the old people they may not recover from their illness. You will cause them to be more sick if you do not support them and they will lose trust of ever becoming better when they are ill".

Respondent three: "I gladly appreciate to work here (at the old age home) although there are some days that are not well. To help the elderly is the most important thing in our world, but sometimes it makes us very impatient".

Respondent four:" to be a caregiver you must have a good heart and honestly be a helpful person at all times. You must be patient with people as they are different, sometimes they become rude but as a caregiver you must know you position. I have also experience that some of the old people are like babies, today it's this tomorrow it's that. Being a caregiver must come from deep down in your heart".

Respondent five:" working in the home for me has been a good change, sometimes it feels like I'm in my own home because I spend so much time here, but if you have been trained you will understand how to work with the old people. I make sure that I am happy at work and I try hard to satisfy everyone around me. Days are not the same but it's a blessing to work in a home because you learn every day; you laugh, you cry and sometimes you get angry at yourself and maybe at your boss, but you just have to be human at the end of the day. You have to make everyone happy because you came to nurse and give love".

Respondent six: “Good things I experience as a caregiver is to give elderly care that other people cannot give to them. The things that make old people feel comfortable are that other people care about them. Bad things to work with elderly are that sometimes they become mentally disturbed and they forget things, or where they have put their things, they sometimes say you have stolen, which is sometimes wrong”.

Respondent seven: “Sometimes it’s bad because the elderly don’t listen in everything you tell them, but I really enjoy it because I always tell myself that life is challenging. Sometimes you feel that you want to take your bag and go home, because of the elderly, because they keep shouting at you, but I enjoy working with the two elders”.

Respondent eight: “I like to be a good ward helper, because of the people. I am a person who cares. I need more experience. I think I manage the old age home, but sometimes it’s difficult, but I do my work”.

Respondent	Themes
Respondent one	”Being a caregiver is something that needs **love**, **dedication** so I am **enjoying** it because everybody young or old needs love and needs to be taken care of. Sometimes it is hard because you work with sick people that mean you can also **catch** some of their

	disease." a) **love** and **dedication** b) **enjoyment** of the caregiving job c) exposure to **diseases**
Respondent two	"My good experiences as a caregiver are to **give** the old people **care**, especially those who are ill. I become **glad** when I have helped someone who is ill, from the bottom of my heart. So when you are a caregiver you must be **patient,** you must give your time with **love** and you must give them care until they recover from their illness. My bad experiences are that if you are not patient with the old people they may not recover from their illness. You will cause them to be more sick if you do not support them and they will lose trust of ever becoming better when they are ill". a) **giving care** b) **enjoyment** of the caregiving job c) **patient** attitude d) **love**

Respondent three	"I **gladly** appreciate to work here (at the old age home) although there are some **days** that are **not well**. To help the elderly is the most important thing in our world, but sometimes it makes us very **impatient".** a) **enjoyment** of the caregiving job b) **days not well** (challenging) c) **impatient**
Respondent four	" To be a caregiver you must have a **good heart** and honestly be a **helpful person** at all times. You must be **patient** with people as they are different, **sometimes** they become **rude** but as a caregiver you must know you position. I have also experience that some of the old people are like babies, today it's this tomorrow it's that. Being a caregiver must come from deep down in your heart". a) **good heart** b) **helpful person**

	c) **patient** attitude d) sometimes they become **rude** (challenging)
Respondent five	” working in the home for me has been a **good** change, sometimes it feels like I’m in my own home because I spend so much time here, but if you have been trained you will understand how to work with the old people. I make sure that I am **happy** at work and I try hard to satisfy everyone around me**. Days are not the same** but it’s a **blessing** to work in a home because you learn every day, you **laugh**, you **cry** and sometimes you **get angry** at yourself and maybe at your boss, but you just have to be human at the end of the day. You have to make everyone happy because you came to nurse and give **love**”. a) **enjoyment** of the caregiving job b) **days are not the same** (challenging) c) you **laugh**, **cry** and get **angry** d) **love**
Respondent six	“Good things I experience as a caregiver is to **give** elderly **care**

	that other people cannot give to them. The things that make old people feel comfortable are that other people care about them. Bad things to work with elderly are that sometimes they become **mentally disturbed** and they forget things, or where they have put their things, they sometimes say you have stolen, which is sometimes wrong". a) **giving care** b) **mentally disturbed**
Respondent seven	"Sometimes it's bad because the **elderly don't listen** in everything you tell them, but I really **enjoy** it because I always tell myself that life is challenging. Sometimes you feel that you want to take your bag and go home, because of the elderly, because they keep shouting at you, but I enjoy working with the two elders". a) **elderly don't listen** (challenging) b) **enjoyment** of the caregiving job
Respondent eight	"I **like** to be a good ward helper, because of the people. I am a

	person who **cares**. I need more experience. I think I manage the old age home, but sometimes **it's difficult**, but I do my work". a) **enjoyment** of the caregiving job b) **giving care** c) **it's difficult** (challenging)

	Common themes	**Number of caregivers**
T1	Love and dedication	3
T2	Enjoyment	6
T3	Giving care	3
T4	Patient attitude	2

4.2.2.2 Common themes

The common themes elicited from the respondents gave the impression that they shared common feelings about certain things, such as love and dedication, enjoyment, giving care and patient attitude.

Most of the respondents revealed that love and dedication are some of the prerequisites of becoming a caregiver in an old age home. This is due to the nature of the job as in most cases caregivers will have to treat the care giving recipients with dignity.

In terms of enjoyment respondents indicated that part of what they feel about their job is enjoyment. They feel enjoyment during the process of interacting with the care giving recipients, who sometimes appreciate the job done by caregivers.

There were also some respondents who reflected on caring and patient attitude as other significant prerequisites that a care giver should have.

The study done on caregivers by Cohen, Colantonio, and Vernich (2002), also revealed caregivers could find at least one positive aspect of caregiving. Some of the things that were mentioned were companionship, fulfillment/reward, enjoyment, duty/obligation, meaningful/important, love.

	Unique themes	**Number of caregivers**
T1	Exposure to diseases	1
T2	Good heart	1
T3	Helpful person	1
T4	Days not well	1
T5	Day are not the same	1
T6	Laugh, cry and anger	1
T7	Mentally disturbed	1

T8	Elderly do not listen	1

4.2.2.3 Unique themes

The respondents also highlighted many other significant, but uncommon themes among them. The uncommon themes may be due to each respondent's personal experience of care giving. One respondent reflected that it is important to have a good heart when one is a care giver, one other caregiver reflected on being a helpful person as one of the significant prerequisite of being a care giver.

The respondents also reflected on some challenges they have experienced in the care giving job, such as exposure to diseases, that days are not the same when doing the job of care giving, there are days not well and presumably those that are better than others. There are days on which one laughs those on which one cries and those on which one is angry. This could be due to the challenges that some old people are mentally ill, and thus become difficult to handle, some do not listen, as many have become like children.

4.2.3 The respondents' profiles

The experiences of the caregivers were further analyzed in terms of their age, gender, level of experience and amount of time spent caregiving at the elderly home.

Respondent	Age	Gender	Level of work experience	Hours spent caregiving (per month)	Number of deaths experienced
Respondent one	28	Female	Three years	155	5+
Respondent two	35	Female	Three years	155	5+
Respondent three	29	Female	One year, eight months	155	5+
Respondent four	39	Female	Five years	155	10+
Respondent five	28	Female	Five years	155	10+
Respondent Six	30	Female	Three years	155	10+

Respondent seven	32	Female	One year, six months	155	10+
Respondent eight	39	Female	Six years	155	10+

The age and the number of years of experience do contribute in how the caregivers will appraise the experience caregiving. This is also evident in Weman, Kihlegren, Fagerburg (2004).

4.3 RESUME`

This chapter has presented a detailed discussion on the results of the research study. The main themes were identified and discussed. The next chapter will discuss the conclusions that were drawn from the findings of the study followed by the recommendations for further investigation.

CHAPTER FIVE

DISCUSSION, CONCLUSION AND RECOMMENDATIONS

5.1 INTRODUCTION

This chapter presents a discussion of results, including limitations of the study. It also draws conclusion on the findings that have been presented and then suggests recommendations on the study as a whole.

5.2 DISCUSSION AND RESULTS

5.2.1 The psychological problems experienced by caregivers

It is evident that every job has its own distressing factors that may lead an individual to experience difficulties at work, such as job burnout. This is indeed relevant to the caregivers as well, who are normally found in the old age homes. This study discovered that a high percentage of caregivers at La Gratitude are not experiencing any signs or symptoms of physical or psychological distress. This indicates that the caregivers of La Gratitude do not present with any physical or psychological problems from caring for the old people. They are still able to maintain healthy lives, despite their work roles.

The results of this study do not reflect the general population of caregivers, as its sample only focused in one old age home. Therefore it is inappropriate to generalize the findings of this study beyond its sample. However, the study notes that it would be possible that some caregivers who were not part of the study are experiencing even worse

psychological distresses in the workplace. Evidently psychological disorders can have a detrimental impact on an individual's personal life as well as work life.

5.2.2. Caregivers and job satisfaction

The caregivers of La gratitude experienced more job satisfaction from their work roles, as the findings indicated that most of the caregivers seem to be enjoying working with old people. Even when caregiving demands become more intense and result in high levels of distress and depression in most cases, nevertheless, caregivers often cite positive aspects of the experience. They report that caregiving makes them feel good about themselves and as if they are needed, gives meaning to their lives, enables them to learn new skills, and strengthens their relationships with others (Schulz & Sherwood, 2008). Caregiving can add meaning to one's sense of self (e.g. they also may include gaining a sense of fulfillment for meeting a duty or obligation and enjoyment) derived from caregiving itself or from companionship with the care recipient (Koerner et al., 2009).

It is then without any doubt that the caregiving job has different effects on different caregivers and it is not unlikely that some caregivers experience positive effects from their job. Caregivers vary in the degree of caregiver burden that they experience when caring for the frail elderly. It has not been clear which specific aspects or characteristics of the caregiving situation lead to burden or affect caregiver burden. It has also been unclear which areas of caregiving are hardest for individual caregivers and most affect their health or well-being (Chenier, 1997).

5.2.3 Caregivers' work challenges

The caregivers at La gratitude highlighted concerns about catching diseases, and that days are not the same. There are days where one laughs, there days where one cries, and there are days where one feels frustrated and angry as a caregiver. Nevertheless, the respondents overall experiences indicate that the good experiences outnumber the bad experiences. There is also evidence that negative and positive outcomes often co-exist within the same caregiver. For example, it was found that a large majority of caregiving events evoked both positive and negative appraisals by caregivers. Other researchers have found that a large proportion of caregivers (70 – 80%) experience both positive and negative emotions as a result of their caregiving role (Koerner et al., 2009).

5.3 CONCLUSION

This study investigated the experiences of caregivers in caring for the elderly. The general findings of the study indicated that more caregivers did not experience problems in caregiving, while a small number of caregivers did experience problems, which included among other things, depression and other serious psychological problems in the caregiving job. The results obtained from this study about caregivers at La gratitude also indicated the rewarding and positive outcomes of the caregiving experience. Although references were also made to some challenges about their job, they did not stand out as the positive experiences. The results of this study should not be generalized, as it was done in only one of many old age homes in South Africa.

5.4 RECOMMENDATIONS

i. More studies of this nature including a bigger sample of all racial groups representative of the South African context should be conducted.

ii. A study of this nature involving Black rural population group would provide more insight into emotional satisfaction that was reported by the participants in this study.

5.5 RESUME`

Notwithstanding potential methodological and sampling limitations, the present study made important advances in the understanding of the challenges faced by caregivers in caring for the elderly and their experiences of caring in this regard.

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APPENDICES

APPENDIX A: **INFORMED CONSENT**

CONSENT FORM

Research study entitled: "An investigation of the experiences of the caregivers in the Newcastle home of the elderly"

I understand that I am participating in research and that the research has been explained to me so that I understand what I am doing. I understand that I am not forced to participate. I am assured that there will be no mention of any of my identifying details when the research is published.

Signed _____

Date _____

APPENDIX B

A letter from La Gratitude granting permission to conduct a study in this Old Age Home follows in page 84.

La Gratitude

"The People Who Care"

Home for the Aged
Huis vir bejaardes

Fro. No. 066003230000

✉ 1418, Newcastle 2940
c/o York & Bird Street
Newcastle

Tel: (034) 315 5466
Tel/Fax: (034) 315 5467

2010-06-21

To: Miss Portia Ngubeni

RE: REQUEST TO CONDUCT A STUDY AT LA GRATITUDE HOME FOR THE AGED.

Hereby I would like to inform you that the abovementioned was approved by our Chief Executive Officer, Mrs JA Batista.

You can therefore come on the appointed date which is 24 June 2010 to 30 June 2010, to do your study. You will be assisted by a caregiver.

We look forward in working with you on this project.

Hope you find this in order.

Yours faithfully

Ms JA Batista
CHIEF EXECUTIVE OFFICER

General Health Questionnaire

Name.....

We want to know how your health has been in general over the last few weeks. Please read the questions below and each of the four possible answers. Circle the response that best applies to you. Thank you for answering all the questions.

Have you recently:

1. been able to concentrate on what you're doing?

better than usual (0) | same as usual (1) | less than usual (2) | much less than usual (3)

2. lost much sleep over worry?

Not at all | no more than usual | rather more than usual | much more than usual

3. felt that you are playing a useful part in things?

more so than usual | same as usual | less so than usual | much less than usual

4. felt capable of making decisions about things?

more so than usual | same as usual | less than usual | much less than usual

5. felt constantly under strain?

Not at all | no more than usual | rather more than usual | much more than usual

6. felt you couldn't overcome your difficulties?

Not at all | no more than usual | rather more than usual | much more than usual

7. been able to enjoy your normal day to day activities?

more so than usual | same as usual | less so than usual | much less than usual

8. been able to face up to your problems?

more so than usual | same as usual | less than usual | much less than usual

9. been feeling unhappy or depressed?

not at all | no more than usual | rather more than usual | much more than usual

CHS M278/EHS M270: Work and Health Winter 2004 10. been losing confidence in yourself?

not at all no more than usual rather more than usual much more than usual

11. been thinking of yourself as a worthless person?

not at all no more than usual rather more than usual much more than usual

12. been feeling reasonably happy, all things considered?

more so than usual same as usual less so than usual much less than usual

General Health Questionnaire Scoring

Scoring – Likert Scale 0, 1, 2, 3 from left to right.
12 items, 0 to 3 each item
Score range 0 to 36.
Scores vary by study population. Scores about 11-12 typical.

Score >15 evidence of distress

Score >20 suggests severe problems and psychological distress 3

Qualitative Questionnaire

Gender:

Male	Female

Age:

18-25	26-30	31-40	41-50	51 and above

Race:

White	Black	Indian	Coloured	Other

Residence:

Newcastle	Vryheid	Ladysmith	Other

1. Kindly briefly describe your experience as a caregiver in this institution. Please feel free to relate good and challenging experiences:

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Thank you for your participation!

APPENDIX C: **COMMON THEMES**

	Common themes	**Number of caregivers**
T1	Love and dedication	3
T2	Enjoyment	6
T3	Giving care	3
T4	Patient attitude	2

APPENDIX D: **UNIQUE THEMES**

	Unique themes	Number of caregivers
T1	Exposure to diseases	1
T2	Good heart	1
T3	Helpful person	1
T4	Days not well	1
T5	Day are not the same	1
T6	Laugh, cry and anger	1
T7	Mentally disturbed	1
T8	Elderly don’t listen difficultly	1

APPENDIX E: **PROFILES OF PARTICIPANTS**

Respondent	Age	Gender	Level of work experience	Hours spent caregiving (per month)	Number of deaths experienced
Respondent one	28	Female	Three years	155	5+
Respondent two	35	Female	Three years	155	5+
Respondent three	29	Female	One year, eight months	155	5+
Respondent four	39	Female	Five years	155	10+
Respondent five	28	Female	Five years	155	10+
Respondent Six	30	Female	Three years	155	10+
Respondent seven	32	Female	One year, six months	155	10+
Respondent eight	39	Female	Six years	155	10+