

# **A communal holistic therapeutic approach for psychosocial health management among Southern African indigenous communities**

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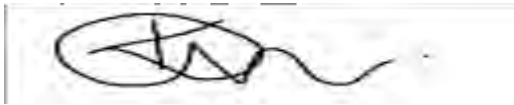
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**October 2023**

## Declaration

I, **KHAUHELO SUCCES MAHLATSI**, do hereby solemnly declare that the scholarly work found herein titled “**A communal holistic therapeutic approach for psychosocial health management among Southern African indigenous communities.**” Submitted to the **University of Venda, Department of Advanced Nursing Science** for the requirements of **Doctor of Nursing**. Is my original work, has been language edited, all other resources used have been acknowledged accordingly, and has not already been submitted to any other university.



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Khauhelo S. Mahlatsi:

October 2023

## Acknowledgments

### *Research and Scholarly Support*

I acknowledge the Seboka research community including the indigenous communities, for cuddling me in the warmth of scholarship, steering my journey of learning for the last decade through the mentorship of Prof. Dr A.J. Pienaar.



#### **The potency of a lifelong initiative**

This research project is a sub-project of the Seboka research Team. The African academic is firstly the child of mother Africa and secondly the creator of knowledge in the primary context of Africa and secondarily in the global sphere. The configuration of an African scholar's identity necessarily entails accepting a bundle of responsibilities shaped by mother Africa's potent imperatives. Etymologically defined, 'Seboka' denotes a 'group,' a 'team,' a 'community' and a phenomenal 'coming together' of sorts. The term of necessity subsumes one's ephemeral individuality under the value-generating ethos of 'communitarian' solidarity. A signifier of the shared benefits of synergy, the Seboka emblem - depicting a pride of lions on a mission under the supreme guidance of collective vision - is a celebration of the invaluable wealth of sharing and reciprocal engagement which lies at the heart of Africa's philosophy. As such, the Seboka concept was born out of respect for the imperatives of mother Africa, whose breast has availed the milk of human kindness moulding the African children into a team of valiant warriors in legitimate defence of their priceless heritage.

The Seboka logo summons to memory the telling axiom, 'A lion that goes on a hunt by itself, without co-existing in a pride, will always fail to catch even a limping deer.' In the same communitarian spirit, Seboka uses the claypot as a key emblem, symbolising sharing and communal solidarity. The Seboka team perceptively unpacks this definitive element of African life and essence, the profound *Ubuntu* philosophy, potently encapsulated in the dictum 'I am, because we are,' hence placing community and group care above the focus of the self. This Seboka team is a rich confluence of various tributaries, but the Community is their first consideration.

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## List of acronyms and abbreviations

AIHKS	- African Indigenous Health Knowledge System
APA	- American Psychological Association
CVI	- Content Validity Index
I-CVI	- Item Content Validity Index
CVR	- Content Validity Ratio
DSM - 5	- Diagnostic and Statistical Manual of Mental Disorders – version 5
HIV and AIDS	- Human Immunodeficiency virus, Acquired Syndrome.
ICN	- International Council of Nurses
LGMH	- Lancet Global Medical Health Group
LMICs	- Lower-middle-income countries
NCDs	- Non-Communicable Diseases
NGO	- Non-governmental organisation
SDGs	- Sustainable Development Goals
STT	- Support, holistic-therapeutic care, and tranquillity
SADC	- Southern African Development Community
P.R.N	- Pro re nata
RSA	- Republic of South Africa
U.N	- United Nations
WHO	- World Health Organization

## Abstract

**Background:** Mental health remains on the backseat of the global healthcare system. With more than a third of people suffering from mental health having no access to mental health services. Consequently, this research realizes that communality and *Ubuntu* are considered the epitomes of living systems in African indigenous communities. Therefore, the aim was to develop, confirm, and validate a Middle-range Theory of psychosocial health management among indigenous Southern African communities.

**Methods:** An explorative sequential mixed methods design was conducted. For the qualitative strand (Phase One), a qualitative approach was used where classical Grounded Theory was employed as a design. *Makgotla* were used as data collection method, and theoretical sampling was used for participant selection. In Phase Two, a qualitative approach followed where a critical, integrative literature review was conducted. Purposive sampling was employed for the literature collection. Finally, for the quantitative strand, a quantitative approach was used where content validity index (CVI), content validity ratio (CVR), and Kappa statistic were used to confirm and validate the emerging theory. Purposive sampling was used, where experts were selected for the confirmation and validation of the emerging theory.

**Findings:** This research presents an emerging Middle-range theory referred to as the 'Inclusive Holistic Communal Psychosocial Health Management Approach.' This approach is informed by the shared cultural belief system, co-living system, and communal therapeutic techniques. Fundamental to the emerging Middle-range theory are the five cultural axioms found in this research to be of evidential value to culturally congruent and needs-aligned psychosocial health management. Embedded in the belief that life is a holistic-circlis continuous process independent of living, wherein the point of equilibrium (good health) is the sense of balance between life and living. Furthermore, it has been found that the emerging Middle-range theory expressed through the 40-item instrument is content valid and comprehensive as all the items were found to be relevant and acceptable with I-CVI values greater than 0.79 and Kappa values above 0.74.

**Conclusions:** The emerging theory expresses the significance of increased community involvement and meaningful participation, shifting the paradigm of

custodianship of care to local people in the management of psychosocial health. To be utilized by nurses and other mental health care workers.

**Contribution:** The research uniquely contributes an emerging Middle-range theory for psychosocial health management among indigenous Southern African communities. This emerging Middle-range theory proposes an Inclusive Holistic Communal Psychosocial Health Management Approach that can be used by nurses and other mental health care workers. Furthermore, the outcome of this research solidifies the position and improvement of psychosocial health in nursing and mental health.

**Key concepts:** Communal, health, illness, healing, psychosocial health, Mental health nursing

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# Chapter One

## OVERVIEW OF THE RESEARCH

*Delineation of the problem from a blank slate?*

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### 1.1. Introduction and Background

*“...2030 Agenda has provided a blueprint for shared prosperity in a sustainable world—a world where all people can live productive, vibrant, and peaceful lives on a healthy planet”.*

*(António Guterres, Secretary-general of the United Nations in the SDG report 2019)*

*“Can all people live productive, vibrant, and peaceful lives on a healthy planet?”*

Contrary to the previous question the importance of the 2030 Agenda is the link to the Sustainable Development Goals (SDGs) three (good health and well-being) and 17 (partnerships for the goals). Hence, the position held by this research is that among indigenous African communities, ‘a blueprint for shared prosperity’ seems like an accessible dream, particularly in the pursuit of psychosocial well-being as embedded in SDGs three and 17.

Paradoxically, mental health and, therefore, psychosocial health remain on the backseat of the global healthcare system. World Health Organization (2022:37) reports that, on average, only two percent of health budgets is allocated to mental health, while one in eight people live with a mental health disorder, with more than a third receiving no mental health care. Between 2000 and 2019, an upward 25% of the world’s population were suffering from mental health disorders, whereas, in 2019, about 970 million people were living with a mental health disorder accounting for 13% of the world’s population (WHO, 2022:39). To this date, with the world’s population growing at a relatively constant rate, even though a substantial increase due to COVID-19 was noted, the rate of mental health disorders has not increased or decreased considerably (WHO, 2022:42).

Contextually, mental health contributes to 10% of the world's disease burden (International Council of Nurses, 2024:17). With more than a third having no access to mental health services. This neglect has resulted in a magnitude of adverse effects on the overall well-being of the world's inhabitants, especially in Africa (WHO, 2024:26). As a result, for acceptability, accessibility, and a needs aligned mental health approach, the World Health Organization (WHO) emphasizes the need for community-based mental health services (WHO, 2021:69). In so doing, WHO highlights the importance of incorporating and prioritizing psychosocial health at a primary health care level.

Unfortunately, mental health problems are becoming increasingly burdensome, and therefore, important to Africa. It is believed by Sankho *et al.* (2018: e954) that there is a deliberate intention to ignore the problems faced by Africans. To demonstrate, Africa finds itself with a low number of psychiatrists, mental health nurse specialists, hospital beds, and outpatient facilities, whilst reporting 1.4 mental health workers per 100 000 people, compared to the average of 9 per 100 000 found abroad (Sankho *et al.*, 2018: e954). These realities demand an appreciation and understanding of Africa and its unique mental health-related challenges through indigenous solutions.

Furthermore, the current realities in caring for mental health care users also need us to fully comprehend the position of psychosocial health care nursing. The International Council of Nurses (ICN, 2021) depicts the importance of psychosocial health care as a key aspect of comprehensive nursing care and significant to universal health care. Hence, there is a need for nurses to deliver holistic nursing care. Subsequently, it is now a common cause that nursing is the backbone of health care, by virtue of its cardinal role in the delivery of quality patient care and the total operations of health care systems globally (Mogbil *et al.*, 2023:1932). However, a study conducted by Al-Nawafleh and Altarawneh (2023:5) informs us that nursing students are generally preoccupied with and value technical skills over psychosocial care. Contrary, the ICN (2024:17) pivotally argues that there is no overall health without psychosocial health. Thus, with nurses being the frontline soldiers of the health systems, this research is important for comprehensive and holistic nursing care, positioning psychosocial health management as an integral component of patient care. Therefore, psychosocial health

is an area of nursing science that this research seeks to place as a fundamental competence in achieving comprehensive and holistic quality patient care.

On the other hand, the structure of the comprehensive action mental health plan 2013-2020 of the WHO envisions, *a world in which mental health is valued, promoted and protected, mental disorders are prevented and persons affected by these disorders are able to exercise the full range of human rights and to access high quality, culturally-appropriate health and social care in a timely way to promote recovery, in order to attain the highest possible level of health and participate fully in society and at work, free from stigmatization and discrimination* (WHO, 2013:9).

With the latter vision in mind, Bock (2015:46) asserted that in the best interest of mental health care users, mental health care should encompass relevant and culturally competent management. Congruently, Lancet researchers submit that with mental health and a broader spectrum of life, the key principle should be the understanding and appreciation of *the complexity and provision of meaningful choice* (Frankish *et al.*, 2018:1494). Accordingly, the health services rendered should not be shortsighted or negligent to healthcare users and the context thereof. Thus, mental health should be inclusive of services and mindful of context.

Before engaging further on the overview of this research, it is important to first clarify the question on the *Delineation of a problem from a blank slate*. This is tackled without prematurely indulging the methodological aspects of this research by confronting the long-standing argument on literature use in classical Grounded Theory studies. However, from inception, classical Grounded Theory (Glaser & Strauss, 1967) typically discourages reviewing the existing literature by exploring the 'known' and 'unknown' about the phenomenon under study before data is collected and analysed. Glaser (1998:67) puts it clear that, "*do not do a literature review in the substantive area and related areas where the research is to be done; and when the grounded theory is nearly completed during sorting and writing up, then the literature search in the substantive area can be accomplished and woven into the theory as more data for constant comparison.*" This stands to preclude researchers from forming theoretical ideas prematurely and even misconceptions. Hence, it is the position in classical Grounded Theory that if the researcher is aware of existent concepts, found in the literature, these might contaminate the theory and misrepresent its social reality

(Glaser & Strauss, 1967). Therefore, the researcher is required by the founders of classical Grounded Theory to stay open and discover the emerging theory from the raw data, hence the delayed literature review (Turner & Astin, 2021:286).

The central issue with classical Grounded Theory is that conducting a literature review before the collection and analysis of data may easily distract the researcher from what is meaningful to the emerging theory (Mccallin, 2003:63). That is why the researcher should be determined and mainly focused on the 'discovery' of the emerging theory and not speculations as can be found in the literature, referred to as rhetorical jargon by classical Grounded theorist (Glaser, 1998:68).

Despite classical Grounded Theory discouraging preliminary literature review, there has been a strong counterargument. Deering and Williams (2023:5) argue that a preliminary review is required before commencing any study. Consistently, El Hussein *et al.* (2017:1200) submit that as controversial as it is, a preliminary literature review in Grounded Theory is an unavoidable need. Equally, (Mccallin, 2003:67) disbar the myth of a researcher is a blank slate in Grounded Theory. That is why, for this research, of importance is the position of Turner and Austin (2023:287) reporting that the foremost issue in Grounded Theory is to remain clear and unambiguous on how the literature review was used to develop the emerging theory.

Hence, in this burning debate on how, and when to use the literature in Grounded Theory, this research opts for a non-committal literature review. This type of literature review is accepted in this research as synonymous with a preliminary or pre-study literature review. However, the emphasis is on the non-committal approach taken by the researcher. A non-committal review is defined by Urquhart and Fernández (2013:9) as an approach to scanning through the literature to develop theoretical sensitivity and for the delineation of the research problem. This non-committal approach is befitting for the delineation of the problem in this research because classical Grounded Theory was used in the qualitative strand of the study. Equally because the researcher cannot remain a blank slate in classical Grounded Theory research.

To this end, a no-committal review of the literature is needful and meaningful in locating the skeletal edifice of the research to provide a firm overview of the study.

First, the chapter provides the current standing of mental health globally followed by the progress made by the SDGs thus far. Western and African culturally inclined therapeutic approaches have been deliberated upon. Finally, a discussion on South Africa and Malawi as unique contexts ensued. Furthermore, a clear demonstration of the rationale and significance of the research is provided. Therefore, this problem was carefully delineated. The chapter also presents the overall aim of the research, with clear and measurable objectives on how to overcome the delineated gap.

The remainder of this chapter demystifies the concepts deemed necessary. Moreover, a central theoretical argument is postulated. This chapter also briefly discusses the research methods used in this research. A summary of this chapter is presented. Finally, an illustration of how this thesis is divided into chapters is provided.

## **1.2. Non-committal literature review**

Illuminating this challenge requires the researcher to introduce and focus this research, as asserted by Creswell (2014). Fundamentally, this literature review uses the literature sparingly to avoid influencing the inductive and deductive nature of the research methods. Glaser and Hilton (2004) regard the pre-study literature review as "a waste of time and a derailing of relevance." The purpose of this non-committal literature review is to delineate the research problem with no intention of influencing emerging results. Therefore, premature reasoning for the outcome of the research is avoided at this point (Creswell, 2014).

### **1.2.1. Delineation of the problem**

This research endeavours to delineate the problem by first illuminating mental health concerning psychosocial health, the current state of the health system, and the way forward. Furthermore, it undertakes the challenge of rendering the therapeutic approaches found in the Western paradigm. Moreover, various psychosocial and culturally aligned (respecting and sensitive) psychosocial approaches have been discussed.

#### **1.2.1.1. Mental health in relation to psychosocial health**

In the Western health system, a global subject of discussion in psychosocial health management is the *Diagnostic and Statistical Manual of Mental Disorders (DSM - 5)*.

The researcher's mental health training involved the aforementioned DSM. It is argued that this diagnostic tool places more weight on psychosocial functioning and disregards the holism of psychosocial health. This argument can be understood in confirmation with Ro and Clarks' (2009:314) assertion that one's performance regarding relationships and occupation, together with functioning in the broader context of life for the pursuit of values, holds an integral part in the diagnostic procedure of the manual. However, this does not mean that the researcher is not mindful of the psychosocial functioning that plays a critical role in psychopathology conceptualization, which is a core purpose of the manual (assessment and diagnosis). Fundamentally, to the researcher, these facts mean that the delivery of psychosocial health care from a Western perspective is compartmentalized and not approached from a holistic paradigm (assessment of physical health and mental health and treatment thereof).

It is widely known among the health workforce what WHO (2018) asserts "*there is no health without mental health.*" This slogan, together with this evidence by LGMH (2007:1241), presents mental health as an essential and inseparable component of health. Mahlatsi *et al.* (2021:2) affirmed that mental health cannot be separated from holistic health issues. Furthermore, this is a view held by the WHO (2013:7) with an emphasis on the obvious connection between mental- and social health in the management of psychosocial health challenges. Thus, the researcher asserts that one cannot divorce "mental health" from its social, physical, and spiritual elements.

As importantly, it is generally known that the WHO (2013:6) theorises mental health with a dual interpretation. First, it is a state of well-being in which one understands and appreciates their abilities, can cope with the normal challenges of life, attends to their occupational responsibility with positive results, and can play a significant role within the community in which they live. Ultimately, the conceptualization of mental health when looking through the lens of children places more attention on the developmental aspects of life. For example, when a child has a positive sense of identity, the skill is to have a positive outlook on his/her thoughts and emotions, as well as to maintain relationships and the ability to learn and to achieve in education, with a central goal of actively participating in the community they live in. However, Mahlatsi *et al.* (2021:2) stated that psychosocial health is integral to human nature and appreciates the

connectedness of communal heritage with its interpretation of the present and past. Congruent with the WHO (2013:7) assertion that mental health is an integral part of health and well-being, this holistic notion of mental health depicted by Mahlatsi (2021:9) and Pienaar (2017:90) is especially evident among African indigenous communities. Considering the above, psychosocial health, and mental health are deemed synonyms and used interchangeably in this research.

Be that as it may, it is the view of the researcher that one must be mindful and appreciate that we live in a world characterized by diverse paradigms, influenced by politics, culture, socioeconomic status, education, food security, and psychological outlook. With that said, the researcher perused the progress of the WHO and SDGs in relation to their targets in conjunction with the state of mental health globally.

#### **1.2.1.2. Statistics on non-communicable diseases and mental health by World Health Organization (WHO).**

The WHO (2018:7) reported that in 2016, approximately 41 million deaths were due to non-communicable diseases (NCDs), accounting for 71% of the overall 57 million deaths. The WHO further reported that adults in low-and-middle-income countries (LMICs) faced the highest risks (21% and 23%, respectively), almost double the rate of adults in high-income countries (12%). Virtually 800, 000 deaths were estimated to have been caused by suicide in 2016. Men are 75% more likely to die by suicide than women. However, suicide also occurs in adolescents and adults of all ages (WHO 2018:7).

Additionally, the WHO (2018:7) argues that more decisive and rapid progress is warranted to reach the targets of reducing premature NCD mortality by one-third by 2030, with actions pertinent to primary risk factors such as tobacco use, air pollution, unhealthy diet, physical inactivity, and harmful use of alcohol coupled with better disease detection and treatment.

In the mean, WHO (2018:7) reports that aged 15 years or older, the global level of alcohol intake in 2016 was 6.4 litres of pure alcohol per person, though it is a level that remained stable since 2010 consumption levels and trends vary across WHO regions. Just as Trangenstein *et al.* (2018:1) submit that in 2011, South African adults (aged 15 years and older) consumed 9.5 l of absolute alcohol each year. The author further

argues that this intake is higher than the average for Africa (6.0 l) and the world (6.2 l). In 2015, alcohol was the fifth leading cause of death and disability in South Africa. Similarly, the South African National Department of Health (2016:315) also stated that alcohol consumption is seen more among men than women (61% of men and 26% of women aged 15 years and older have ever consumed alcohol, and 37% of men and 10% of women drank alcohol within 7 days before the survey). Hence, Mbandlwa and Dorasamy (2020) reported that South Africa is recorded to be among the top 20 nations abusing alcohol.

Noticeably, according to the action plan document by the WHO (2013:8), these disquieting statistics are a result of inadequate health resources to the burden of mental disorders. It is reported in the comprehensive plenary report that between 76% and 85% of people with severe mental disorders have no access to treatment in low-income and middle-income countries; notably, even for high-income countries, it is relatively high, between 35% and 50%. Moreover, the action plan document strongly argues that another problem is the poor service delivery of mental health care to those who receive mental health treatment. As a solution, stakeholders involved in the plenary document submit that a redirection of funding for community-based mental health services would improve the quality of service, allow access, and contribute to cost-effective interventions.

Notwithstanding the efforts proposed by the WHO, the researcher further postulates that for an inclusive solution, mental health policy developers should realize the importance of community partnerships and appreciate the health practices found within these marginalized communities, particularly African indigenous communities.

### **1.2.1.3. Important points on the report on Sustainable Development Goals (SDGs).**

With the statistics mentioned in the previous discourse, the SDG (2019) report on the other hand, demonstrates that since 2016, there has been noticeable progress with respect to a certain number of Sustainable Development Goals and their targets. The response from governments and other stakeholders to the 2030 agenda is appreciated. However, this report shows slow progress on many SDGs, and for that reason, most marginalized communities continue to suffer unabatedly. Evidently, it is

unfortunate that actionable responses globally have not been aspiring enough. Casting doubt on the commitment of ‘a blueprint for shared prosperity’ by United Nations (UN) through its secretary-general.

Be that as it may, when looking forward to the continual implementation of the SDGs over the next ten years, the report offers directives on essential issues where political will, leadership, and fastidious multi-stakeholder action are warranted to radically effect change. Consequently, this will enable the United Nations to steer the world onto an exciting path that is friendly to competition across cultural bounds through the achievement of the Sustainable Development Goals by 2030.

In summary, from a psychosocial health perspective, vulnerable countries are rural areas of the world, such as Africa, which demands a shift in its health services model. As a result, there is a need for urgent realization by African politics and all stakeholders involved that Africa is all that it has and cannot remain helpless for eternity. Fundamentally, the health services model needs to be indigenously characterized and accessible to indigenous communities across cultural borders.

From the moral-ethical grounds of this standpoint, the research is evident in the Life Esidimeni tragedy in South Africa where over 2 000 mental health care users were hastily moved to ill-equipped and unlicensed non-governmental organizations (NGOs) in an attempt to curtail financial losses. As a result, the state as the custodian of health and justice failed to exercise their legal and moral responsibility in ensuring the respect, protection, and value of human life for mental health care users (Ferlito & Dhai, 2018:157). Under these circumstances, the result is lethal (Dhai, 2018:384 & Dhai, 2017:2). Lastly, from a human rights perspective, Dhai (2018:384) argues that because the health professionals who were involved opted to steer their loyalty towards the government of the day, this resulted in a dual-loyalty conflict that then generated a severe human rights violation.

Shockingly, all this is amidst the provision upheld in chapter three of the Mental Health Act (17 of 2002) of South Africa, which stipulates that the right to human dignity and privacy must always be respected. Furthermore, the Act advances that the treatments provided thereof should only be in the best interest of the mental health care user. All

things considered, the researcher observed the need for the development of a communal holistic therapeutic approach to psychosocial health management.

A communal holistic approach that involves community partnership to provide needs-aligned health care which is ethically and morally grounded in the protection of the human and cultural rights of its users. Opportunely, to the latter submission of the researcher, the WHO in the 2013 – 2020 plenary document proposes that the stakeholders position themselves that mental health includes not only individual functioning but also politics, social structures, culture, economy, and environmental factors, such as national policies, social protection, living standards, working conditions, and community social support, which are crucial determinants of mental health.

Essential, but not limited to responding to the global burden of mental health disorders, this comprehensive plenary document by the WHO (2013:7) condemns the prevalent human rights violation and discrimination towards people with mental disorders. In response, the action plan emphasizes the call for health services, policies, legislation, plans, strategies, and programs to protect, promote, and respect the rights of persons with mental disorders at the same breath as the International Covenant on Civil and Political Rights, the International Covenant on Economic, Social and Cultural Rights, the Convention on the Rights of Persons with Disabilities, the Convention on the Rights of the Child, and other relevant international and regional human rights instruments (WHO, 2013:7).

In addition, Mahlatsi (2018:11) concurs with the WHO (2013:8) that in low-income and middle-income countries, there is an evident scarcity of specialized and general health workers in the field of mental health. The WHO (2013:8) states that there is one psychiatrist at the most attending 200,000 or more mental health care users. Experientially, this can be supported by the researcher being a mental health nurse in a rural province of South Africa, where only one psychiatrist serves the whole mental health fraternity.

In line with the above, it is noteworthy to mention that Kadzin (2017:16) corroborates the WHO's (2013) assertions by admitting that treatment gaps for mental health are attributed to access to services. Kadzin (2017:16) further argues that in the USA and

across the world, many people in need of mental healthcare services are unable to receive treatment. Kadzin (2017:16) further submits that the situation prevails because services are provided at a site mostly on a one-to-one basis. Kadzin (2017) recommended convenient and accessible therapeutic interventions. Therefore, it is the researcher's view that there is a noticeable mismatch in mental health care services in relation to the psychosocial health needs of diverse contexts, such as Africa.

#### **1.2.1.4. The current state of mental health and the challenges faced in rendering therapeutic approaches by nurses trained and practising in the Western paradigm.**

Amidst, a decade ago, there was an urgent call by the Lancet Global Mental Health Group that governments across nations and inclusive stakeholders should realize the need to scale up mental health services, including the quality of attending to the treatment gap, especially in vulnerable communities with low-income and middle-income socioeconomic status (Frankish *et al.*, 2018:1493 & LGMH, 2007:1241). The authors argue that a basic, evidence-based platform of services for mental health needs to be established, and that it is equally important that the human rights of mental health care users and their families be protected and strengthened. Strikingly, this comes with the understanding that the burden of mental health disorders is immense worldwide. As already mentioned, there are an estimation of 1.1 billion people affected by mental or substance use disorders worldwide (Frankish *et al.*, 2018:1493).

In the meantime, some of the inevitable challenges in attending to the call by the LGMH group are enumerated by Lund *et al.* (2016:1), which include but are not limited to the lack of priority for mental health; high levels of poverty; cultural indifferences and discrimination; poor coordination by global, national, and local governments; lack of accountability; burden on first-line health workers; and unnecessary bureaucracy, all of which lead to a slow response to the burden of mental health across the world.

The LGMH group proposed four specific approaches to address the burden of mental health. However, for this research, strength will be drawn from the adjustment and corroboration of the first and fourth mentioned approaches by the group, which is a cost-effective community-based delivery of psychosocial therapies where specialized health practitioners are not found. Hence, this research proposes a communal holistic

therapeutic approach for the management of psychosocial health among indigenous communities with little to no access to mental health services. This communal holistic therapeutic approach for psychosocial health management posited by the researcher is supported by Lund *et al.* (2016:1) in response to the urgent call by the LGMH group regarding the implementation and scaling up of quality mental health services. The authors conducted a multi-country study (Ethiopia, India, Nepal, South Africa, and Uganda) in which the development and piloting of a district mental healthcare plan were undertaken, where a significant step in answering the burden of mental health was established.

Regarding the delivery of quality mental health care, nursing as a profession has a therapeutic approach to mental health users at the heart of mental health nursing care. Mirhaghi *et al.* (2017:4), supported by Acford and Davies (2019:7), hold that the nurse-patient relationship has been an important tool with the recognition of its benefits by nursing theorists. Congruently, Mirhaghi *et al.* (2017:4) further emphasized that even Florence Nightingale and Virginia Henderson emphatically upheld the nurse-patient relationship. Essentially, they trust the interpersonal, interactive, and constant relationship between the nurse and client, which helps patients improve their health. Perraud *et al.* (2006:224) continue to agree that a therapeutic management approach should be embedded in the concept *relationship*. Similarly, Mirhaghi *et al.* (2017:4) ascents that the therapeutic relationship is composed of significant knowledge and meaningful connections with patients.

However, Mirhaghi *et al.* (2017:4), Acford and Davies (2019:2), Harris and Panozzo (2019:110), Moreno-Poyato *et al.* (2016), and de Pinho *et al.* (2017:332) worry that there is compelling evidence on the challenges faced by nurses in delivering therapeutic relationships within the confinements of a hospital setting. For this reason, Mirhaghi *et al.* (2017:4) argue that, for the most part, there is a crisis of shortage of nurses across, and this becomes a strong barrier for nurses to carry out their therapeutic self. Harris and Panozzo (2019:104) found that the growing medical model has a significant influence on nurse-patient therapeutic relationships. On the other hand, Moreno-Poyato *et al.* (2016) realized that uncertainty around the conceptualization of therapeutic relationships is an impeding factor. Last but not limited, de Pinho *et al.* (2017:332) advance that a therapeutic relationship is not easy

as it demands nurses themselves to be therapeutic first – *therapeutic self* that involves active listening, empathy, and authenticity.

To put this into perspective, the researcher's clinical experience in the present time as a mental health nurse in both private and public health services in South Africa. There has been an avoidable paradigm shift in nurses' job descriptions and clinical roles. In general, mental health nurses in South Africa are being reduced to administrators sitting at nursing stations – writing notes and answering phone calls from psychiatrists, psychologist and social workers. Limiting the therapeutic role of a nurse. Thus, for the most part, mental health nurses only interact with the patients during the administration of medication. This is largely not by choice, but by how the system is set up.

Accordingly, N'Gambi and Pienaar (2013:95-96) argue that nurses in developing contexts work routinely and lack current mental health nursing skills as there is no in-service training, seminars, and further education. Disappointingly, even when evidence is abundant on the positive effects of in-service training, such as Bock (2015:202) found significant efficacy of a training program on mental health nurses in managing mental health care users with aggression in the South African context. No initiative is taken to implement such empirical and needful evidence-based findings by the policymakers and nurses themselves.

Regretfully, the dubiousness of the role of mental health nurses can be understood in line with the conclusion made by Higgins *et al.* (1999:60) in a study conducted in the United Kingdom that registered nurses and specialist nurses tend to spend less face-to-face contact with mental health care users. Furthermore, Fourie *et al.* (2005:136) in a study conducted in New Zealand with acute inpatient stay where mental health nurses' roles were explored, concluded that while nurses clinically perceived the therapeutic role as their most important role, they were often prevented from carrying out it.

This is even after Evans (2001:33); Harris and Panozzo (2019:110), and Mirhaghi *et al.* (2017:5) conceded that the role of nurses has been organically holistic where one-to-one nurse-patient relationships and therapeutic self are of priority. In essence, the researcher holds it as evidence that there is a lack of ownership by nurses and a lack of nurse leadership bringing about decisive and necessary positive change in the

clinical field. In totality, this regrettably goes against *objective 3* of the mental health action plenary document by the WHO, which calls for the strengthening of effective leadership and governance for mental health (WHO, 2013:10).

In addition, by comparing the views of Campbell and Simpson (1986:23) and Kales *et al.* (2018:6) the researcher observed that mental health nurses are found to be dependent on seclusion, physical restraint, and pro re nata (p.r.n) medication for effective management of difficult and aggressive patients. Even though the most compelling evidence is found by Bock and Pienaar (2013:110) that seclusion is used mostly when not needed as mental health nurses overly depend on the physical containment of mental health care users to manage aggressive behaviour.

Currier (2003) and Donat (2005:1108) showed that p.r.n medication has now substituted physical restraint in the form of chemical control. Furthermore, in light of p.r.n. medication preferred as first-line therapy, Donat (2005:1108) reported that benzodiazepines often lead to addiction and can affect the development of daily living and coping skills. Barlow *et al.* (2000) and Carlson *et al.* (2019:7-8) lodge that understanding psychotropic medication is pertinent to the history of substance abuse as a contributing factor to aggression and disruptive behaviour.

It is worth noting that in a retrospective study conducted by Curtis *et al.* (2007:322-324) in Australia, mental health nurses relied on psychotropic medication (p. r. n. in particular). The concern is that these pharmacological interventions are for *quick-fix* purposes that are more beneficial to health workers than mental health care users. Juxtaposed to all (Curtis & Capp 2003:324; Geffen *et al.*, 2002:647; Gray *et al.*, 1997; McKenzie *et al.*, 1999:191 & Usher *et al.*, 2001:389), it is clear that all these studies support the mentioned challenge that nurses are overly reliant on pharmacological interventions. Asher *et al.* (2017:3) contest that pharmacological interventions alone are insufficient in managing the complexity of social, economic, and health challenges of those affected by chronic and highly disabling illnesses, such as schizophrenia.

On the other hand, Duxbury and Baker (2004:666) and Mirhaghi *et al.* (2017:8) in line with this research proffer that local evidence-based therapeutic interventions are needed more than ever before. Usher and Luck (2004:20) discovered in a literature review that medication should be the mental health nurse's last resort where

interventions such as de-escalation, talking, or separation from the group are prioritized for the betterment of the patient. At the same time, de-escalation skills are referred to by Sookoo (2004) as well as Acford and Davies (2019:5) as the understanding of contributing factors to disruptive behaviour or aggression where the mental health remains calm; appears in control but not confrontational by maintaining less eye contact, using reflective listening, and presenting yourself as an advocate for help.

Overall, the researcher submits that the above argumentation on psychosocial health management found in the Western model with the marked shift in the role of a nurse as a therapeutic self. The latter give rise to the development of the needed communal holistic therapeutic approach for psychosocial health management in the African context.

#### **1.2.1.5. The culturally aligned therapeutic approach found in the African or other similar indigenous health paradigms.**

As has been noted, psychosocial health challenges around the world are a challenge, particularly in Africa, where indigenous communities are predisposed to the disproportionation of resources, resulting in no access to health care. Community-based therapeutic management of psychosocial-related health challenges appears to be less of a priority among researchers. Hence, the researcher endeavoured to confront and deliberate the available literature on relevant psychosocial interventions, particularly within indigenous African communities.

To start with, the researcher battled with the reality of being a Western-educated health practitioner in the African context, where health workers across cultural boundaries offer biomedical measures as a solution to mostly indigenous health problems. Equally, these sentimentalities are shared by Bock (2015:1), who posits that as a mental health care practitioner, the author was doubtful about implementing biomedical measures with violent patients, such as seclusion. Hence, Bock (2015:2) came to the deduction that the misunderstanding of the culture being practised by mental health care users contributed greatly to the lack of a patient-nurse therapeutic relationship.

Fundamentally, Pienaar (2013:1) submits that at the centre of mental health care in Africa is the belief that the philosophy of *Ubuntu*, I am because you are, personifies the care provided with its three key principles: support, holistic therapeutic care, and tranquillity (STT).

Given this position, Phokane (2018:63) concluded that health professionals find themselves in diverse communities, which necessitates them to develop cultural awareness to comprehend and respect the complexity of the African indigenous context. This understanding is upheld by Mahlatsi *et al* (2021:8) and Mphuthi (2015:14), who contend that illness in the African indigenous context is understood as a shift in the connectedness of the physical, mind, and spirit of the communal person. This understanding is a result of the sensitivity and respect shown by these scholars in unique, marginalized communities.

Meanwhile, N'Gambi and Pienaar (2013:89-104) provide a categorical solution to these challenges in the chapter *facilitating therapeutic mental health nursing in a developing African context* with the aim of sensitizing the reader to health care in Africa. The authors demystify therapeutic mental health nursing as a medium to deliver care to the whole person (spiritual, psychosocial, and physical) in a compartmentalized manner. According to these authors, the whole person extends to the inclusion of family, extended family, health practitioners, and the community (N'Gambi & Pienaar, 2013:89).

Furthermore, Pienaar and Uys (2013:69-88) position time and purpose as key principles in the therapeutic interaction when managing a HIV-positive person. These authors argue that the counselee appreciates the principle of time to de-escalate their emotions to make informed decisions and appropriate health choices based on their readiness. While purpose is interlinked to the first principle of time, it is appreciated that the common goal of the interaction is centered on the counselee and not the routine professional tasks (Pienaar & Uys, 2013:82). Hence, the care giver is guided by the care user and not vice versa. The purpose is further appreciated when the care giver affords the user the space to open up and not negate the suffering experienced by the counselee (Pienaar & Uys, 2013:82). Conclusively, the authors found that harmony is equally crucial to the two principles, together with the appreciation and acceptance shown by both the care giver and care user towards each other.

Overall, this discourse set a pivotal premise for researcher's understanding of therapeutic nursing care for vulnerable individuals in diverse contexts such as those in Africa. Explicitly, this premise speaks to the appreciation and understanding towards the consumers of therapeutic nursing care practice in the management of psychosocial challenges across cultural paradigms. The researcher further argues that this research seeks to inform the practice as well as teaching and learning in mental health to appreciate the cultural diversity of Mother Africa, but also, aspires for mental health researchers to realize the significance of being sensitive to indifferent cultures when contributing to the body of knowledge. is empirical in response to the burden of mental health across the world.

In sync, Bock (2015:95) comments on the importance of cultural competency when diagnosing and managing mental health challenges. The author found that the Basotho and Khoisan communities deduced a significant link between the cause and management of mental health challenges (Bock, 2015:96). Significantly, this accentuates the premise of the current research that mental health nurses need to be culturally congruent and sensitive to culturally diverse communities found in Africa. Hence, the researcher intended the development of a communal holistic therapeutic approach for psychosocial health management in African indigenous communities that upholds cultural awareness and respects communal individuals. This is in line with one of the cross-cutting principles and approach of WHO in the comprehensive action mental health plan 2013-2020 avowing that evidence-based practice on mental health strategies and interventions for treatment, prevention, and promotion needs to be grounded on scientific evidence and/or best practice, taking cultural considerations into account (WHO, 2013:10).

#### **1.2.1.6. South Africa as a Context**

South Africa is in the southernmost part of the African continent, with an estimated population of 62 million with an annual rate growth of 4.1% (Department of Statistics, 2022:2). Evidence of inequalities in South Africa is established in the literature. Consequent to these realities comes the downside of access and affordability of health care in general. Thus, it was found by (Burger & Christian, 2020:51-52) that even with the efforts of the post-apartheid government in South Africa, rural communities have little or no access to health care. What calls for further concern is that South Africa has

no more than 700 psychiatrist specialists, with a population of 62 million. These challenges led to the Life Esidimeni tragedy where over 2 000 mental health care users were hastily moved to ill-equipped and unlicensed non-governmental organizations (NGOs) in an attempt to curtail financial losses. Consequently, the state as the custodian of health and justice failed to exercise their legal and moral responsibility in ensuring the respect, protection, and value of human life for mental health care users (Ferlito & Dhai, 2018:157). These results were lethal (Dhai, 2018:384 & Dhai, 2017:2). Even though the model was for deinstitutionalization, where mental health care users relocated to community efforts failed because of unpreparedness.

#### **1.2.1.7. Malawi as a Context**

Malawi is a landlocked country situated on southeastern Africa. Tanzania, Lake Malawi, Mozambique, and Zambia border the country to the north, east, south, and west. According to the 2018 Malawi Population and Housing Census main report, the population stands at more than 17 million, at a growth rate of 2.9 per cent per annum (National Statistics Office, 2019:4). Malawi is a densely populated area, particularly in rural areas, with more of its population residing in rural locations. As reported, population density increased from 138 persons per square kilometre in 2008 to 186 persons per square kilometre in 2018 (National Statistics Office, 2019:12).

With the above demographic revelations, there is a collage of concern regarding access to health services within the country, particularly in rural communities. Malawi has established itself for its free access to public health services (Makwero, 2018:2). However, in addressing the SDGs, Malawi still finds itself lacking. Accordingly, in light of the above realities, Makwero (2018:2) proffers a need for policy support for the provision of quality care and accessibility. It is also important to note that traditional healers form an integral part of primary healthcare in the health system. In the meantime, like many other African countries, it was found by Kauye *et al.*, (2015:127) that Malawi has a daring shortage of psychiatrists and broader mental health staffing wherein the rendering of quality health services is affected. It is reported by the Health Sector Strategic Plan II 2017-2022 that across levels of care, there is a 29% vacancy for medical officer positions and 66% for nursing officer positions. This means that there are 114 medical officers and 2 177 nursing officers providing health services to a population of approximately 17 million. It is further reported that there are currently

no clinical psychologists or consultant psychiatrists in the country (Health Sector Strategic Plan II 2017-2022:27).

Therefore, these damning facts further set a pivotal premise for the researcher's endeavour for holistic therapeutic care that is accessible, cost-effective and efficient for vulnerable individuals in diverse contexts that are readily accessible, cost-effective, and efficient. Hence, the researcher endeavoured to develop a communal, holistic therapeutic approach that upholds cultural beliefs.

Evidently, in summation of this argument and in terms of the Constitution of South Africa together with the Mental Health Act 17 of 2002, one must reconcile with the appreciation that mental health is a matter of basic human rights. Even in resource-stricken contexts such as Africa, this endorsement by the WHO should be a priority for those in positions of decision-making in respective countries. Amidst this, Africa finds itself with a Western-dominant paradigm that characterizes itself with a compartmental health services approach. Even under these conditions, health services are discriminatory and costly for the poor masses in Africa. In the midst, the WHO shows alarming statistics on non-communicable and mental health across the world. The latter regression coupled with some progress noted from the work done by the SDG, together with the latest tragedy at the hands of healthcare workers in South Africa on the Life-Esidimeni outrageous loss of lives and violation of human rights.

Consequently, all of these informed the researcher of the urgency that Africa needs to find herself and use all that is befitting to save herself. Be that as it may, the researcher infers that one must be mindful and appreciate that we live in a world that is characterized by diverse paradigms, influenced by politics, culture, socio-economic factors, education, food security, and psychological outlook. Even within the paradigm of Western healthcare, there is an amorphous tone on the clinical role of a mental health nurse, now overcompensated by the abuse of psychiatric medication administered to mental health care users.

Hence, with this evident clinical mismatch the researcher stood for the development of a therapeutic approach cantered around the principle of "*Ubuntu*" that involves community partnership to advance a need-aligned health care, characterized by ethical-moral grounds and protection of human and cultural rights of its users.

### 1.3. Problem Statement

The disquieting evidence that 970 million people across the world suffer from mental-related problems (WHO, 2024:39). Unavoidably, juxtaposed with an ineffective mental health services model or lack thereof on the African continent, the crisis of mental health care is palpable.

Furthermore, this crisis needs to be understood in the context that the Sustainable Development Goals (SDGs) Report (2019) shows that progress in many SDGs is lagging, resulting in unabated suffering for most marginalized communities. Worryingly, South Africa, with a population of about 62 million, has only approximately 700 psychiatrists and a 40% vacancy of mental health nurses, which illuminates a serious shortage of mental health practitioners. It can be concluded that these severe shortages have led to the Life Esidimeni tragedy. Similarly, Malawi has a severe shortage of psychiatrists and general mental health personnel, which hampers the provision of quality health services. According to the Health Sector Strategic Plan II 2017-2022, there are 29% and 66% vacancies in medical and nursing positions, respectively, at all levels of care. With this concern, psychosocial health care provided among these indigenous communities remains inaccessible, unaffordable, and ineffective, with no desire on the side of the governments of Africa to find mutual beneficial solutions.

At the same time, despite the encouraging vision of the 2013 – 2020 plan by WHO, including the slow progress made by the SDGs, the researcher argues that the approach of the Western-modelled health system found across the world, particularly in Africa, is underappreciated by the complexity of mental health needs in Africa. Despite many efforts to alleviate this challenge, the status quo continues unabatedly, which has led to an ineluctable mismatch in mental health care provision concerning the needs of indigenous communities.

Unfortunately, if the crisis is left unattended and in the hands of Western-characterized health services, the gross human rights violations in South Africa will continue unabated. Where the lives of those living with mental disorders were disregarded in the explanation of cost-cutting measures between Life Esidimeni and the state (Ferlito & Dhai, 2018:157). Moreover, policymakers will continue to find less value for community involvement in policy formulation. Therefore, resulting in disapproval of the

health practices found within vulnerable communities, particularly African indigenous communities. Equally important, funding for mental health is disproportionate. Furthermore, even with inpatient mental health care, nurses are found wanting with their therapeutic self and the one-to-one relationship, shifting to a less constructive role of 'medicine-oriented nurses' because of how the Western model is laid out.

These inherent consequences affect communities, such as Khoisan in the Northern Cape. In contrast, during the researcher's community partnership engagements, it was observed that this community manages various psychosocial challenges, even though there are no qualified mental health nurses, counsellors, or therapists in this community. Psychosocial challenges are evident in the community based on substance abuse-related, relationship stressors, work-related issues, and child and adolescent stressors, however not limited to the mentioned. Equally, Malawi is affected by the challenges alluded to. However, this community is also known to follow their own communal processes because they are far from the nearest health centre. Psychosocial challenges are evident in the community based on relationship stressors, socio-economic-related issues, and child and adolescent stressors, however not limited to the mentioned. After self-reliant functioning in the community to address psychosocial issues, this evidence has not been explored and added to the body of knowledge.

Therefore, as an evidence-based solution, the researcher proposed a communal holistic therapeutic approach for psychosocial health management in African indigenous communities, with its services embedded in a strong relationship with communities to promote health in these communities. Expectantly, this research is geared towards revitalizing indigenous communal use, informing teaching and learning, and further research, and informing health service policymakers. Thus, this should immediately acknowledge the self-reliant health practices of the Khoisan community in Northern Cape, South Africa, and Malawi for the management of psychosocial health challenges.

#### **1.4. Aim of the research**

The overall aim of this research is to develop, confirm, and validate a communal holistic therapeutic approach for psychosocial health management among indigenous Southern African communities.

### 1.5. Objectives of the research

The objectives of the research are to:

- Develop a formal theory from the preliminary conceptual framework using Grounded Theory (**Phase I**).
- Conduct a critical, integrative literature review to compare and contrast the constructs that emerged from formal theory against alternative models from the existing literature (**Phase II**).
- Develop a preliminary communal holistic therapeutic approach for psychosocial health management in indigenous African communities for nurses and other mental health care workers (**see the outcome of Phases I and II**).
- Confirm and validate the emerging theory through expert validation {Content validity Index (CVI), Content validity ratio (CVR), and kappa statistic} (**Phase III**).

### 1.6. The Rationale of the research

The Middle-range theory developed in this research is a gap identified in the existing body of knowledge. This gap in psychosocial health exists in nursing specifically and the broader health domain as evidenced by the findings of Nishikawara et al. (2023:4), in which patients report that they do not find a connection with the psychosocial health care provided to them. Because there is no comprehensive, patient-centred psychosocial health management approach demonstrating respect to the role of the patient in the care provided with effective medical and nonmedical referrals. On the other hand, Alinaitwe *et al.*, (2024:7) advocate for culture sensitive and context specific psychosocial health management approaches that involves and positions family participation as a pivotal role in patient care. Hence, the need for the current study which its developed theory regards the indigenous communities as the custodians of psychosocial health care.

After the non-committal literature search and refractive exploration, Pienaar and Uys (2013:69-84) only limited their therapeutic approach to HIV and AIDS care in South Africa. In the meantime, Bock (2015:2) conducted research in the southern region of Africa on mental healthcare users presenting with aggressive behaviour. The author advanced that the misunderstanding of the culture being practised by the mental

health care user contributed greatly to the lack of a patient-nurse therapeutic relationship (Bock, 2015:2).

In a retrospective study conducted by Curtis *et al.* (2007:322-324) on psychotropic medication in Australia, it was found that there is a reliance on psychotropic medication by mental health nurses. By and large, the concern is that these pharmacological interventions are for *quick-fix* purposes, which is more beneficial to health workers than to mental health care users. Juxtaposed to (Curtis & Capp 2003:324; Geffen *et al.*, 2002:647; Gray *et al.*, 1997; McKenzie *et al.*, 1999:191 & Usher *et al.*, 2001:389), all of which support the aforementioned challenge that nurses are overly reliant on pharmacological interventions. These authors contest that pharmacological interventions alone are insufficient in managing the complexity of social, economic, and health challenges of those affected by chronic and highly disabling illnesses such as schizophrenia.

Holzapfel (2018:46) argues that the use of antidepressants in managing bipolar depression was controversial in a study conducted in South Africa on pharmacotherapy prescription patterns. However, a study conducted in Botswana by (Olashore *et al.* 2017:5) found that in recent times newer psychotropic medications with fewer adverse effects were prescribed more often than older medications. The authors further suggested that more evidence is still needed on the efficacy of new psychotropic agents.

In Zimbabwe, Masuka and Khoza (2020:7) conducted research on the reporting system of pharmacological therapies and found that important milestones have been reached. However, currently, the system is only limited to the mechanical functioning of medicines instead of broadening the spectrum to the adverse drug reaction burden experienced by patients. In Malawi, it was found by (Chikowe *et al.*, 2019:5) that mental health care users who are on chlorpromazine or haloperidol experience severe side effects, such as sexual disturbances and weight gain, which negatively affect their lives. Moreover, another study conducted in Malawi found that outpatients who take second-generation antipsychotics are more likely to be readmitted 12 months after discharge (Msiska, 2019:60).

Amid these challenges, this research posits that the proposed solution is an approach that is readily available to communities. This is particularly true during these times of uncertainty imposed by COVID-19. Luykx *et al.* (2020:471-473) found that challenges brought by COVID-19 include reduced access to mental health care, serious drug interactions between psychotropic medicine and COVID-19 drugs can be serious, adjusting psychotropic therapies, and changes in the pattern of prescription.

Thus far, it can be concluded that for the nursing profession and the broader health practices, culturally aligned psychosocial health models are becoming important to accessible, cost-effective quality patient care. Derouin (2022:121&124) argue that because the science of the profession of nursing is centred on biosocial-psychological models. It is of significance that nursing is differentiated from other professions that are diagnosis and problem-solving centred. Hence, for the comprehensive and holistic nursing care, the psychosocial health nursing approach should demonstrate patient-and-family-centred delivery model, cultural competency, family participation, beliefs and practices. Equally, Rempusheski *et al.* (2018:304) submits from the authors' research on community engagement model to match psychosocial health needs that the existing health knowledge found with a particular community plays a fundamental role in the provision of quality nursing care. In a study conducted by Segalovich *et al.* (2022), it was found that mental health nurses should start appreciating the local shared values, culture, and preferred health practices of patients. That is why the current research is needful to the broader health professions, particularly nursing sciences. Hence, the researcher, as a community mental health nurse, proposed that for quality psychosocial nursing care through an approach that patients can relate to, an accessible, culturally competent, inclusive, and needs-aligned approach was warranted, particularly in the Southern African region.

### **1.7. Significance of the research**

Psychosocial health is an important competence for nurses and other mental health care workers (ICN, 2024:17). Therefore, the psychosocial health management approach found in this research is envisioned as a lifestyle means for indigenous communities to revitalize indigenous communal use. Second, the research, through a partnership with the communities involved, was pursued to inform teaching, and learning in nursing and mental health to appreciate the cultural diversity of Mother

Africa. This research further aspired to open the lens of mental health nursing research to a broad spectrum that realizes the significance of being sensitive to indifferent cultures when contributing to the body of knowledge of nursing specifically and mental health generally. Finally, this research anticipates the rise of new research innovations to inform policymakers in health, including nursing, in the Southern African context.

### **1.8. Pre- liminary conceptual definitions**

These pre-liminary conceptual definitions should not be misunderstood as preconceptions that might have contaminated the openness of the research at the pre-study level, since classical Grounded Theory is opposed to the early formation of conceptual ideas. Equally, they were not meant to be operationalised but to provide an adequate overview of the phenomenon under study. That is why they should be understood as definitions emanating from a conceptual framework used in this research as the substantive area of the emerging theory. Furthermore, it is important to note later in the study (see findings of Phase I) that the majority of these concepts are integral to findings of the qualitative strand emerging into new constructs as the levels of the theory advance from the raw data.

#### **Communal**

*Communal* in this research is appreciated in line with Mahlatsi (2018:13) who in collaboration with the Khoisan community confirmed that "it refers to the societal context where sharing and caring is of primary importance, especially noted in an indigenous community." *Communal* will be further applied and attributed in this work as Nare *et al.* (2018:5), stating that indigenous African communities hold the connectedness between the living and those who passed on to another realm, those who were here before us.

#### **Communal individual**

Fundamentally, application and understanding of this concept are drawn from Mahlatsi *et al.* (2021:2), where the author in collaboration with an indigenous Khoisan community operationalizes *communal individual* as "person(s) who is seen as a whole (body, mind, emotions and spirit), connected to other persons; surroundings; and those who were here before us living with a principle of sharing and caring."

#### **Health**

*Health* in this research is understood and appreciated in line with Pienaar (2013:48) and Mphuthi (2015:13-14), who assert that health is a matter of restoring the balance between the mind, body, emotions, and spirit. At the same time, its application draws strength from Nare *et al.* (2018:5), who found that health in African indigenous communities is valued as a holistic healing approach (focusing on the *whole person*).

### **Health management**

Health management is demystified from an artificial intelligence paradigm by Khan and Yairi (2018:242) as the practice of diagnosing and preventing system failures, as well as forecasting the reliability and remaining useful life of its components. These authors stand to position the aim of health management as the gathering of pertinent data from different sources and delivering the necessary processing involving the removal of key features, fault diagnosis, and predictions (Khan & Yairi, 2018:248).

However, in this study, health management is appreciated as a collective action of identifying, assessing, diagnosing, and managing an imbalance of life through community participation and for the community.

### **Holistic therapeutic approach**

In this research, a therapeutic approach is regarded as a health service that envisages delivering care to the *whole person* who is rooted in involving not only the mental health care user but also the family and the community at large to source for the support system available. The primary purpose of this therapeutic approach is healing and alleviation of suffering through the restoration of the balance of life (Uys & Middleton, 2004:16; Mahlatsi, 2018:9 & N'Gambi & Pienaar, 2013:89).

### **Psychosocial health**

In this research, *psychosocial health* is deemed a multifaceted (cultural, socio-economic, political, and belief system) phenomenon where a human being will be seen as a collective attached to a communal history with its interpretation understood and appreciated within its context. Moreover, commonality speaks to the understanding of health for sustainable psychosocial health; the communal individuals within the community should be in control with a sense of ownership in the problem system (Mahlatsi *et al.*, 2021:2).

### **Whole person**

In this research, *whole person* refers to a person(s) who are seen as spiritual, psychosocial, and physical beings in the totality of the family, extended family, and the community at large, as stated in (N'Gambi & Pienaar, 2013:89).

### **1.9. A brief discussion of the research methodology**

This study followed a Mixed Method Research in which both qualitative and quantitative methods were used to generate, confirm, and validate the emerging theory (Creswell & Creswell, 2023:229). The design employed was an Exploratory Sequential Mixed Methods Design. Creswell & Creswell (2023:242) argue that exploratory sequential mixed methods design involves the development of new meanings through qualitative methods not necessarily available in the literature and then testing it through quantitative methods. This design is put into perspective by Creswell and Creswell (2023:236&242) as a Three-Phase Design where a qualitative phase begins the process, followed by a design phase refining the findings for quantitative testing, and then by a quantitative phase for testing the emerging constructs. Hence, this research consists of three phases in which the first two phases represent a Qualitative Strand, with the last phase representing a Quantitative Strand.

For the qualitative strand, firstly, in Phase One, a qualitative approach was used where classical Grounded Theory was employed. *Makgotla* was used as a data collection method, and theoretical sampling was used for participant selection guiding collection and analysis of data. Subsequently, in Phase Two, a qualitative approach followed where a critical, integrative literature review was conducted. Purposive sampling was employed for the literature collection. Finally, for the quantitative strand, in Phase Three, a quantitative approach was used where content validity index (CVI), content validity ratio (CVR), and Kappa statistic were used to confirm and validate the emerging theory. Purposive sampling was used, where experts, predominantly nurses, were selected for the confirmation and validation of the emerging theory.

As suggested by Creswell and Creswell (2018), data collection primarily took place at three points in the research: for the qualitative strand, initial qualitative data was collected in the first phase and another qualitative data in the second phase. Finally, for the quantitative strand, the quantitative data was collected through the confirmation and validation of the emerging constructs in the third phase. Therefore, the data analysis took place separately, where the findings from phase one built into the

hypothetical models (phase two) were confirmed and validated in the third phase. That is why in Phase one, a joint collection and analysis of data took place as guided by the process of theoretical sampling. Secondly, a two-coding process ensued where substantive (open) coding and theoretical coding were used to excavate the deep meaning of the data. Thirdly, a constant comparative analysis was employed to compare and contrast the raw meaning of the data from the two groups. Lastly, a collaborative analysis method was used to collectively bring out the essence of the emerging data.

It is important to note that the population of the three phases was not similar. In the first qualitative phase, human participants in an African indigenous context were sampled through theoretical sampling. Participant-group one - South Africa and participant-group two - Malawi; in the second qualitative phase, documents were sampled and in the last phase, a criterion was developed to sample experts (human) to confirm and validate the outcome of the research.

Lastly, the rigor of the qualitative strand was safeguarded by ensuring trustworthiness of the research through the principles of credibility, transferability, dependability and confirmability as guided by Lincoln and Guba (1985). At the same height, the rigor for the quantitative strands was safeguarded by ensuring the principles of validity and reliability of the findings.

### **1.10. Chapter summary**

The research began with an overview of the phenomena being researched. In setting the premise, the chapter started with a scholarly question “*Can all people live productive, vibrant and peaceful lives on a healthy planet?*”. Giving life and direction to the debate on the accessible dream of a shared prosperity emanating from the quoted prologue.

In attempt to address the mentioned question the argument continued to the disheartening conditions mental health finds itself across the world and in Africa. This was followed by a non-committal literature review demystifying mental health juxtaposed to psychosocial health, where a consensus was reached that the concepts are appreciated and applied synonymously. Furthermore, quantified data on non-communicable diseases from WHO together with the important points in the progress

report from SDGs was illuminated, where it was evident that to address these challenges, the health service model must be aligned with the needs of the context in which it finds itself; more importantly, it should be defined and indigenously characterized as being relatable, relevant, and accessible to the indigenous communities.

The state of mental health in the Western paradigm was explored with a noticeable misunderstanding of the role of the mental health nurse and the role of the 'therapeutic self' as a functioning tool. In response, the culturally aligned approaches found in Africa have been proffered. Thus, it is becoming evident that a solution that is inclusive and needs to be aligned is urgently required. With all things considered, the problem is carefully delineated.

Consequently, the concepts used in this study was demystified. This is followed by an exploration of the *problem* of the research problem. Moreover, the *overall aim* of the research was demonstrated and how the aim will be achieved in the form of defensible *four objectives* of the research. Finally, a brief explanation of the *methodology* used to solve this problem is provided.

The following chapter focuses on the preliminary conceptual framework and the process of theory generation employed in the research.

### **1.11. Division of chapters**

**Chapter 1:** Overview of the research.

**Chapter 2:** The Process of an Emergent Middle-range Theory (Theory Generation).

**Chapter 3:** Research Methodology.

## **QUALITATIVE STRAND**

**Chapter 4:** Phase one: Grounded Theory.

**Chapter 5:** Phase two: Critical, Integrated Literature Review.

## QUANTITATIVE STRAND

**Chapter 6:** Phase three: Content validity index (CVI), content validity ratio (CVR), and Kappa statistic.

**Chapter 7:** Overall summary: Outcome of the research, Unique Contribution, Recommendations, Limitations and Strengths

## Chapter two

### The Emerging Theory

# THE APPLICATION AND PROCESSES OF THE EMERGING MIDDLE-RANGE THEORY

*From a conceptual framework to a formal theory, followed by a Middle-range theory.*

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#### 2.1. Introduction

The previous chapter provided an overview of the research by delineating the research problem. This chapter continues the research by expounding on the development of a holistic communal therapeutic approach for psychosocial health management in Southern African indigenous communities. This chapter further deliberates the preliminary conceptual framework used to proffer the blueprint for the emerging Middle-range theory. Finally, this chapter explores the application and process of emerging theory achievement. Hence, key deliberations on how the emerging theory process was applied to achieve the emergent Middle-range theory ensued. This began with a testimony to the irrelevance of the usage of a theoretical framework for this research. This was followed by deliberations on why and how the literature review was used. Finally, the importance of the conceptual framework as a substantive area was explored.

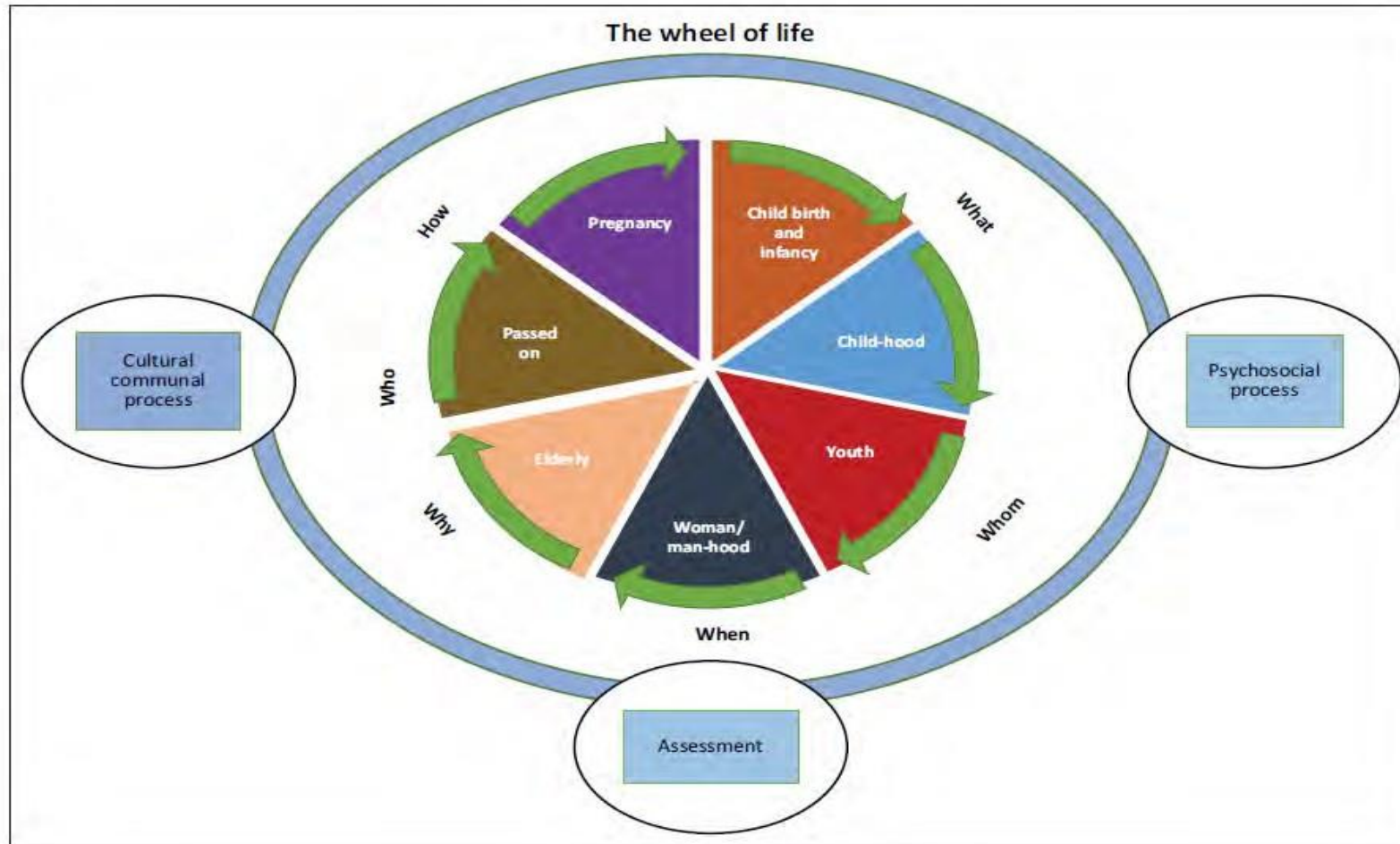
##### 2.1.1. A substantive area for the emerging Middle-range theory

The intention of this research was not to follow any theoretical framework. First, at a methodological level, the research was guided by the Classical Grounded Theory school of thought (Glaser & Strauss, 1967). Hence, the emerging theory is data dependent. This means that the data were collected and analysed simultaneously by constantly comparing 'data with the data itself' (Glaser & Strauss, 1967: 23 & 45). Therefore, Middle-range theory was developed without the influence of a theoretical framework.

Second, at the conceptual level, the research entrusted a substantive theory in the form of a conceptual framework that is later explained (see Figure 1). Intentionally, the

purpose of this conceptual framework (substantive theory) drew strength from Classical Grounded Theory (Glaser and Strauss, 1967). Thus, the conceptual framework (substantive theory) proffered the control of local concepts in forming the theoretical sampling process (Glaser & Strauss, 1967:45), even though the conceptual framework might appear to afford the research a rich, complex, and dense beginning foothold. Classical Grounded Theory guides a theory that is 'ever developing'. Hence, these dense local concepts do not translate into the core categories of the theory itself (Glaser & Strauss, 1967: 37 & 45). In the main, the theory was generated from the data collected, thus developing a formal theory into a Middle-range from a substantive theory (conceptual framework) through a rigorous constant comparative method of analysis (Glaser & Strauss, 1967:82).

Given this foundation, the usage of literature is equally important to this research. It has been established that classical Grounded Theory discourages the use of literature in the substantive area. This discouragement is made by keeping away from extensive reading to avoid polluting the data dependence on the emerging theory (Glaser & Holton 2004). On the other hand, MCcallin (2003:67) argues that the use of literature cannot be disregarded. However, the author further submits that it can be used with a great sense of theoretical understanding. Hence, in this study, the literature is used in three stages. First is a non-committal literature review, in which the research endeavoured for congruence and sensitivity for problem delineation (Urquhart & Fernández, 2006:461). Second, it was used at the methodological level to interrogate and appreciate the use of research methods of choice (MCcallin, 2003:62. Lastly, the literature was used for integrative purposes at the data analysis stage to advance the emergence of the theory (MCcallin, 2003:67). Given this understanding, the following is a schematic demonstration of the preliminary conceptual framework of substantive theory (see Figure 1).



SOURCE: Adapted from Mahlatsi, K.S., 2018, as cited in Mahlatsi, K.S., Pienaar, A.J., Nare, N.E. and Mulaudzi, T.M. 2021. A conceptual framework for psychosocial health management grounded in the therapeutic merits of indigenous KhoiSan health dialogues. Health SA Gesondheid, 26, (0), 1-10.

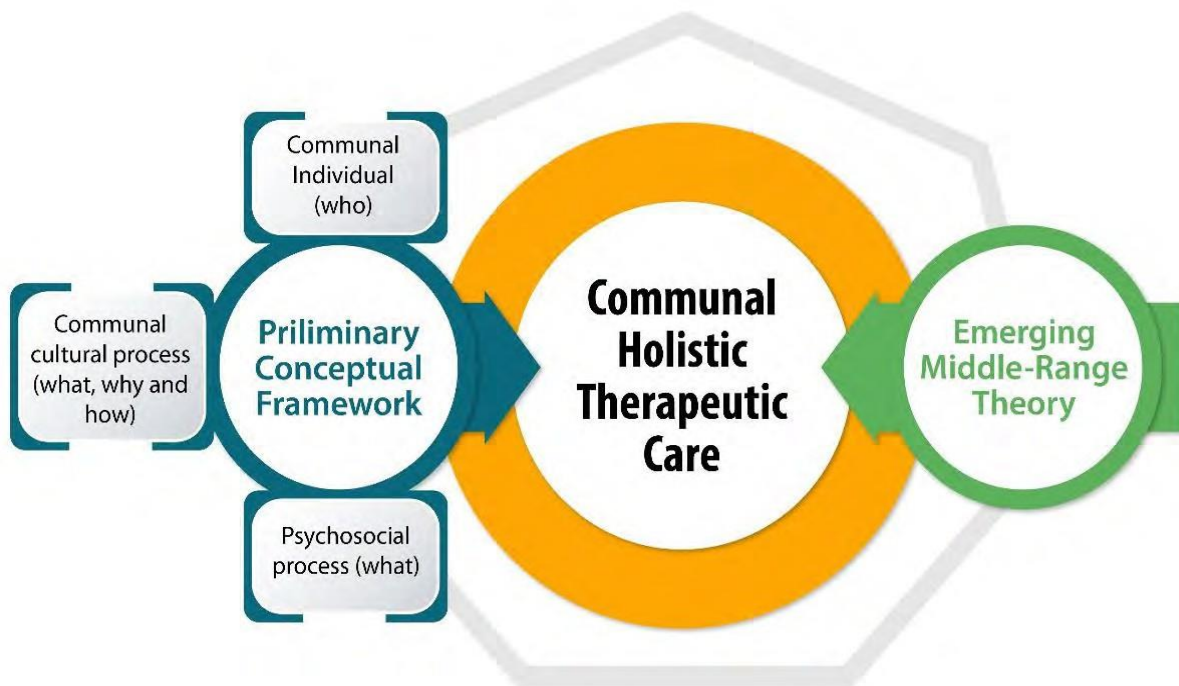
**Figure 1:** The Wheel for the Management of Psychosocial Health Challenges in an Indigenous Khoisan Community.

This framework is referred to as *the wheel for the management of psychosocial challenges in an indigenous Khoisan Community* (Mahlatsi, 2018). Grant and Osanloo (2016:17) presuppose that the purpose of a conceptual framework is to provide a structure for defining the philosophical, epistemological, methodological, and analytical standpoints of the research. As indicated, the conceptual framework in this research was primarily used to illuminate local concepts and enhance the theoretical sampling method. Similarly, this framework guided the researcher in resonating with the conceptualization of the research – the literature explored, definition of the problem identified, and methodology (Adom *et al.*, 2018:438).

## 2.2. Description and Logical Structure of the conceptual Framework (substantive area of the emerging Middle-range theory)

To illustrate, the *Wheel for the management of psychosocial challenges in an indigenous Khoisan Community* contains a circlic “stages of life” characteristic. In the centre of these stages of life, ‘*the wheel*’ is the philosophy where an individual is seen connected to the surroundings and those who were here before us (refer to Figure 1). This shows life as a continuum. It should be noted that psychosocial life in this indigenous community is dependent on a balance of communication between the surroundings and those who were here before us (Mahlatsi *et al.*, 2021:8). Moreover, the framework articulates that, in every stage of life, communal practice and day-to-day practices are an integral part of the introduction of the communal individual moving in the new stage of life. This is to maintain the balance of life (Mahlatsi *et al.*, 2021:8).

Essentially, the framework clarifies that there should be appreciation and respect of **who** is saying **what** to **whom**, **when** as well as **why** and **how** including at which stage of life (Mahlatsi *et al.*, 2021:8 & 9). As shown in Figure 1, the framework indicates that African dialogues of healing in psychosocial management involve a cultural process in which an assessment and psychosocial process must take its course (Mahlatsi *et al.*, 2021:8&9). This means that for every psychosocial challenge, there is a communal team (“*who*” and “*whom*”) assembled where an assessment will be made based on “*the wheel*” of that given communal individual, family, or community at large (Mahlatsi *et al.*, 2021:8). Importantly, this communal team must possess a sense of various techniques – “*what* and *how* to say it”–for example, silent communication, humility, and self-resilience disclosure. In coherence, an action – evaluation and decision–must be taken. This elucidates the “*what*” in the framework.



**Source:** Data Compilation

**Figure 2:** Summary Concepts and Relational Statements

As shown in Figure 2, the main preliminary concept found in the framework, in line with the emerging Middle-range theory, is “*communal holistic therapeutic care.*” In this research, the concept is understood to refer to a societal context that is characterized by sharing and caring with the prime principle of Ubuntu, whose person(s)’ belief in the connectedness of the living and the living dead (Nare *et al.*, 2018:5 & Mahlatsi, 2018:13) for the departed are only dead physically, not spiritually. This is also because the concept shares a cultural meaning for both the conceptual framework and the emerging Middle-range theory that firstly, a person is seen as “whole” (***communal individual***) and connected to the nature around him/her. At the same time, the person is believed to be connected to a wheel of life (***psychosocial process***), that for the person’s psychosocial life to have equilibrium, one should have satisfied all stages of life (***communal cultural process***).

In the following section, the researcher illuminates the theory generational process followed in this study.

### 2.3. Inductive-deductive theory generation process

“Published word is not the final one, but only a pause in the never-ending process of generating theory” (Glaser & Strauss 1967:40).

This part of the research argues that the theory-generative process used in this study includes two qualitative approaches and one quantitative approach. Thus, the development of this theory was grounded within the principles set out by Glaser and Strauss (1967) and Elo *et al.* (2013). It is argued by Glaser and Strauss (1967:36) that constant comparative analysis grounds theory generation. Hence, in this study, an existing conceptual framework was refined through Classical Grounded Theory generation, wherein a formal theory emerged.

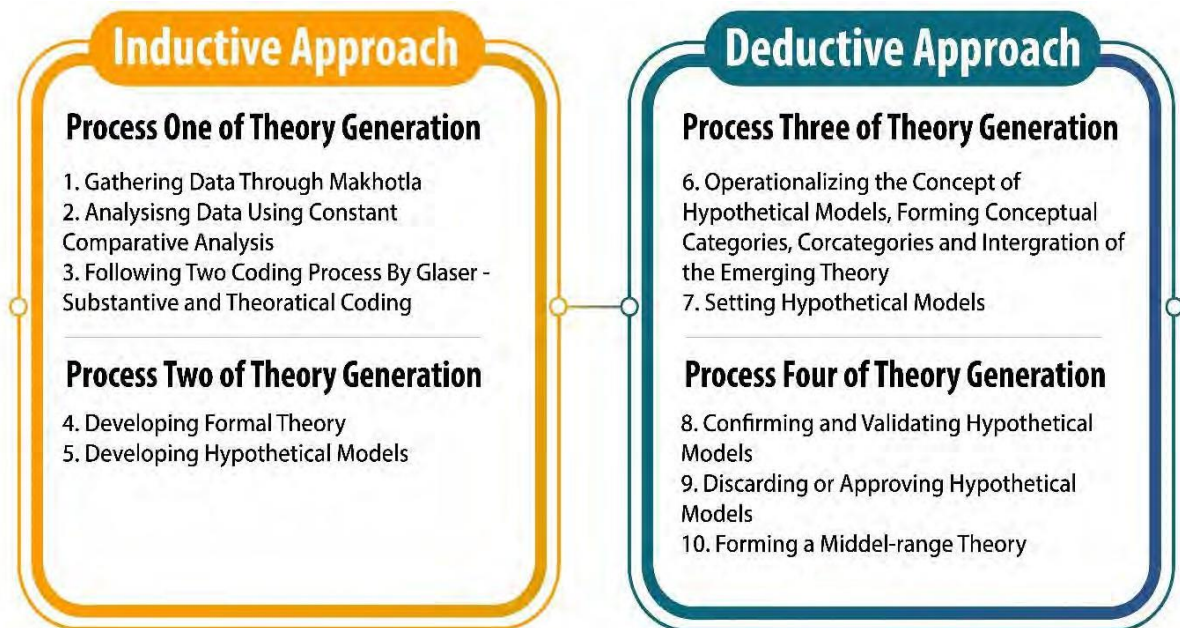
Glaser and Strauss (1967:36) advise that theory has the following elements: **conceptual categories** and **their conceptual properties** and **hypotheses or generalized relations** among the categories and their properties (Glaser & Strauss, 1967:36). Elo *et al.* (2013) also appreciate this fundamental proposition in Grounded Theory. Hence, for the purpose of this research, these elements were folded into a process and put through an **inductive-deductive theory generation** process (Elo *et al.*, 2013:2). This theory was developed according to Elo *et al.* (2013) and Glaser and Strauss (1967).

- 1) Selection of concepts and their synthesis,
- 2) definition of relationships between concepts,
- 3) setting hypotheses,
- 4) presentation and verification of the theory.

The first two processes represent an inductive approach, and the last two are deductive in nature (Elo *et al.*, 2013:2).

Accordingly, this research meticulously followed an inductive-deductive theory-generative process, as already alluded to. This includes two qualitative approaches and a quantitative method. The inductive process has two theory processes, as coined in this study (see Figure 3). This inductive approach speaks to the qualitative method (**Phase I – Grounded Theory**) of the research. This is followed succinctly using a deductive approach with a two-theory process. This approach builds from phase one

of the research into **Phase Two** (qualitative method—**critical, integrative literature review**), ending with **Phase Three** of the research (**quantitative method**).



**Source:** Adjusted from Elo., *et al.* (2013)

**Figure 3:** Inductive-deductive Theory Generation Process

### 2.3.1. Process one and two of theory generation: Inductive (see Figure 3)

An *inductive approach*. The aim of this approach is to observe concepts systematically and disciplinarily. This means that the concepts are formulated and formed through constant comparative analysis (Elo *et al.*, 2013:3; Glaser & Strauss, 1967:21-43). After jointly collecting and analysing all the data through *makgotla* and classical Grounded Theory coding processes (substantive and theoretical coding). The categories that emerged were used to construct concepts by grouping and organizing data concerning the phenomenon that developed into formal theory. Consequently, with the emerging constructs, a critical integrative literature review was used to develop hypothetical models.

### 2.3.2. Process three and four of theory generation: Deductive (see Figure 3)

A *deductive approach*. This is where the hypothetical models will be set, confirmed, and validated (Elo *et al.*, 2013:3) through a CVI, CVR and Kappa statistic method.

## 2.4. Chapter summary

This chapter outlined the justification and urgency in the development of a communal holistic therapeutic approach for psychosocial health management in African indigenous communities. Similarly, this was followed by an appraisal of the conceptual framework in relation to the emerging middle-range theory. Finally, the theory generation process is explained.

# Chapter three

## RESEARCH METHODOLOGY

### Mixed Methods Research

*Approach, Design, and methods.*

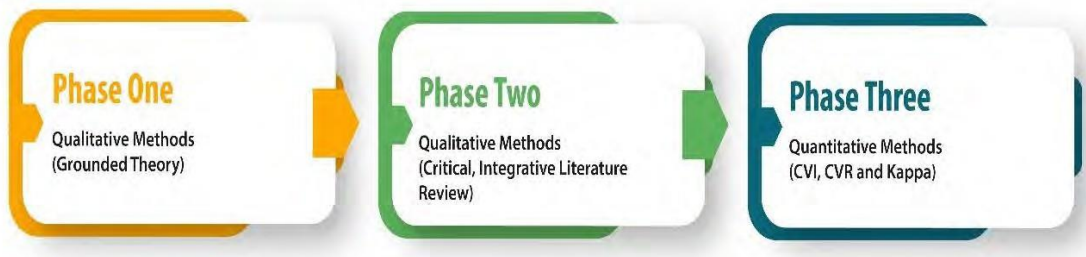
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#### 3.1. Introduction

The previous chapter discussed key deliberations on how the emerging theory process was applied to achieve the emergent Middle-range theory. This chapter focuses on the research processes followed to address the identified research problem. These research processes are summarized in a table under Annexure Q. The chapter discusses the research approaches, designs, and methods meticulously followed, as the objectives of the research demanded. This discourse is carried out by first expounding on the rationale for the usage of mixed methods, second, expansion of the rationale for the employment of the explorative sequential design, and third, the description of the research methods used is attended to by a demonstration of the three sequential phases of the research. These three phases include Grounded Theory (Phase I), critical, integrative literature review (Phase II), and a non-experimental design of the content validity index (CVI), content validity ratio (CVR), and Kappa statistic (Phase III). At a later stage, the chapter discusses the rigor of the research, trustworthiness, and the ethical codes considered when conducting the research. Finally, the chapter concludes with a summary.

It is crucial to understand that a preliminary conceptual framework has been applied. This necessitated the researcher to continue by anticipating a formal theory from the existing framework, and therefore, the development of the middle-range theory. This understanding led the researcher to plan and conduct the research, as discussed below.

### 3.2. Research design



**Source:** Data Compilation

**Figure 4:** Rationale for Mixed Methods (development, dependent and interactive)

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#### 3.2.1. Rationale for mixed methods

This research followed Mixed Method Research where an explorative sequential mixed method design was used (Creswell & Creswell, 2023), as warranted by the nature of the problem and the anticipated solution thereof. This research followed mixed methods procedures in accordance with Creswell and Creswell (2023). Fundamentally, Creswell and Creswell (2023:229) argue that mixed methods research draws strength from both qualitative and quantitative methods to mitigate the limitations of both approaches (see Figure 4). Mixed methods research ultimately encompasses collecting, analysing, and mixing qualitative and quantitative approaches in a single research study (Creswell & Clark, 2011; Leech & Onwuegbuzie, 2009:267; Creswell & Creswell, 2023:231). Therefore, a mixed method design is appreciated in this research as method consisting of a minimum of one qualitative method that is meant to collect conceptual data and quantitative methods that are meant to focus on numeric data. Hence, this research employed the aforementioned mixed design to strengthen the anticipated outcomes of the research.

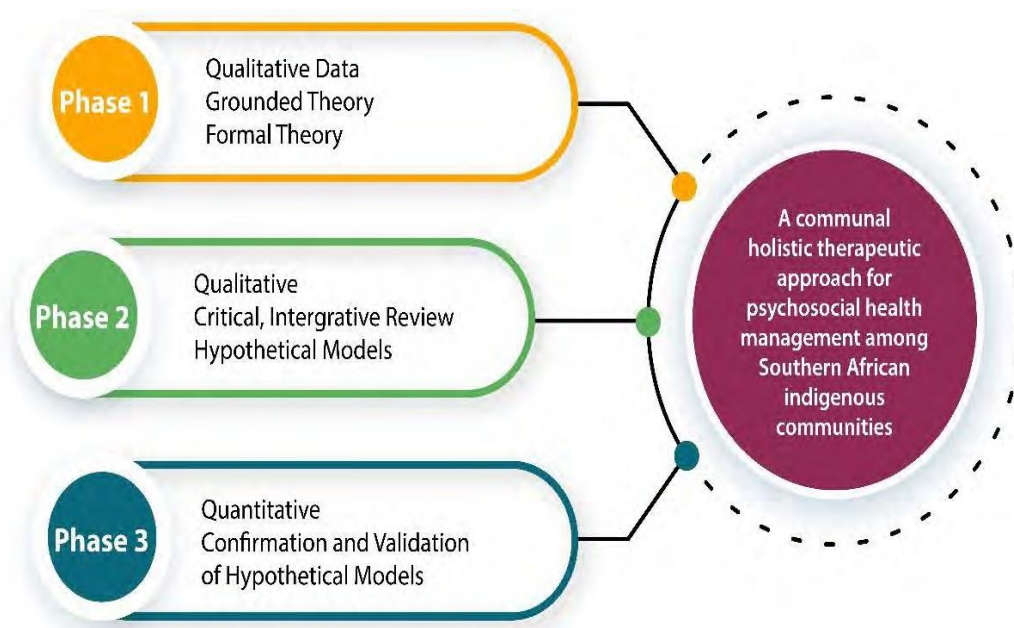
Notably, Mclean (2006: iii), an expert statistician, found that in the early 1970s, limitations were imposed by having only quantitative ways of knowing “a hard pill to swallow.” However, not as admitted by Ivankova *et al.* (2006:8-9), where the authors persuaded a consensus that mixed method tools only serve the quantitative community. In turn, Ivankova *et al.*, (2006:3) further weighs in by saying that the justification for bringing these two methods together illuminates the fact that results

from either of the methods alone at times are inadequate for the true outcome of the research.

Therefore, the *purpose* for mixed methods in this research is as asserted by Greene *et al.* (1989:259-68), that mixed methods are *developmental* in nature. The research procedures followed in phase one are therefore important for the development of the following phase and progressively the next phase (see Figure 4).

Essentially, the mixing of qualitative and quantitative methods in this research was sequential, where the results of the first method were *dependently* on the development of the other. In addition, the timing was *sequential*, and the implementation was expected to be *interactive* as different methods were used to assess a similar phenomenon (see Figure 4 & 5).

It is noteworthy that the problem in this research demanded a multiphase mixed method design due to the following: **1)** a conceptual framework in the management of psychosocial challenges in an indigenous Khoisan community was available; **2)** for an adequate solution to the problem, the mentioned framework needed to be refined by qualitative methods (**Phase I**); **3)** enriched by existing qualitative data (**Phase II**); **4)** and, finally, confirmed and validated by experts through quantitative methods (**Phase III**). Hence, this research followed the principles of a three-phase explorative sequential design, as shown in the following diagram (see Figure 5).



**Source:** Adjusted from Creswell and Creswell (2018)

**Figure 5:** Exploratory Sequential Design (Three phase design):

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### 3.2.2. Rationale for explorative sequential design

As indicated previously, an exploratory sequential design was used in this research (see Figure 5). Creswell and Creswell (2023:242) defines exploratory sequential design as a research procedure with the aim of first exploring qualitative data to inform quantitative data. In this research this definition is applied in two parts, first, 'exploration' by means of qualitative methods and lastly, 'sequential', that is, the qualitative methods will begin the process followed by a quantitative method. Correspondingly, the researcher began the qualitative phase by exploring the phenomenon. The results thereon informed the consequent qualitative methodology, which in turn informed the quantitative phase in confirming the findings from Phase Two (Creswell, 2014; Creswell, 2018; Creswell & Creswell, 2023). The researcher analysed the sets of data from each phase separately and the interpretation of the mixed results first reported on the two qualitative findings, followed by quantitative results of the final phase (Creswell, 2014; Creswell, 2018; Creswell & Creswell, 2023)

Furthermore, this research followed a three-phase mixed method explorative sequential design (Creswell & Creswell, 2023:236&242), with results integrated during the interpretation of the emerging theory (see Figure 5). Therefore, the research is organized into three phases in which the first two phases represent a Qualitative Strand, with the last phase representing a Quantitative Strand. For the qualitative strand, firstly, in **Phase One**, *classical Grounded Theory* was used. Secondly, for **Phase Two**, an *integrative literature review* was used. Lastly, for the quantitative strand, in **Phase Three**, *quantitative testing by means of expert validation and confirmation* was used (See Figures 4 and 5). The comprehensive mixed methodology is mapped in the following diagram (see Figure 6).

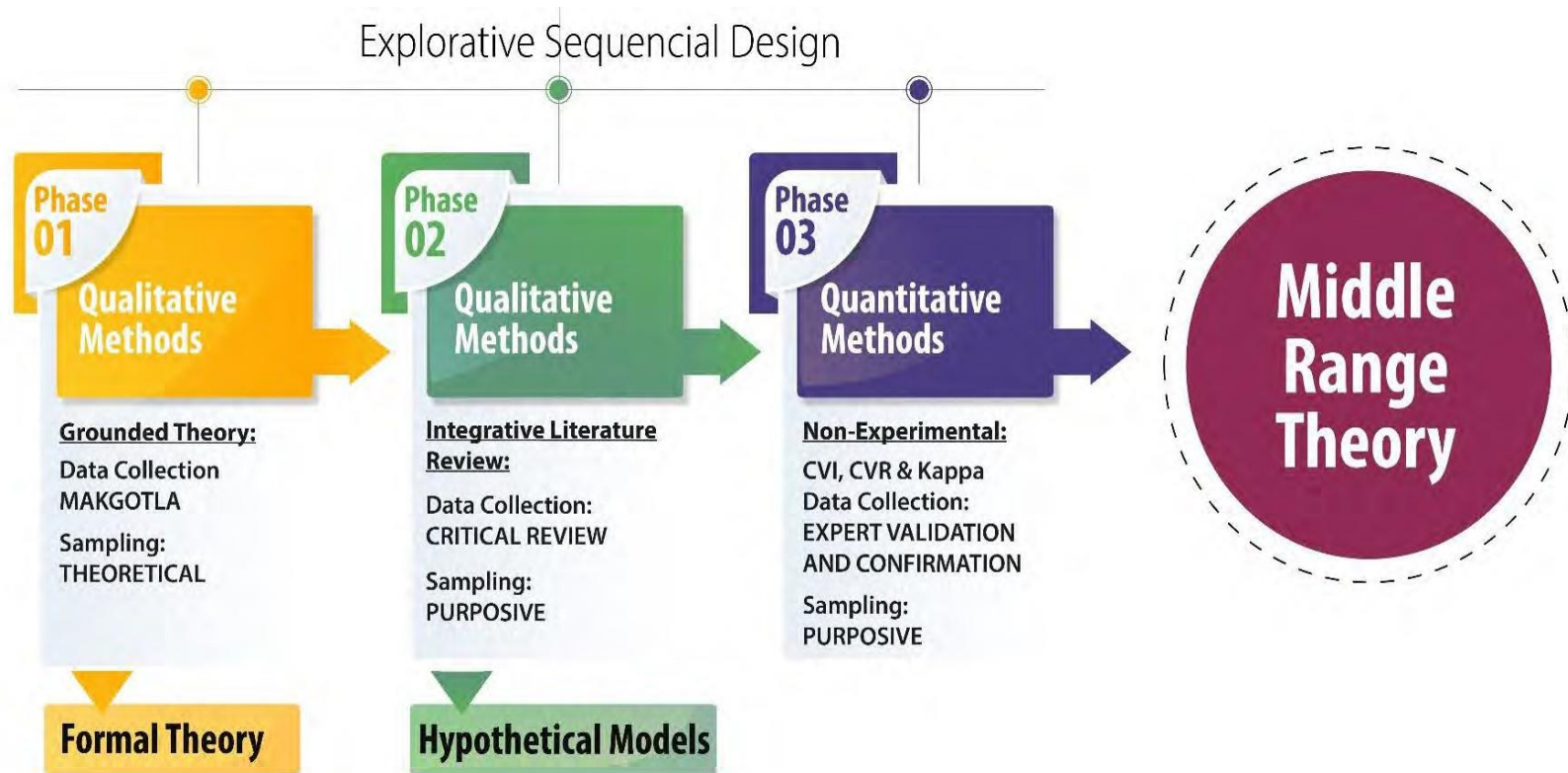


Figure 6: Research Methodology

### 3.3. Justification for using Mixed Methods Research

As previously mentioned, the research used a mixed methods explorative sequential design. This was because: **1)** the conceptual framework in the management of psychosocial challenges in an indigenous Khoisan community is already available to the researcher and befitting the research problem; **2)** for a sufficient solution to the problem, the mentioned framework needed to be refined by qualitative methods. This was achieved in **Phase One**; **3)** Moreover, the refined framework was enriched by existing qualitative data in the form of literature. This was achieved in **Phase Two**; **4)** and lastly, the emerging theory was confirmed and validated by experts through quantitative methods (**Phase III**). Accordingly, this research followed the principles of a three-phase explorative sequential design.

The discussion below maps out how the methodology of the research was carried out. This discussion begins with the qualitative strand, followed by the quantitative strand:

## *QUALITATIVE STRAND*

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### 3.4. PHASE ONE: QUALITATIVE APPROACH, CLASSICAL GROUNDED THEORY

For this qualitative strand in phase one, the research approach was qualitative in nature, deploying classical Grounded Theory with its principles conceptualized and championed by Glaser and Strauss (1967). Classical Grounded Theory is a research method developed by Blaser and Strauss in the 1960s (Creswell & Poth, 2018), sometimes referred to by grounded theorists as the Glaserian approach. Fundamentally, Glaser and Strauss (1967:1) even though complex, simplify grounded theory as a process of discovering theory purely from the data. The method used in this research is referred to as 'classic' because from their (Glaser and Strauss) original work, then came in the early 1990s two school of thoughts – Glaserian Grounded Theory and Straussian Grounded Theory (Thornberg, 2012:244). Consequent to this dichotomy, Glaser from the original work continued to build a school of thought arguing

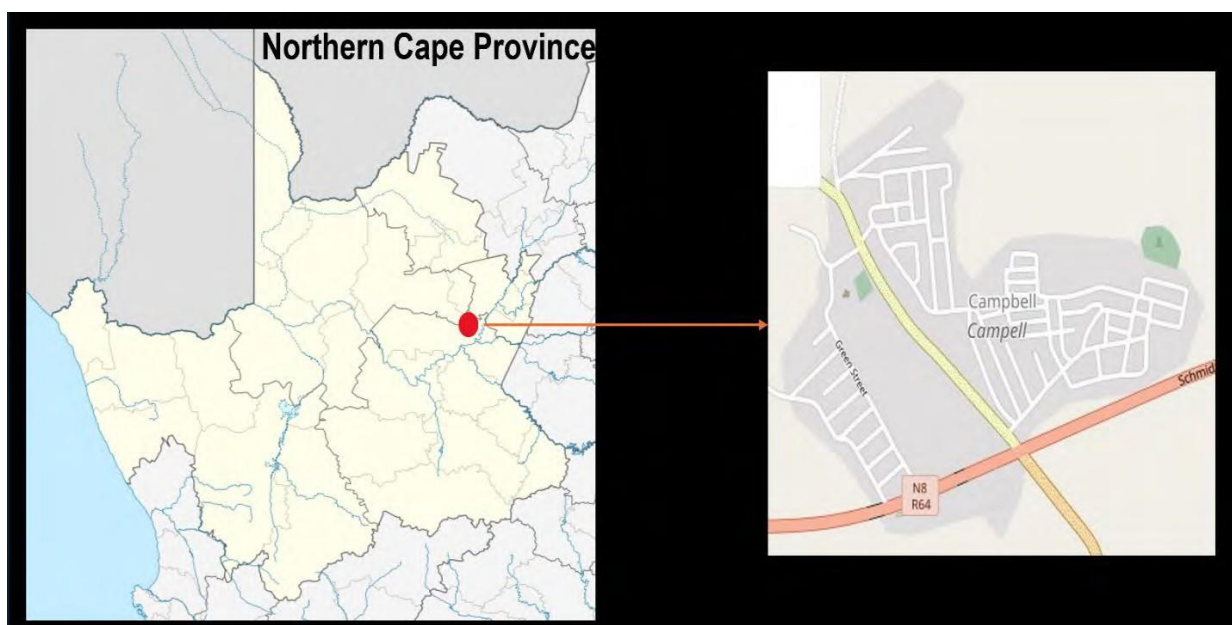
for the avoidance of early literature review until data collection and analysis (Glaser, 2002, 2005, 1998). Hence, the term ‘classic Grounded Theory’.

Therefore, this phase of the research followed classical Grounded Theory by ensuring first, a phased literature review starting with a non-committal approach and a delayed integrative review that is limited later in the findings. Secondly, the emerging theory is data dependent. That is, the theory emerged from the raw data. Thirdly, this phase of the research used theoretical sampling as a sampling technique (Glaser & Strauss, 1967:45). Fourthly, the researcher used an open and theoretical coding process where, at different levels of the theory, data are broken down into meanings and assigned a label to capture the emergent meaning of the data (Glaser and Holton, 2004). Furthermore, the researcher kept a trail of memos. Hence, data was constantly compared with data as the theory emerges using a constant comparative analysis method (Glaser and Strauss, 1967:105). Above all, data were collected inductively, analysed, and presented. Consequently, this inductively resulted in a formal theory that informed the subsequent phases (Elo *et al.*, 2013). The purpose and outcome of this phase was to develop a formal theory (see Annexure Q & Figure 6).

### 3.4.1. Research setting.

The research was conducted in two Southern African countries: South Africa and Malawi.

#### 3.4.1.1. Country one: South Africa, Northern Cape Province.



**Source:** Republic of South Africa, Province of the Northern Cape.

**Figure 7:** Map of Northern Cape Province, South Africa

The Northern Cape Province is geographically located to the north-west of the Republic of South Africa (RSA), which is the largest of the nine provinces but the least populated (see figure 7). The Northern Cape Province is bordered to the west by the Atlantic Ocean, while it meets in the south and east with the province of the Free State, the Eastern Cape, the Western Cape, and the North-West province, respectively. It is bordered north by Namibia and Botswana.

### 3.4.1.2. Country two: Malawi, Blantyre.



**Source:** Google maps (2021)

**Figure 8:** Map of Blantyre, Malawi

Malawi is one of Africa's smallest countries and consists of four major cities, including Blantyre, which is its oldest city. Blantyre is the capital of Malawi, located in the Shire Highlands in the country's southern region within the district of Blantyre (see figure 8).

### 3.4.2. Research population.

**Country one:** This research was conducted within and in partnership with the Khoisan community situated in the Northern Cape province of South Africa (Griqualand-West). The community is a small town found 48 km east of Griquatown on the N8 road. The community is under the chieftaincy of the honourable Adam Kok from the Griqua royal house. This community forms part of the multitude of research conducted by the Seboka Research Consortium. Testament to this is the longstanding relationship that

exists between the researcher and the Khoisan community (see Annexure D). This community is not only important to the research because the Khoisan are believed historically to be the first people to occupy the Southern region of Africa. Also, this community was identified as it suffers the dire circumstances of the crisis presented in Chapter One of the research, however, still have a sustainable way of managing psychosocial health. Therefore, this community is important to this research as it possesses the required knowledge to close the identified gap and generate the emergent theory. Finally, the conceptual framework used in this research was developed within the context of the same community. Hence, the researcher finds it beneficial for the emerging theory to refine the conceptual framework by involving the same community. Therefore, the application of theoretical sampling is strengthened as guided by classical Grounded Theory.

**Country two:** The research was conducted with and in partnership with a community of postgraduate students at Kamuza College of Nursing in Malawi, Blantyre. The participants were from various indigenous communities in Malawi. This community comprises of people of African indigenous origin who are born and raised in different rural villages across the regions of Malawi. This community is important to the emerging theory firstly, for the challenges deliberated (see Chapter One), secondly, for the purpose of comparing the different areas of the theory against another context within the southern region of Africa.

### 3.4.3. Sampling method

This research followed a theoretical sampling method (see Figure 6 & Annexure Q). Theoretical sampling is a process controlled by the emerging theory, where data are collected, coded, and analysed at the same time, which led the researcher to what data and where to collect it next (Glaser & Strauss, 1967:45). This analysis was constant comparative in nature (Glaser & Strauss, 1967:105). The authors further argue that this helps develop the theory as it emerges. In this study, the local concepts from the conceptual framework guided the initial decision for the theoretical collection of data.

### 3.4.4. Data collection

Notably, *makgotla* as informed by Pienaar (2004:25-26) and Pienaar (2017:88) as a data collection method, was used (see Figure 6 & Annexure Q) to gather data using

an unstructured schedule built from the aforementioned conceptual framework. *Makgotla* as a communal colloquium, is seen befitting as it advocates for the indigenous practice of problem resolution by holistically encouraging psychosocial and social discourse (Pienaar, 2017:88). *Makgotla* is a plural form of *lekgotla*, etymologically derived from Sesotho and Setswana ways of knowing (Educalingo, 2020). The Setswana Oxford Living Dictionaries (2020) submit that *lekgotla* fundamentally means gathering. At the same time, Educalingo (2020) and Pienaar (2017:88) advanced *lekgotla* as community meetings, community councils, or traditional law courts, particularly in the villages of Botswana, traditionally coined as a customary court. Commonly chaired by the village chief or headman, in this setup, community decisions are always arrived at through consensus.

Importantly, in this research, *makgotla* followed the same specific procedure adjusted by Pienaar (2017). This specific process is outlined where the chief must be aware of the matter of concern from the researcher. The matter is accordingly escalated to the chief's attention informally, privately, and confidentially. Thus, as the chief sees fit, he will then communicate with his advisors with a deep knowledge of the matter raised by the researcher, which is then communicated to the community.

#### **3.4.5. Data analysis** (see Annexure Q)

It is important to note that the nature of the sampling used in this phase of the research (***theoretical sampling***) dictates that data collection and analysis occur concurrently. This process was strengthened by employing constant comparative analysis method as guided by Glaser and Strauss. Hence, in this research, data collection and analysis were illuminated and discoursed jointly (see Table 1 & Figure 9). Notably, in this research, the indigenous communities involved are an integral part of the golden thread in rolling out the research process; hence, they are acknowledged as experts who played a fundamental role in the collection, analysis, and presentation of data. Additionally, the researcher, an independent co-coder who is a qualitative research expert, and the promoter collaboratively analysed, coded and, compared the raw data as it emerged.

#### **3.4.6. Role of the researcher**

As informed by Glaser, since the inception of Grounded Theory, the main role of the researcher has been to exercise the highest level of ***theoretical sensitivity*** (Howard-

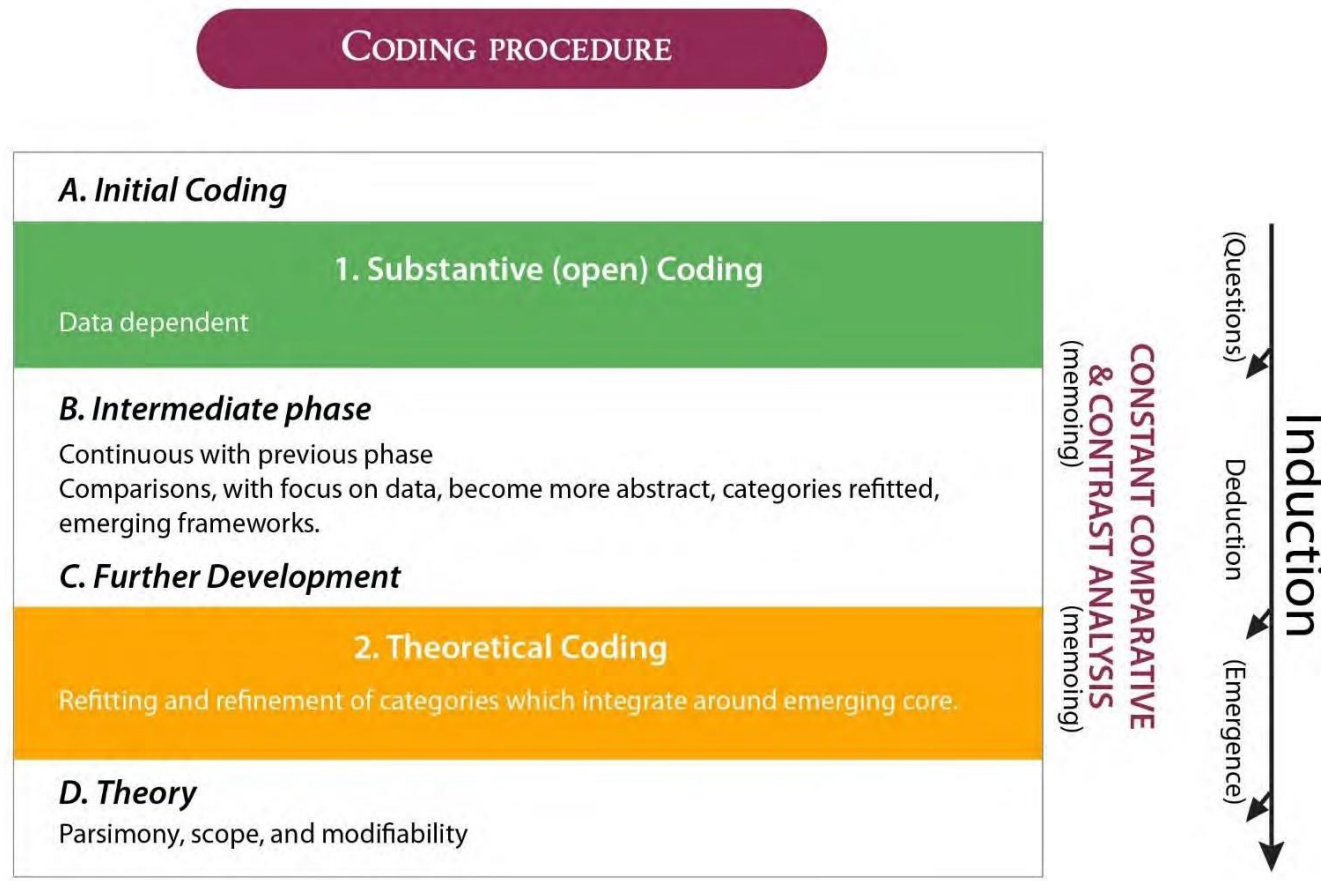
Payne, 2016:54; Glaser & Holton, 2004). In this research, the researcher listened to participants voicing and engaging matters without encouraging them to a particular narrowed interest (***bracketing***). Hence, the concepts were treated as “in vivo,” where emergence was data dependent. That is, the concepts in the substantive area of the theory were taken directly and only from the words of the participants.

Meanwhile, the researcher possessed the ability to demonstrate personal and temperamental talent to uphold analytic distance, endure, and accept moments of confusion and regression. This characteristic was demonstrated by the remaining open, trusting the preconscious processing of emerging concepts. Second, the researcher demonstrated the ability to develop and progress theoretical insights into emerging concepts by conceptualizing, organizing, making abstract meaning, and imaging (Glaser & Holton, 2004). Thus, the process unfolded during data collection and analysis.

### 3.4.7. Coding procedure

**Table 1:** Coding procedure

**Source:** Adjusted from Heath & Cowley (2004:146)



Glaser and Holton (2004) proposed that the conceptualization of data through coding is the foundation of grounded theory processes and development. To achieve this outcome, as shown in Table 1, the research followed an intertwined two coding process, **substantive (open) coding** and **theoretical coding**. This procedure followed four interconnected phases: initial coding, intermediate development, further development, and theory (Heath & Cowley, 2004:146).

Essentially, the intention of **substantive (open) coding** was to conceptualize the empirical substance of the emerging phenomenon (Glaser & Holton, 2004). Categorically, with **substantive (open) coding** in the initial phase, the researcher maintained openness and was honestly dependent on the data emerging by minimizing any existing preconceptions to generate codes and find relevance (see Table 1 & Annexure Q). Conjointly, the researcher continued with substantive (open) coding through comparisons with the focus on emerging data. This is where the researcher became more abstract with the intention of fitting and refitting as many categories as possible and the emerging frameworks (see Table 1 & Annexure Q). To achieve this, the researcher interrogated the data by asking the following questions: "What is this data a study of?" "What category does this incident indicate?" "What is actually happening in the data?" "What is the main concern being faced by the participants?" and "What accounts for the continual resolving of this concern?" (Glaser & Holton, 2004).

At this point, the substance of the emerging phenomenon is identified. Hence, with **theoretical coding** the intention was to conceptualize how substantive codes may relate to one another as hypotheses to be integrated into the theory (Glaser & Holton, 2004). Thus, to achieve the **parsimonious theory** the researcher and the main supervisor continued to fit the "in vivo" concepts by reflecting on the meaning, pattern, and relevancy.

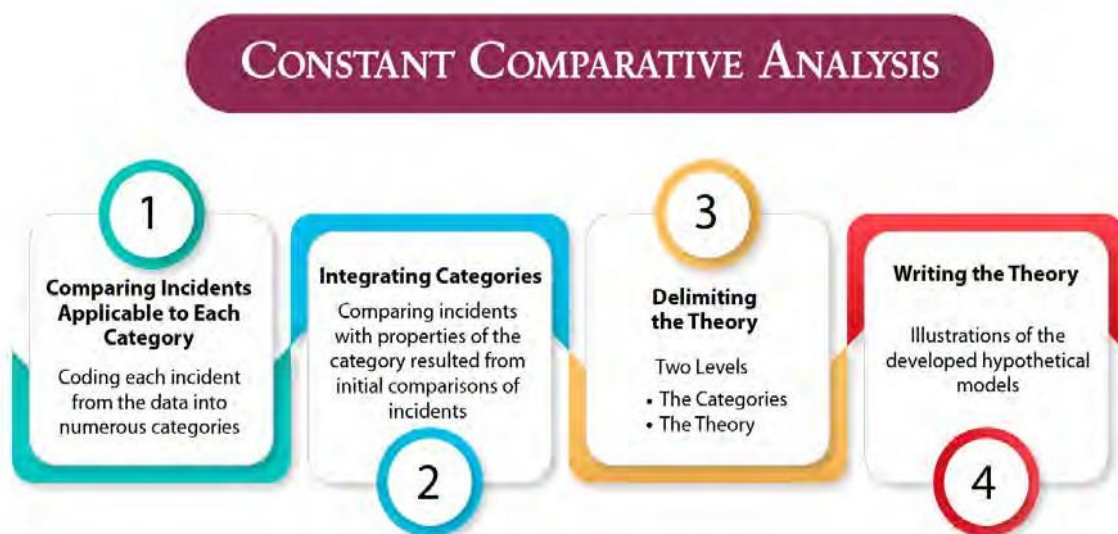
#### **3.4.8. Constant comparative analysis** (Glaser & Strauss, 1967)

In this research, a four-stage method conceptualized by Glaser and Strauss (1967:105) delineated below was followed (see Figure 9 & Annexure Q).

1. *Comparing incidents applicable to each category*
2. *Integrating categories and their properties*

3. *Delimiting the theory*
4. *Writing the theory*

The coding procedure was interwoven with a constant comparative method. Glaser advanced the idea that the constant comparative method is a continuous growth process in which one stage of the method is interdependent on the other. Hence, in this research, one stage of the method transitions into the next stage, whereas the previous stage remains in function throughout the collection and analysis of data. Thus, this process provided continuous development to the following stage until the analysis was terminated (Glaser & Strauss, 1967:439). A constant comparative analysis comprises four stages, as discussed below.



**Source:** Data Compilation

**Figure 9:** Constant Comparative Analysis

**Stage one:** Comparing incidents applicable to each category (see Figure 9).

First, the researcher commenced by coding each incident from the data into numerous categories, as long as the data emerged to fit an existing category (Glaser & Strauss, 1967:105). This was done by the following two rules of the constant comparative method,

where the researcher continued coding incidents for a category by comparing previous incidents in the same and different groups coded in the same category (Glaser & Strauss, 1967:106). This approach of constant comparison of incidents started to gradually develop the theoretical properties of the category.

Later in the procedure, there was a realization of conflict between the researchers' immersed reflections and a category. As this was building, the researcher applied the second rule, where *a stop of coding and a start of recording a memo of ideas* is encouraged. Glaser and Strauss (1967:107) advances this rule with caution. The authors says that the researcher in doing so should allow much time in reflection and thinking, which is grounded in the emerging data to maximize logical conclusions and not assumptions. This care brought about the relevance, saturation of categories, emergence of new categories, and the formulation of the theory.

**Stage two:** Integrating categories (see Figure 9)

The integration stage of constant comparison is accentuated by theoretical sampling, as is the case in this research. Questions guided the collection of data to accumulate and fill knowledge gaps and allow for the emergence of theory. In turn, this is an integrative approach.

At the same time, the emergence of the integration of categories occurs in analyses that are separate from data collection. Thus, the researcher started comparing incidents where properties of the category resulted from initial comparisons of incidents (Glaser & Strauss, 1967:108). These comparisons of incidents with properties resulted in informed and logical conclusions involving a property of the category to seamlessly become integrated, that is "related in many different ways, resulting in a unified whole" (Glaser & Strauss, 1967:109). Subsequently, the diverse properties were integrated. Consequently, as related theoretical conclusions were drawn from different categories and property integration, the theory was developed.

**Stage three:** Delimiting the theory (see Figure 9)

This stage unfolded at two levels: theory and category (Glaser & Strauss, 1967:110). At the theory level, delamination occurred through a constant comparison of the incidents of

a category with its properties, where the modification decreased. The researcher then continued to modify the emerging theory by clarifying the logic, maintaining relevance, integrating accumulated knowledge of properties into the major outline of interrelated categories, and the most important reduction.

Glaser and Strauss (1967:110) demystifies and advanced the application of reduction as the discovery of rudimentary uniformities in the original set of categories/properties. Thus, at this level, the researcher began to formulate the theory with a smaller set of higher-level concepts by delimiting terminology and text. As a result, while maintaining a tight lifeline of theory and data, the theory began to achieve two fundamental requirements of emergence: **parsimony** of variables and formulation. Second, the **scope** in the applicability of the theory to a broader spectrum of conditions is emerging.

As the theory grew, the second level for delimiting theory was at the category level, where a reduction in the size of categories for coding was achieved (Glaser & Strauss, 1967:111). Furthermore, the delimiting of theory was in turn achieved by theoretical saturation, where a realization of whether to continue to code incidents for the same category or whether a new meaning accumulated came into being.

#### **Stage four:** Writing theory (see Figure 9)

At this stage, in the process of constant comparative analysis, the researcher reflected and applied interrogative thinking to the available data. The data were coded in a series of memos to develop a theory. At this point, the researcher provided illustrations of the developing hypothetical models of the theory to inform the subsequent phase of the research.

To demonstrate, the analysis and coding were achieved by the researcher and the main supervisor by being explicitly aware of the following.

#### *Pattern naming.*

In the substantive area of the emerging Middle-range theory in this research, as explained by Glaser (2002:24) a concept is the naming of an emerging *pattern* grounded purely in data. This was achieved by applying a constant comparative method strengthened by

theoretical sampling, as employed in the research endeavouring through conceptual saturation by the analysts. This means that in this research, many incidents were compared and developed into concepts, which are the building blocks of the pattern emanating from the category and the sub-patterns that are the properties of the category.

#### *Time, place, and people*

The method of analysis employed in this research intended to have the abstraction of time, place, and people as focal points of theoretical sensitivity (Glaser, 2002:25). Hence, the participants in this research were deemed experts and formed an integral part of the research. This was achieved by the researcher assuming a constant questioning approach of – *what? when? how? when? why? Where?* These abstractions strengthened the understanding and appreciation of data dependence as a pivotal exercise in this research. In demonstration, this gives context, accuracy, construction, and clear description of what “is” (Glaser 2002:25).

Concomitantly, this phase (**Phase I**) of the research generated a hypothetical model that was constantly applied to relevant time, place, and people with emergent fit and was then modified by constant comparison with new data, as it explained the substantive area of the emerging Middle-range theory. Glaser (2002:25) argues that essentially at the heart of Grounded Theory is the appreciation that concepts are immemorial, while descriptions are matters that lose meaning over time. Illustratively, in this research, emphasis is placed on the conceptual level as concepts are related (**relational**) to concepts as hypotheses (**conceptual ability**).

#### *Writing memos and reflections (Memoing)*

As guided by Glaser, the researcher prioritized memoing as an integral task to ensure the retention of every possible meaning of the emerging data. Hence, it has become an important part of this research as delineated forth.

#### **3.4.9. Memoing**

The entire analysis procedure is grounded within the act of memoing. Memos were employed to enhance the experience of the research (Birks et al., 2008:74). This research

benefited from memoing by coherently communicating, reflecting, and confronting the interpretation of reality in relation to the raw data. The intention was to generate data-dependent theoretical assertions that carry the qualities of conceptual abstraction. Memoing in this research followed the lead of Birks (2008:69), who attests that for expediency, the functions of memoing can be described using the mnemonic 'MEMO': Mapping research activities, extracting meaning from the data, maintaining momentum, and opening communication.

#### *A. Mapping research activities*

It is important to note that this memoing function kept records and trials of sampling, collection, and analysis of the data. These records guided the research to the next participant (theoretical sampling) and enhanced the direction.

#### *B. Extracting meaning from the data*

In this phase of the research (Phase one), hypothetical models were developed through a constant comparison of similarities and contrasts of differences. Through memoing, this was deepened by extracting meaning from the data through definitional statements. The researcher explored the meaning of *What? When? How? Why? Where?* (Birks, 2008:70). Through this exercise, the abstraction of time, place, and people is enhanced.

#### *C. Maintaining momentum*

Essentially, the development of a theory is an evolutionary journey which bears the variation of ideas and change in conceptual directions as a result of what 'is' in the data (Birks, 2008:71). In this research memos played a major role in mediating and identifying variations. This means that the record and trial enabled the researcher to make conceptual decisions without fear of being biased and continue to make meaning of the raw data.

#### *D. Opening communication*

Memoing in this research became a significant mode of maintaining the communication of different ideas, meaning, and relevancy by the researcher and main supervisor. At the completion of phase one of the research, the outcome was a formal theory that was

used to inform the processes of phase two, as demonstrated in Chapters Two and Three.

### **3.5. PHASE TWO: QUALITATIVE APPROACH. CRITICAL, INTEGRATIVE LITERATURE REVIEW**

#### **3.5.1. Purpose of the phase and justification of the approach used.**

The purpose of this phase was to use the findings from Phase One of the research to develop hypothetical models to enhance the emergence of theory generation in Phase Three for quantitative validation and confirmation (see Annexure Q & Figure 6). Categorically, this phase attended to Objective Two of the research, which equally offers an epitome posture to the research by aiming to develop hypothetical models to advance the emerging Middle-range theory (see Annexure Q). It is worth mentioning that hypothetical models in this research were developed through an inductive-deductive approach to theory generation (see Figure 5) by operationalizing the concepts, forming items, and setting hypotheses, as set out by Mouton and Marais (1996:103) and Elo *et al.*, (2013:3). Thus, the handling and management of data is qualitative in nature. To illustrate, these hypothetical models primarily informed theory assumptions, questions, and suggestions about new directions to be validated and confirmed in the following phase (Phase III) of this research.

The researcher holds the view that the phenomenon being studied in this research is new (though not its praxis nature), dynamic, and complex in nature, with evident malnutrition from innovative research and comprehensive review of the phenomenon over time. Similarly, this stance is upheld by Torraco (2016a:1), who submits that topics that are relatively new have not received the benefits of comprehensive literature reviews. For this reason, this phase (Phase Two of the research) was conducted through a qualitative critical, integrative literature review (see Annexure Q & Figure 6). Integrative literature reviews research **reviews**, **critiques**, and **synthesizes** representative literature on a phenomenon in an integrated manner, aiming for new frameworks and perspectives concerning the phenomenon being studied (Torraco, 2005:356; Torraco, 2016a:1 & Torraco, 2016b:62). Furthermore, the author advances the argument by acknowledging that the review of such topics is more likely to lead to the development of a new model or

framework. Congruently, the intention of the critical and interpretive literature review in this research was to develop and form hypothetical models for the progression of theory generation with a shared purpose. Correspondingly, the intention of the critical and interpretive literature review in this research was to develop and form hypothetical models for the progression of theory generation with a shared purpose.

Of greater importance, when comparing the views of Torraco (2005), Torraco (2016a:1), and Snyder (2019), it should be noted that integrative review in this research was best suited. This approach was essentially used for a new developing phenomenon that accentuates a growing body of literature. Accordingly, the researcher is in line with Torraco (2016a) and Torraco (2005), who further advanced the argument that this body of literature may include misrepresentation of the phenomenon. Similarly, the researcher posits that the phenomenon being studied in this research has been unabatedly misrepresented with contradictions and observations, which are not addressed in the existing literature. Hence, the researcher believes that a critical integrative review made a significant and value-added contribution to the outlook of the theory in development. Overall, the critical, integrative literature review approach is employed for new questions and assumptions, which, in turn, aids theory development and future research (Torraco, 2016a:6).

As noted above, the purpose of this integrative literature review was to address the new emerging phenomenon under study, develop hypothetical models, and advance the theory for future research. Accordingly, the critical, integrative literature review in this research followed the guidance of Snyder (2019), who proposed a four-phase process of conducting literature review, namely, designing the review, conducting the review, analysis, and writing up the review. However, for logical flow, this phase is referred to in this research as **parts** (parts one, two, three and four respectively). Moreover, this **part** was organized in order by following Torraco (2016a), who advises on carrying out an integrative literature review.

### **3.5.2. Part one: Designing the review.**

The population in this research was accessed through an Internet search. In this section, the building materials in the review are identified and clearly demystified. Preliminary

considerations of the review were clearly designed, the phenomenon was clearly defined, the purpose of the approach was demystified, and the need for the review was also deliberated upon (Snyder, 2019:336). In this research, the audience targeted general scholars, health science scholars, social science scholars, indigenous health practitioners, African indigenous communities, and the public. At the same time, the search strategy was guided by the emerging formal theory resulting from Phase One of the research.

### **3.5.3. Part two: Conducting the review (Sampling and Data collection)**

This part is where the review was carefully conducted. As advised by Snyder (2016:337), a pilot study was deemed important in this research. A pilot study was conducted by testing the search terms and inclusion criteria on a smaller sample (see Annexure Q). As previously mentioned, the search strategy and inclusion criteria were developed from the findings of Phase One of the research. It is important to note that the sampling strategy of this phase was purposive in nature (see Annexure Q & Figure 6), where the saturation of the data determined the sample size. Purposive sampling is defined by Brink and van Rensburg (2022:150) as a technique dependent on the researcher's judgement concerning subjects of interest to the study. Hence, referred to as 'judgemental sampling. Moreover, Brink and van Rensburg (2022:151) submit that the method chosen for sampling is closely related to the research design. Hence, data were collected from the sampled documents through a critical review. Moreover, it is regarded as common practice to use two reviewers of the data (Snyder, 2016:337). Similarly, the researcher, together with the supervisor and another reviewer, selected articles to ensure the quality and reliability of the search protocol. The reviewer was appointed by the researcher and supervisor through consultations with members from the indigenous communities that were involved in the research.

The selection of articles was done in stages by reading abstracts first, making selections, and then reading the full text of the article later, before making the final selection. Subsequently, the full texts of the articles were screened to ensure that they met the inclusion criteria. To advance the scope of the search and the final sample, references in the selected articles were scrutinized to identify other articles that may add value to the

review (Snyder, 2016:337). Finally, the criteria used for retaining and discarding the literature yielded by the literature searches were clearly illustrated as guided by the selection strategy.

To elucidate the keywords to be used, the database used, retaining, and discarding approach. Finally, the quality assessment of the data was a process that was transparent and detailed to the reader. To simplify the process, as guided by the findings of Phase One, a table or matrix was used to track which keywords led the search to relevant data and which did not.

#### **3.5.4. Part three: Analysis (Data analysis)**

As we now already know, the purpose of this review was experienced with a broad goal in mind being to review, critique, and synthesize the literature (Snyder, 2016a:335 & Toracco, 2016:8). It is noteworthy that an integrative literature review is critical (See Annexure Q). Hence, in this research, data were critically analysed by carefully examining the main ideas and arguments presented in the literature through a critical lens (Toracco, 2016a:16). Critical analysis involves deconstructing pieces of the literature on the phenomenon into their basic elements. This was done by carefully examining the main ideas, relationships between concepts and ideas, and finally, providing a critique (Toracco, 2005:361).

Critique involves a critical evaluation of the representation of the phenomenon (Toracco, 2005:361). First, the phenomenon was deconstructed into its rudimentary elements. This process of deconstruction focused on the history and origin of the phenomenon, its main concepts, the key relationships through which the concepts interact, research methods, the perspective and assumptions made by the author on the phenomenon, and lastly, the application of the phenomenon. In addition, the researcher followed the guidance of Toracco (2005:361) who emphasized that a researcher's critique should identify the strengths and key contributions of the literature as well as noted deficiencies, omissions, inaccuracies, and other problematic incidences in the literature. To extend this, the researcher identified aspects that are incomplete and poorly represented in the literature as well as inconsistencies among published perspectives on the phenomenon.

Meanwhile, a comprehensive synthesis essentially meant integrating existing ideas with new ideas to create a new formulation of the phenomenon (Toracco, 2005:362 & Torraco, 2016a:8). In agreement, Toracco (2016a:8) advanced this stance by saying that synthesis is a **creative act**. This means that the review actively intertwines the flow of research to establish a focus that will develop a new model, conceptual framework, or other unique conception informed by the reviewer's extensive knowledge of the phenomenon. These were achieved using alternative models or conceptual frameworks as forms of synthesis (Torracco, 2016a:18). Therefore, in this research, we refer to this as a hypothetical model. As Torraco (2016a) opined, this has enabled new ways of thinking about the phenomenon. This means that, derived directly from critical analysis and synthesis, alternative models or concepts were proposed by the researcher.

Originally, Torracco (2016a:17) advanced that critical analysis aids the literature review in shaping the strengths and limitations of the literature to create a better understanding of the phenomenon through synthesis. In the meantime, for organization and structure, conceptual structuring was followed as a form of structure for the review, as recommended by Torracco (2016a:12). This structuring provided coherence and clarity for the golden thread of the literature review, and how the main concepts of the phenomenon were brought together as an integrated idea. This means that the main concepts of the phenomenon (results from Phase One of the research) provided a framework around which the review could be organized.

#### **3.5.4.1. Constant comparative analysis** (see Annexure Q & Figure 9)

To advance the theory development, following a critique and synthesis of literature, the reviewers employed constant comparative analysis as guided by Glaser and Strauss (1967:101 - 113). This is where the relationship between the concepts of the typology developed in Phase One was constantly compared to the alternative models inductively deduced from the literature review. This is where crystallization of the data occurred. The purpose of constant comparative analysis was to discover a hypothetical model and to further establish the generality of the hypotheses (Glaser & Strauss, 1967:24 & 101). In this research, a four-stage constant comparative method is followed, which includes 1) comparing incidents applicable to each category, 2) integrating categories and their

properties, 3) delimiting the theory, and 4) writing the theory (Glaser & Strauss, 1967:105) respectively.

### **3.5.5. Part four: Description of the review**

To write the review, the researcher followed Torraco's (2016a) guidelines. The author stated that the main body of writing should be organized into three sections: 1) – preliminary considerations, 2) methods, and 3) writing a review that is integrative, definitive, and provocative.

## ***QUANTITATIVE STRAND***

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### **3.6. PHASE THREE: QUANTITATIVE, A NON-EXPERIMENTAL DESIGN – CVI, CVR & KAPPA STATISTIC**

#### **3.6.1. Introduction**

For this quantitative strand in phase three of the research the researcher employed CVI, CVR and Kappa statistic. This phase was quantitative in nature, where the researcher followed a non-experimental design to confirm and validate the findings of Phase Two. The purpose of this phase was to confirm and validate the hypothetical models emerged from the previous phase advancing the findings into Middle-range theory (see Annexure Q & Figure 6). Therefore, this involved confirmation and validation by a specific number of experts, demonstrating that approach items and the entire approach have content validity. For this purpose, an expert panel was appointed. Hence, the validity of the emerging theory was established to ensure its recognition and acceptance (Lam, 2018:372). It is worth noting that validity is not the property of an instrument, but the property of the scores achieved by an instrument used for a specific purpose on a special group of respondents (Zamanzadeh *et al.*, 2015:165). Accordingly, in this phase of the research a group of experts was sampled for input.

### 3.6.2. Preliminary definitions of experts and inclusion criteria

First, to mitigate the limitations of CVI, the researcher conducted a pilot study to test the extent to which the instructions sent to experts are clear and understandable. The experts in this study were indigenous community members, traditional leaders, community leaders, traditional health practitioners, health science researchers, and health professionals. Additionally, a criterion was developed, and experts were expected to fulfil these requirements. The sample selection was conducted using a purposive sampling method. The recruitment procedure was transparent to the readers. The recruitment process was as follows.

The first step involved initial contact with the experts through either an online meeting or email asking for their availability for the project. Depending on the answer from the latter, an approach with a cover letter, along with clear and comprehensive instructions, was sent to each person who agreed. The cover letter clearly explained the significance of the research, instructions to follow, the importance of each expert's response, and the need to respond promptly. A deadline is specified for each cycle in the cover letter. Additionally, all participants were assured of confidentiality throughout the process. Moreover, they were asked for their input and suggestions for improvements to enhance the content validity of the approach. As guided by Lynn (1986:383) the number of experts was determined by how many the researcher could reach and how many agreed to participate and not on a population estimation principle. However, the author, in consensus with Zamanzadeh *et al.* (2015:165), continued to suggest that a minimum number of five experts was sufficient for assessment of validity to have sufficient control over chance agreement.

After appointing an expert panel, the researcher collected and analysed their quantitative and qualitative viewpoints on the relevancy or representativeness, clarity, and comprehensiveness of the items to measure the construct operationally defined by these items to ensure the content validity of the instrument or approach.

### 3.6.3. Confirmation and validation of the emerging Middle-range theory

As already mentioned, the researcher believes that the phenomenon under study is complex in nature, for which a valid approach for the management of psychosocial health is needed. Validity is defined as the ability of an instrument to measure the properties of the construct under study (Lynn, 1986:382 & Lam, 2018:372). Not to be misunderstood, yes, validity involves three common pillars: content, construct, and criterion-related validity (Lynn, 1986:382). However, content validity is a precondition for other validity; hence, in this research, it was deemed crucial to focus on it for the confirmation and validation of the emerging theory (Zamanzadeh *et al.*, 2015:165). This is why the researcher implored expert validation and confirmation of the hypothetical models developed from Phase Two using the content validity index (CVI) and content validity ratio (CVR). These deductively resulted in the development of a Middle-range theory. Content validity is defined as the ability of the selected items to replicate the variables of the construct in the measure (Pilot *et al.*, 2007:459). Essentially, as submitted by Zamanzadeh *et al.* (2015:165), content validity attends to the degree to which the items of an instrument sufficiently represent the content domain. At the same time, Lynn (1986:382) and Scholtes *et al.* (2011:239) simplifies this argument by suggesting that the purpose of content validity is an indication of the content representativeness or content relevance of the items of an instrument by application of a two-stage process (development and judgement). In this study, the assessment of validity was applied through a one-stage process – **judgement**. This is because the content validity development stage was already achieved in the first two phases of the research. Overall, the **judgement-quantification stage** involved two steps: (1) assertion by a specific number of experts that the items are content valid and (2) assertion that the entire instrument is content valid (Lynn, 1986:383 & Lam, 2018:377). This was achieved through two methods (CVI and CVR) of analysis that were followed in this research for a completely free biased approach.

#### 3.6.3.1. Content Validity Index (CVI)

The first method of analysis was the Content Validity Index (CVI) concerning the degree to which an instrument had an appropriate sample of items for the construct being

measured (Pilot & Beck, 2006 & Lam, 2018:377). The CVI is a proportional agreement procedure with which independent experts review and evaluate the relevance of a sample of items to the domain of content represented in an instrument (Wynd *et al.*, 2003:510). Following this research, the Content Validity Index was used to calculate content validity quantitatively (Rodrigues *et al.*, 2017:1 & Pilot *et al.*, 2007:460). This means that a simple rating form was given to the experts to pass judgement on the items of the approach by rating them. The researcher tallied the proportion of cases in which the experts agreed and determined the stability of their agreement. This is because each item of content validity (I-CVI) expresses the proportion of agreement on the relevancy of each item, which is between zero and one (Zamanzadeh *et al.* 2015:169 & Pilot *et al.* 2007:460). Similarly, each judgement (rating, i.e., very relevant) from the experts of each item was divided by the total number of experts. Accordingly, judgement was made as follows - values range from 0 to 1 where CVI is greater than 0.79 (79%), the item was considered relevant, between 0.70 (70%) and 0.79 (79%), then the items needed revision, and if the value is below 0.70 (70%) then the object was illuminated (Zamanzadeh *et al.* 2015:169; Rodrigues *et al.* 2017:3; Pilot *et al.* 2007:460 & Lynn, 1986:384).

Experts were requested to indicate any areas of omission from the approach. This means that if omissions are indicated even though the entire approach is judged to be valid, supplementary clarification and addition are necessary (Lynn, 1989:384). However, this was achieved without interfering with the validity assessment. Notably, if no omissions are brought forward by experts and the approach is judged as content valid, juxtaposed with the knowledge of the magnitude of CVI numbers. In this case, the content validity of the approach was asserted. However, where the researcher experienced that an expert identified no areas of omissions and evaluated the approach positively yet judged the approach as invalid, this led to considering replacing the expert as his or her expertise is deemed in doubt (Lynn, 1989:384).

### **3.6.3.2. Content Validity Ratio (CVR)**

The second type of analysis followed the Content Validity Ratio (CVR). Consequently, the CVR measures the essentiality of an item (Zamanzadeh *et al.* 2015:168; Rodrigues *et al.* 2017:3). Thus, in the quantitative content validity method, confidence is maintained when

selecting the most important and correct content in an instrument, which is quantified using the content validity ratio (CVR). This agrees with Zamanzadeh *et al.* (2015:168) and Pilot *et al.*, (2007:462) the researcher's intent to uphold confidence in selecting the most important and accurate content in an instrument, which is quantified by content validity ratio (CVR). Therefore, experts were asked to judge whether an item was important or necessary for operating a construct in a set of items. In this case, experts were asked to score each of the items from 1 to 3 with a three-degree range of - *not necessary, useful but not essential, essential* accordingly (Zamanzadeh *et al.* 2015:168). Notably, CVR varies between 1 and -1 (Zamanzadeh *et al.* 2015:168 & Rodrigues *et al.* 2017:3), where a higher score indicates further agreement of members of the panel on the necessity of an item in an instrument. According to Zamanzadeh *et al.*, (2015:168) and Rodrigues *et al.*, (2017:3), the CVR formula is as follows:

$$\text{CVR} = (\text{Ne} - \text{N}/2) / (\text{N}/2)$$

Where Ne is the number of panellists indicating *essential* and N is the total number of panellists.

### 3.6.3.3. Multi-rate Kappa statistic

Notably, according to Polit *et al.* (2007:462), CVI captures inter-rater agreement but not completely. This results in proportion agreement, which by nature lacks a value indicating "no agreement," thereby creating the potential for inflation of agreement due to chance. To further mitigate the limitations of CVI, Cohen's (1960) Kappa statistic method was employed to adjust for the possibility of inflated values of chance agreement.

The Kappa statistic represents the proportion of agreement remaining after chance agreement is removed (Wynd *et al.*, 2003:511 & Cohen, 1960:40). Alternatively, instead of comparing the total proportion of agreements ( $P_c$ ) to a maximum value of 100%, the total is mirrored to a maximum possible value that accounts for agreements occurring by chance alone ( $1 - P_c$ ), given the marginal distribution of item ratings assigned by each expert.

Moreover, the test of agreement concerns the 1 - pc of the units for which the hypothesis of no association would predict disagreement between the judges. Accordingly, this term serves as the denominator (Cohen, 1960:39).

*Formula.*

First, the probability of chance agreement for each item (Zamanzadeh *et al.*, 2015:169).

$$P_c = \frac{N!}{A! (N-A)!} \cdot 5N.$$

N = number of experts in a panel

A = number of panellists who agree that the item is relevant

After calculating the I-CVI for all items. Finally, the Kappa statistic was calculated by entering the values of the probability of chance agreement (Pc) and the content validity index of each item (I-CVI).

$$k = \frac{(I-CVI - P_c)}{(1 - P_c)}$$

*Evaluation criteria for Kappa*

Zamanzadeh *et al.* (2015:169-170) proffers that the values above 0.74, between 0.60 & 0.74 and the ones between 0.40 and 0.59 are considered excellent, good, and fair respectively. After controlling for items by calculating adjusted kappa, each item with I-CVI equal to or higher than 0.78 is considered excellent.

Finally, the experts were requested to evaluate the entire approach for its total comprehensiveness (Zamanzadeh *et al.*, 2015:170).

### **3.7. Rigor of the research**

The rigor in this research was best practised and ensured by the clear study area and context, with a focused problem accentuated by a strong fitting conceptual framework. Accordingly, these practices guided the researcher to select the best-fitting research methods (see Annexure Q). Furthermore, the researcher's reflexivity strengthened the truth value of the research by providing sensitivity and insight into the potential bias and rationale for decision-making throughout the research. To provide life and authenticity to

the research, the best specific practice methods used in the sampling and data collection processes increased the trustworthiness of the research.

The rigour of this research is embedded in both qualitative and quantitative research; therefore, the description of trustworthiness, validity, and reliability follows.

### **3.8. Trustworthiness** (see Annexure Q)

This research followed the four criteria to establish the mechanics of trustworthiness by Lincoln and Guba (1985) and as cited in Johnson *et al.* (2020:141); Morse, (2015:1212); Trainor & Graue (2014:268); Anderson, (2017); Cypress (2017:257); Maher *et al.* (2018:3); Henry (2015) and Chambers (2015). The establishment of overall rigour was practised as analysed below.

**Credibility**, the researcher through the involvement of the participant groups, ensured that the results accurately uphold the highest confidence in the truth value of the outcome of the research (Johnson *et al.*, 2020:141; Morse, 2015:1212-1213; Cypress, 2017:257 & Maher *et al.*, 2018:3). This practice was achieved as follows.

- Prolonged engagement with the Participant-groups ensured that the findings are credible (Lincoln and Guba, 1985:301 & Maher *et al.*, 2018:3 ). At the same time, even during the challenging times of COVID-19 prolonged engagement was achieved with Participant-group Two. This was particularly achieved by a longstanding trust-relation between the researcher and Participant-group One. The research has learned the culture and ways of life of the community for over ten years, this provided opportunities for clarity of misinformation. This prolonged engagement commenced during the researcher's Master's degree to this date. Furthermore, the researcher at all times bracketed his own preconceptual views and beliefs to avoid distortion of the emerging findings (Lincoln & Guba, 1985:302). This created an environment of trust where both participant-groups felt appreciated and respected.

- Sequentially, in **Phase One** at different points, data collection and analysis took place simultaneously to best guard the emergence of the Middle-range theory utilizing *makgotla* and theoretical sampling.
- Data, theory, and method triangulation were used to converge the emerging data obtained in **Phase One** using *makgotla* as a data collection method between the participant groups. Furthermore, observations and transcripts were used for convergence to avoid bias and minimize errors (Lincoln and Guba, 1985:301&304; Johnson *et al.*, 2020:143; Morse, 2015:1216 & Chambers, 2015:2).
- Autonomously, in **Phase One**, member checking was sorted through collaboration with community members (Lincoln & Guba, 1985:314). The researcher returned to the participants to explore whether what they said concerning the interpretation was what was intended (Johnson *et al.*, 2020:142 & Morse, 2015:1212-15).
- Importantly, in **Phase Two**, the researcher and the supervisor appointed independent reviewers for the critical, integrative literature review. To ensure the accuracy and consistency of the search strategy and the sampled literature.
- In **Phase Three**, experts across the discipline of health, practice, and research, were appointed to confirm and validate the emerging Middle-range theory. These experts were given a clear set of instructions and their expectations were defined.
- Overall, the researcher ensured that sufficient (thick description) and quality (rich description) data were collected to achieve saturation (Morse, 2015:1218).

**Transferability**, the researcher deliberated on the rich description of the nature of the research context without implying its applicability to other contexts (Lincoln and Guba,

1985:316; Johnson *et al.*, 2020:141 & Maher *et al.*, 2018:3). This practice was achieved as follows.

- Notably, the research was conducted on the African continent in two indigenous communities in South Africa (Participant-group One) and Malawi (Participant-group Two) with a common solution by proposing a communal holistic therapeutic approach for psychosocial health management in African indigenous communities. Subsequently, the results of the research were interpreted in the context of Africa within the paradigm of these communities. This is done purposefully to revitalize indigenous communal use, inform teaching and learning, conduct further research, and inform health service policymakers.

**Dependability**, the researcher, in collaboration with the participant groups, deliberated in detail the thick description of the research process and the quality of the results so that the work could be repeated and yield the same outcome elsewhere (Lincoln & Guba, 1985:317; Johnson *et al.*, 2020:141; Cypress, 2017:258 & Maher *et al.*, 2018:3). This practice is achieved as follows:

- Constant comparison of data with data and data with codes was performed throughout **Phase One** and **Phase Two**, respectively.
- Following a clear guideline for the assessment of the quality of the literature collected in **Phase Two**.
- The search strategy for the critical, integrative review was guided by the emergence of data from **Phase One** building up to **Phase Two**.
- A pilot study was conducted by testing the search terms and inclusion criteria on a smaller sample in **Phase Two**.
- Reporting the results of the research through the participation of indigenous communities involved was of high quality in clarity, organization, completeness, accuracy, conciseness, and inclusiveness. This was done by going back to the community for clarity of the findings.

**Confirmability**, through the involvement of the participant groups the researcher ensured that the Middle-range theory emerged from the raw data gathered from the participants and was not influenced by biased interpretations of the researcher (Lincoln & Guba, 1985:318; Johnson *et al.*, 2020:141; Cypress, 2017:258 & Maher *et al.*, 2018:3). This practice was achieved as follows.

- Reflective and refractive critique by way of a regular, systematic approach to the question, learning from and during the research process (Johnson *et al.*, 2020:139).
- Bracketing and avoiding biases by the researcher, always assuming a neutral position with an outlook characterized by reflexivity (Lincoln and Guba, 1985:319; Morse, 2015:1215; Trainor & Graue, 2014:271). This practice was achieved by the researcher being open, alert, and inquisitive (Chamber, 2015:3).

### 3.9. **Validity and Reliability** (see Annexure Q)

Equally important, in the terrain of **Phase Three (quantitative)** of the research, practices ensuring rigor were deliberated henceforth. In this case, the research addressed the practices of validity and reliability.

**Validity**, the researcher with the with the involvement of the participant-groups ensured the practices concerning the range to which the phenomenon was accurately measured by the following:

**Content validity:** The researcher, with the involvement of the participant-groups, ensured that the Middle-range theory to be developed sufficiently included the intended content concerning the phenomenon (Heale & Twycross, 2015:66; Terwee *et al.*, 2018:1159 & Rutherford-Hemming, 2015). This was ensured by the appointment of experts from across the academic, research, and practice spectrum. Beyond this, these experts were expected to obtain content validity index (CVI) scores by not only judging the content but also the areas of omissions. Furthermore, the experts were requested to measure the significance of the content by way of judging the ratio of the content (CVR).

Lastly, the experts were requested to evaluate the approach in its totality for cohesiveness, completeness, and comprehensiveness.

## **Reliability**

Practices of reliability dictated the researcher to ensure consistency in the measurement of the contents of the emerging theory (Heale & Twycross, 2015:66; Watson, 2015 & Mohajan, 2017). Accordingly, the researcher adhered to the principles of reliability by:

- A pilot test was performed after appointing experts to measure the extent to which the instructions sent to the experts, were comprehensive.
- Furthermore, an appointment of a quantitative expert for the formulation of statistical forms for CVI and CVR, to conduct and interpret all the quantitative tests and calculations. Moreover, offer expert advice on the overall contents of the chapter.
- Finally, the Kappa statistic was employed to mitigate the limitations of the content validity index (CVI).

### **3.10. Ethical considerations**

Procedurally, the research necessitated the approval provided by the Chief of the Khoisan Community in the Northern Cape, South Africa. Equally, this research went through the rigorous process of the University of Venda for academic and ethical approval. First, at the departmental (nursing) level, the School of Health Sciences and the institutional ethical committee assessed the potential risks and benefits to the participants.

The research further obeyed the general principles set out by the American Psychology Association (2017:3-4), as follows:

#### **Principle A: Beneficence and Non-maleficence**

The researcher entrusted the interests of the participants and took necessary measures to avoid harm. The researcher explicitly informed the participants of the aims and objectives of the research. The researcher achieved this by clearly explaining that there are no costs involved in participating in this research and that participation yields no

remuneration in the research. Furthermore, beneficence and non-maleficence were achieved by the researcher only carrying out the purpose of the research and not introducing any intervention through treatment.

**Principle B: Fidelity and Responsibility**

This researcher always availed himself to clarify questions related participation in the research. This was facilitated by the rapport and trusting relationship the researcher had with the participant-groups particularly Participant-group One. Therefore, the roles of everyone involved were clarified.

**Principle C: Integrity**

The researcher promoted accuracy, honesty, and truthfulness by providing all the necessary information and establishing a communication channel for clarity. Moreover, the information to be gathered is used only for academic purposes.

**Principle D: Justice**

Participants in this research had the benefit of construing their own reality and how they process and interpret it. The participants of this study were informed of every detail of the research from the onset to the finalization of the results to validate whether the outcome is indeed a reflection of their reality.

**Principle E: Respect for People's Rights and Dignity**

The researcher treated every participant with fairness and respect by upholding their privacy, confidentiality, and self-determination. This was achieved by concealing the names of the participants throughout the data collection and reporting the research results to maintain complete anonymity. Hence, the participants clearly explained that the audio recordings to be used would not reveal their identity in the present and future. This was achieved by labelling the recordings of each participant with a unique code. Respect for participants was further achieved solely by using the data collected and reporting for academic purposes.

Furthermore, it was clearly explained to the participants that participation was voluntary, and that refusal to participate in this study involved no penalty. Each participant was free to withdraw consent and discontinue participation at any given time by exercising their or right to withdraw. The consent form was signed on an informed basis by the participants, who clearly stated the right to withdraw.

### **3.11. Chapter summary**

The chapter outlined the extent to which the preliminary framework guided the current research methodology, followed by a comprehensive discourse on the methodology used. The approaches, designs, and methods for each phase are discussed in this chapter.

## Chapter Four

# *QUALITATIVE STRAND*

## PHASE I:

### Classical Grounded Theory

*The emerging Middle-range Theory: From Substantive area to Formal Theory*

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#### 4.1. Introduction

The previous chapter explored the methodological intricacies of the research. However, the intention of this chapter was to meat out the data-dependent findings of an assiduous classical Grounded Theory method in this qualitative strand. Therefore, *makgotla* was employed as a data collection method from two participant groups: South Africa (Participant-group One) and Malawi (Participant-group Two). Synoptically, the need for this research arose because of the absence of a culture-congruent, accessible, and efficient psychosocial health management approach among indigenous Southern African communities. Hence, the rigorous Grounded Theory methodology within this phase of the research emerged as formal theory as an outcome (***Four-Dimensional Inclusive-holistic Communal Psychosocial Health Management for Southern African Indigenous Communities (4IC-PHM-SAIC) theory***). This outcome precisely attends to the first part of the aim of the research, as stated: ‘to develop, confirm and validate a communal holistic therapeutic approach for psychosocial health management among Southern African indigenous communities.’ This was achieved through the realization of objective one of the research as stated: develop a formal theory from the preliminary conceptual framework by utilizing Grounded Theory (**Phase I**). The presentation of data was mainly steered by Glaser’s School of thought, wherein theoretical sensitivity, theoretical sampling, and data dependence take centre stages (Glaser & Strauss, 1967).

As conceded by Glaser and Strauss (1967:31) Grounded Theory "may take different forms." Indeed, the presentation of the generated theory in this research took its self-determining form, although it maintained the effective use of the process favoured by classical Grounded Theory. This chapter consists of three sections (A, B, and C). Section A deliberates on the findings of Participant-group One, whereas Section B focuses on the findings of Participant-group Two. Notedly, sections A and B attend to the first two levels of substantive (open)coding independently, with constant comparative methods being applied across (see Chapter Three). Section C further develops the theory through theoretical coding, expressed as a joint discourse, guided by the emergence of Sections A and B.

As previously alluded to, the development of this theory has emerged from an existing substantive hypothesis to a formal presumption level, guided by classical grounded theorists (Glaser & Strauss, 1967). To achieve this, *makgotla* as explained by (Pienaar, 2004:25-26) and Pienaar (2017:88) was used to gather data by employing an unstructured schedule developed using substantive theory (conceptual framework). The inductive nature (Elo *et al*, 2013) convoluted the sole purpose of developing a formal theory. Therefore, Phase II of the research is informing (see Chapters Two and Three). Hence, *makgotla* was carried out following an unstructured schedule that included confirmatory and central questions (see Annexure F).

Ultimately, following the classical work of Glaser and Strauss (1967), theoretical sampling was used, employing simultaneous data collection and analysis. Typically, in this method of sampling, the first-level participants were identified, and then the data provided by these participants led to the following participants, who could contribute to theory emergence. This process assisted the researcher in developing the following local concepts embedded in the conceptual framework.

***Indigenous communities, Southern Africa, psychosocial health, knowledge holders, communality, communal cultural process, communal individual, psychosocial process, communal holistic care, primal health care, culture, and traditions***

For theoretical purposes and relevance, the researcher initially selected one context and was led by the data to the second for the emergence of the theory. This was achieved through the practice of continuous inclusion (Glaser & Strauss, 1967:50). The two participant groups were one rural community in South Africa, the Khoisan community (substantive theory), and one urban community of postgraduate students originating from different regions of Malawi (for the development of formal theory). These participant groups provided control at the conceptual level and within the scope of the population (Glaser & Strauss, 1967:55). Furthermore, for theoretical properties and the emergence of categories, the groups offered the concurrence of minimization and maximization of similarities and differences in the data (Glaser & Strauss, 1967:55).

The chapter continues the discourse below by first locating the fundamentals of the conceptual framework used. Subsequently, the data collection process ensued. Thereafter, the coding and analysis of the data were explored to form the meaning of the data. Finally, the findings from Participant-group One are discussed. The discourse involved initial and intermediate phases of substantive coding. Lastly, the discussion of the findings for Participant-group Two followed a similar edifice to that of Participant-group One.

#### **4.2. The refinement of the Conceptual Framework**

The conceptual framework in this research is interchangeably referred to as the 'substantive area' or 'substantive theory.' Formal theory refers to theory in development. In the main, as depicted in Chapter Two (see Figure 3) and Chapter Three of the research an inductive qualitative approach was followed to refine the conceptual framework. Hence, Grounded Theory is the research design. This inductive approach involved gathering data using *makgotla* as a data collection method and employing theoretical sampling. The research followed a duo-coding process of substantive and theoretical coding. The data were analysed using a constant comparative method (Glaser & Strauss, 1967).

As shown in Figure 2 (see Chapter Two), the conceptual framework matured from the substantive area that the fundamental concept of the management of psychosocial health

within the Khoisan community is '*communal holistic therapeutic care*'. This main concept is related to the appreciation of an indigenous context grounded in the principles of Ubuntu.

This communal way of life birthed central concepts such as the 'communal individual' which means that a person living in this Khoisan community is understood to be holistic (emotions, mental, spiritual, physical, and social) and is connected to nature and the surroundings. Hence, for the management of psychosocial health, a '*psychosocial process*' is followed throughout the stages of life (see Figures 1 and 2, Chapter Two). This is to realize a '*communal cultural process*' in which a balance of life between the communal person and nature is achieved. This represents the wheel of life.

Granted this maturity of the substantive area of the theory in the management of psychosocial health within an indigenous community, the notion of *what, why, who, whom, how* and *how* arises. Therefore, this research endeavoured to refine the substantive area to the level of formal theory by making use of Grounded Theory guided by Glaser's approach.

### **4.3. Data collection**

As indicated, the research was conducted with and in partnership with two Southern African communities: the Khoisan Community in South Africa and a community of postgraduate students in Malawi. Henceforward referred to as Participant-group One and Two respectively. For both participant groups, the data were collected using *makgotla*, as described in the methodology chapter (see Phase I). It is noteworthy that all the data were collected during the COVID-19 pandemic with lockdown restrictions; hence, *makgotla* was conducted virtually (online). The data were collected from audio and video recordings using the Google Meet platform. Therefore, one confirmatory session with participant group one in South Africa and two sessions with participant group two in Malawi were conducted. Thus, three sessions were conducted for both groups.

The current project forms part of a longstanding memorandum of understanding between the Seboka Research Academy and the Khoisan community in South Africa (see

Annexure D). Given the indigeneity of the context, recorded verbal consent was sorted and accepted to serve the intended purpose. The parent language of the Khoisan community in South Africa is Afrikaans. The *makgotla* for Participant-group One was conducted in both English and Afrikaans using the Google Meet virtual platform. Finally, the data were transcribed in English. Following the heed of theoretical sampling, the emerging data from session one with Participant-group One directed the researcher to engage with another indigenous community that spoke their ancestral language. Hence, Participant-group Two was identified and engaged to form a part of the research. However, it is important to note that it became a challenge to travel to Malawi and identify an indigenous community amid COVID-19, with restrictions on travelling and gathering of people. Because of these challenges, the researcher through the assistance of the Kamuzu Nursing College in Malawi, a community of postgraduate students was identified. The identified community comprised postgraduate students from various indigenous communities across Malawi. The entry point for this community of participants was the Kamuzu College of Nursing. Noteworthy to mention that the participants were of African origin, rooted in their culture as manifested by the speaking of their own indigenous languages. This was important because theoretical sampling directed the researcher to a community that speaks ancestral language. Therefore, strengthening the findings of the research.

Consequently, the participants were engaged through their senior lecturer. Then, arrangements were made for the *makgotla*. Because the participants were all competent in the command of English and to avoid language barriers, English was used during the data collection. However, the participants were allowed to express themselves in their native language, subject to the reinterpretation of English. The two virtual *makgotla* conducted with Participant-group Two were through the Google Meet platform, wherein data were later transcribed. In addition, given the indigeneity of the context, recorded verbal consent was sorted and accepted as serving the intended purpose. It is noteworthy that more similarities than differences surfaced in the data of the two participant groups.

#### 4.4. Coding and Analysis of data

Fundamentally, data collection and analysis were a joint process, as the researcher followed substantive coding, also known as open and selective coding (Glaser & Holton, 2004). Equally, central to Glaser's approach of analysis, a constant comparative analysis was applied throughout the process, followed by memoing. Consistently, this research implemented four stages of the constant comparative method, namely, comparing incidents applicable to each category, integrating categories, delimiting the theory, and writing the theory (see Figure 9, Chapter Three). Importantly, the coding of the data followed a two-level process of substantive coding (initial and intermediate phases) and theoretical coding (final development and theory) (see Table 1, Chapter Three). As importantly, the researcher together with the independent co-coder, and promoter collaboratively analysed and coded the data. Henceforth, data are conveyed, starting with findings in each participant group, followed by a higher-level discussion that combines these findings through constant comparison and memoing.

#### 4.5. SECTION A: Discussion of Findings from the *Makgotla* of the Khoisan Community in South Africa (Participant-group One)

##### 4.5.1. Substantive (open) coding (See Table 1, Chapter Three)

###### A. Initial phase.

For the initial coding, the researcher conducted a confirmatory *makgotla* for this group, as the existing substantive area of the theory was developed by Mahlatsi et al. (2021) involving the same Participant-group. Existing core categories were compared for clarity and advancement. Here, the focus is on emerging findings from the raw data collected (see Table 1, Chapter Three). Therefore, what follows is the emergence of the findings as guided by the data collection schedule beginning with confirmatory questions: *what is good health?, healing?, psychosocial health?, person?, management of psychosocial health?, lastly, the role of persons, what is life?, is life linear or circle process?*. This was preceded by central questions – *What is the source of life?* Finally, *what is the end goal?*

## Confirmatory questions

- What is the meaning of good health versus illness? (*What*).

The initial definition of health in this community was maintained as such in the substantive area that good health means a balance between the body, mind, emotions, spirit, and cosmos. This was confirmed by the participants:

### Spoken word.

*“When you are coping in your mind, emotions, physically.” (Participant J)*

*“When you are doing well within yourself.” (Participant J)*

*“... our nature is what our health is.” (Participant O)*

### MEMOING G1/O1

Meaningfully, as was realized in the substantive area of this Khoisan community, health is not just a compartmental module. Rather, it is a connective phenomenon between who you are as an individual and their relationship with the surroundings (air, sky, land, and those who were here before).

- What is illness (**what**)?

Relatedly, it became evident that good health is the opposite of *what is illness*. Illness is the imbalance of one’s body, mind, emotions, spirit, and how they relate to the surroundings.

### Spoken word.

*“Illness is when there is a problem between your body and how you think.” (Participant L)*

*“... yes, how you feel in yourself.” (Participant L)*

*“Your mind and spirit communicate when you are ill.” (Participant E)*

*“... how you relate also with your people.” (Participant J)*

## MEMOING #G1/02

The appreciation of illness in this Khoisan community seems to remain the same in the substantive area of the theory. At the same time, an advancement of new meaning was achieved, in that illness also involves your relationship with others and how you interact with them.

- What is the meaning of healing? (**what**).

Impeccably, it emerged that healing is not only an outcome connoted process where a balance is achieved between mind, body, spirit, emotions, and how one relates to others and the cosmos. Thus, at this point, the data adduced that healing was sounded by participants, meaning that one must have a shared belief among the indigenous Khoisan community.

### Spoken word.

*“In our culture, Belief is important.”* (Participant X)

*“You will not heal if you don’t belief.”* (Participant J)

*“... Yes... you first have to belief.”* (Participant L)

*“Healing is a process.”* (Participant L)

## MEMOING G1/03

It has been established in the substantive area that the communal belief system is an integral part of psychosocial health management. Thus, the correction of this imbalance is equally dependent on the appreciation and understanding of cultural beliefs within the community.

- What is the meaning of psychosocial health? (*What?*).

Psychosocial health was found to be a multifaceted phenomenon that first drew its meaning from appreciating and understanding the balance between mind, body, emotions, spirit, and cosmos. The latter refers to who you are as an individual and your relationship with the surroundings (air, sky, land, and those who were here before).

Spoken word.

*“Our community is important to us as Khoi people.” (Participant M).*

*“We taught to respect every elder on the streets.” (Participant M)*

*“We belief that nature and the Khoi are connected.” (Participant P)*

*“I am today, because you are.” (Participant L)*

MEMOING G1/04

The aspect of holism was maintained in the substantive area, and it is also emerging that psychosocial health involves the totality of a person and their surroundings.

- What is the meaning of a person within your community? (what).

The meaning has been maintained as in the substantive area in which a person is understood as a communal individual who is holistic in nature (body, mind, emotions, and spirit). Furthermore, an individual is believed to be interconnected with others around him/her, the surroundings, and those who were here before us.

On the other hand, it is emerging that the meaning of a person has expanded in that the responses were:

Spoken word.

*“Every child is taught to respect adults.” (Participant A)*

*“You will not disrespect an elder on the streets.” (Participant A)*

*“It takes a village to raise a child.” (Participant O)*

MEMOING G1/05

It emerged that a person is defined at an early age to learn and inherit the principles of mutual respect, wherein shared respect among the community becomes a lifestyle lived by everyone.

Interestingly, participants introduced an aspect in that shared respect extended to the cosmos (nature and other living organisms). These were noted when the participants continued to say,

Spoken word.

*“Children are taught at a young age never to kill any living organism and are reprimanded if otherwise did. Because this act can affect your being if you were  
“afforded the opportunity to live again.” (Participant D)*

*“.. yes, nature is important to us.” (Participant J)*

*“Preservation of nature means preservation of us.” (Participant D)*

The meaning and appreciation of a ‘person’ was unearthed when incidents in the data were continued to be compered participants stated that –

Spoken word.

*“We are first human, then male or female.” (Participant D)*

*“... that is why it is inherent of us to always practice humility.” (Participant H)*

*“We assume equal responsibility to life and living in our community.” (Participant D)*

*“A person should be gentle, sharing, caring and respectful.” (Participant J)*

MEMOING

Humility is central to the definition of a person in the Khoisan community. Thus, the principles of Ubuntu are maintained. However, it is important to be alive to the phenomenon that the persons in this community assume equal responsibility for life before gender roles.

- How do you manage psychosocial health challenges at the communal level (who is involved, of ‘who is saying/doing what to whom, when, and why and how are they saying/doing it?’)

In the substantive area, a communal communication system is followed in the management of psychosocial health. Hence, appreciation and understanding of the

communal communication system involves *who, what, whom, why* and *how* barebones. Thus, these rudimentary aspects were explored to confirm and advance the theory.

- Who is involved: Who is saying/doing what to whom? (*Who*).

In the substantive area of the theory, it was established that elders in the community normally assume the task of heading towards the communal cultural process in the management of psychosocial health. However, the task can be assigned to anyone (men/women), depending on the nature of the problem. Whether the problem involves a girl/woman and/or a boy/man.

It is illuminating that Khoisan culture within that community is currently female-dominant, wherein women contribute more meaningfully to the community than their male counterparts. However, this is the effect of enslavement when men were removed from Khoisan society to work for the white colonial settlers. This was noted through responses, such as:

Spoken word.

*“At the moment our culture is female dominant, women play a crucial role in our society.”* (Participant E)

*“.... I think part of the reason could be due to slavery, women have been tasked to take up more active role in preserving the life of our community.”* (Participant L)

*“.....women are at the forefront playing a major role in our community.”* (Participant A).

Contrary to the previous assertion, it has been expanded further that males and females have naturally assigned roles. Thus, the participant further stated:

Spoken word.

*“For example, during !nxhabasa, women take the lead of the teachings and other fundamental things concerned. But also, women will gather food and collect wood. On the other side, men will slaughter the animal for sacrifice, dance and play music to welcome the young girl.”* (Participant J)

## MEMOING

The aspect of gentleness among people within the community can be interconnected to and explained by the feminine dominance emerging here. Even so, the outlook of the community is still alive and continues to contribute meaningfully. Therefore, this does not refute the important roles of men within the community.

- What is being said? (*What?*).

Tellingly, it emerged in the substantive area that words and silence are interwoven, manifested by the realization that what is not being said is as powerful as what is being stated. On the other hand, spoken words are also conveyed through covert speech wherein metaphors are used by elders for educational purposes. Furthermore, spoken words in the form of stories were found to be significant for the management of psychosocial health challenges. Thus, their meaning is central to those who were here before us and/or reflect on day-to-day life. Correspondingly, it speaks to the significance of self-resilience disclosure by openness to lived experiences by the care giver to the care user. Even so, direct and instructive language was maintained throughout the healing process.

Currently, there is an unavoidable expansion in the theory that not only what is being said is of importance, as already established, but the use of language is fundamental. This was noted when the participant responded as follows.

### Spoken words.

*“There are certain words that are connoted exclusively as female but also there are ones connoted to male exclusively.” (Participant J)*

*“...When it’s big, and strong is given male connotation.” (Participant O)*

*“...YES... When it’s gentle and fragile it is given female connotation.” (Participant J)*

- How do you conduct yourself and how do you say what do you say? (*How?* and *What?*).

In substantive theory, it was clearly understood that whoever forms part of the communal counselling team should demonstrate the principles and attitudes of communication. Thus, it is important to show humility, not appearing clever/strong as being above the counselee, respecting the process of readiness and non-readiness, and showing patience and/or respectful waiting. Finally, the ability to set boundaries is a critical factor.

This above rendering of the principles and attitudes of communication expected from the communal counselee was confirmed by participants maintaining that humility is at the centre of day-to-day life. This can be noted in the following quote.

Spoken word.

*“Every human should possess those qualities, so every human should be caring and loving.” (Participant E)*

*“... remember, we are first human. That is why we lead with humility.” (Participant J)*

*“Because the Khoisan culture ...is gentle caring and sharing ...that’s the main.”  
(Participant J)*

▪ **When and why?**

The substantive area of the theory in this aspect firstly, it was established that psychosocial health management is a continual process integrated within the communal communication system and the day-to-day lifestyle/practices. Second, the understanding remains that the management of psychosocial health challenges efforts to achieve a balance within oneself, the family, and the community at large (including nature and those who were here before us) is critical. This was confirmed by the following participants:

*“It’s about things been done in mutualistic manner, the one assists the others, in order to make sure that the community as a whole, the family as a whole strives in order to do things better.” (Participant J)*

Psychosocial health management is a lifelong process engaged by persons within a community with a shared belief and understanding to achieve equilibrium. The persons involved were guided first by the belief that they should always practice humility by

demonstrating the principles and attitudes of communication. It is further emerging that, in demonstrating the above principles and attitudes, humility becomes as important as purpose. Finally, there is the importance of language use within the spoken word.

- What is life from beginning to end? (*What?*)

It is emerging that the meaning of life within the Khoisan community originates from the belief that life does not end and is in a circlic form. Importantly, this meaning of life is not only limited to people living within the community but also to nature and other living organisms. This meaning is maintained in the substantive areas of theory. This consistency was noted by the researcher when the participants responded:

Spoken word.

*“Some families belief that our soul cannot perish.” (Participant O)*

*“The life of any living organism is meaningful to us.” (Participant J)*

*“Children are not allowed to kill any living organism.” (Participant J)*

*“... Our bush is our life.” (Participant F)*

- Is life linear or it takes a circular process (*What and why?*)

As was found in the substantive area, life is a circlic phenomenon, as its essence derives from a never-ending circle; thus, everlasting. This meaning was appreciated by the researcher, as the participants responded:

Spoken word.

*“Life is a never-ending process.” (Participant J)*

*“Life is precious and everlasting.” (Participant O)*

*“That is why one leaves a rock when visiting your loved ones in the graveyard to signify that their spirit still remains.” (Participant J)*

*“Physically your body dies but your spirit lives on.” (Participant Z)*

What is significant is that an important element of substantive theory concerning the circular nature of life was advanced. Hence, participants shared the belief that even in

some events of death, there is another person who takes over life. In addition, roles can be shared among different persons within the family. This was realized by the research after the participants responded:

Spoken word.

*“Before someone pass on in the family, they will look at everyone to look at who has the best characteristics to assume the role.” (Participant O)*

*“Most of the time the roles will be divided among different family members – leadership, caring etc.” (Participant J)*

*“Before the person dies, they will look what characteristics you hold to carry on with the nurturing of the family provided that was the quality of the one who died.” (Participant J)*

MEMOING

It became clear that the belief in life as a circle stem from the appreciation that life does not end.

Overall, the researcher notes that the structural components of life within this community are fundamental to shared beliefs. Second, the principle of communality is that every person strives to balance life.

Congruently, it is emerging that life is strongly connected to cosmology.

At the height of this, it appears that from generation to generation, there is a transference of life and responsibility by way of delegation of roles and continuation of life.

- Spirituality in relation to life, cultural practices, and psychosocial health challenges (*What and How*).

With the advancement of substantive theory, it has become evident that spirituality in this Khoisan community has been diluted by the infiltration of Western doctrines. Participants explored spiritual practices such as the trance-dance, one of the pivotal spiritual practices in Khoi culture, as a thing of the past. However, the other end of the foregone closure was the inclusion of a similar practice in Christian churches.

Spoken word.

*“We have not experienced it(trance-dance) in the recent times.” (Participant O)*

*“However, some aspects of it you find them in churches.” (Participant L)*

*“It is done in various sects of Christianity.” (Participant O)*

The participants continued to illustrate the similarities between the trance-dance and some aspects of it being found in the Christian churches. This was noted to be the resemblance of the actual spiritual trance-dance wherein, there is the healer, the communal counselee, and the rest of the people who are there for support (clapping of hands and dancing). The participants further confirmed that the trance-dance and the dance done in the churches have a similar meaning, spiritually and culturally, that is, to bring a message of healing from the Creator. It is further emerging that trance-dance is propelled by joy or hurt that comes from within a person.

#### Spoken word.

*“... For example, singing, clapping of hands, dancing, and forming a circle.” (Participant J)*

*“Dancing rhythmic to the singing and clapping of hands.” (Participant J)*

*“... the purpose of the dance is more or less the same – to transcend into the spiritual helm and bring a message.” (Participant X)*

*“... the message might be how to heal someone or how to assist them in making the suffering less.” (Participant J)*

*“...More like a prophecy.” (Participant J)*

*“For example, the one who transcends can be told to use a certain combination of plants to assist the person with a challenge.” (Participant O)*

*“This is how culture and traditions are incorporated within the Christian religion.” (Participant M)*

*“When you dance it comes from the inside. It might be joy or hurt that comes from within. Hence, it is the spirit within yourself that sends you to dance”. (Participant M)*

## MEMOING

The spiritual meaning of dance seems to be consistent with the understanding of life, in that life does not end. The belief is that one transcends from the physical world into the spiritual realm to collect messages from those who were here before us. In addition, the formation of a circle during dancing can be associated with the understanding that life is a circle.

On the other hand, there was a revelation by the participants that this is how cultural practices are being incorporated into churches, such as the trance-dance that can be related to religionization, Westernization, and deculturization.

### **Central questions**

Thus far, the central questions emanate from research, raising needful explorations on the meaning of data. What is actually happening? How do all of these factors relate? What is the solution for emerging data? Hence, such an interrogation by research that brings the following central question to life is important.

- What is the source of life? (*What*)

Proximately, it is emerging that nature becomes a significant aspect of the source of life. This was appreciated when participants described the life of a specific medicinal plant referred to in the Afrikaans language as “kan-nie-dood.” This means “cannot die” directly translated into English. This was realized as the participants shared the following:

#### Spoken word.

*“There is a plant called die kan-nie-dood which I even see it was not made reference of in the previous research.” (Participant A)*

*“... the name of the plant derives from the life of the plant.” (Participant A)*

*“It is one of the ancient species here in our community.” (Participant A)*

With this interesting emergence, the research continued to interrogate the data by further exploring what this means. How does this relate to the source of life? How can the life history of this plant be explained? The participants continued by saying:

Spoken word.

*“The plant is almost like re-incarnation.” (Participant J)*

*“It is a self-preservation plant.” (Participant O)*

*“The plant grows abundantly around the area of our community.” (Participant J)*

*“It grows for a couple of months and when its time is over, it will die. But the next time grows it will be the stronger strain. It will endure more in essence.” (Participant M)*

*“...yes... it is a self-preservation plant.” (Participant J)*

*“It is not seasonal it grows throughout the year.” (Participant A)*

*“One species can grow throughout winter, and then die in summer. At the same time, another species can grow throughout summer and die in winter.” (Participant J)*

After an understanding of the life of the “*kan-nie-dood*” plant was achieved, the participants assuredly explored the meaning and significance of the plant to the community. This was realized, as participants said:

Spoken word.

*“Psychological value of it is that it does not matter when you die, you will live again and grow bigger in abundance.” (Participant O)*

*“The plant also helps us to grieve, as we all know grieving is a life-long thing.”  
(Participant J)*

*“Thus, the name of the plant – *kan-nie-dood*.” (Participant J)*

## MEMOING

Interestingly, emergence on the source of life leads the research to associate it with the previously noted belief that the lives of all living and non-living organisms are as fundamental as the people within the community. Thus, a relationship with cosmology is essential. However, the life cycle of the “*kan-nie-dood*” plant can be related to the belief that life does not end.

Overall, this holistic way of life in the management of psychosocial health is consistent with the substantive area of the theory, which is referred to as the ***wheel of life***.

### **4.5.2. Inductive synthesis**

Central to the understanding of the epistemological epochs of the Khoisan community, it is emerging that there is an appreciation of the wisdom that life is a never-ending reality. Hence, the life is categorized as circlic. This can be seen in a practice wherein, when an individual passes on, there is an ascendance by another individual to continue the life of those who were here before. Furthermore, this understanding can be corroborated by the belief that nature is as important as everyone is life. Thus, the “*kan-nie-dood*” plant is integral to this appreciation.

Fundamentally, it is emerging that *belief* are central to the Khoisan community. Similarly, belief becomes a medium of life that is shared, respected, and appreciated by people within the community. Integral to this belief, it is coming out that a person should first deem him/herself as *human*, in that humility precedes day-to-day life. Ubuntu precedes the way of life. Thus, respect, caring, sharing, and gentleness become a part of one's lifestyle. Second, a person is seen as a *holistic* being interconnected to nature, living, and those who pass on (*cosmos*). With the same respect to belief, it is understood that illness is the imbalance of *holism* causing disturbance to the interconnectedness of nature, the living, and those who were here before (*cosmos*). Thus, healing is a life-long process with the intended purpose of correcting imbalances and disturbances resulting from illness.

The complexity of *holism* in the Khoisan community is essential to psychosocial health. It is considered a continual process between good health and illness. Hence, psychosocial health management is appreciated as a mutual and continual process among community members. This is why those who are involved as care givers will always demonstrate a high standard of principles and attitudes of communication preceded by humility. However, it is also important to note that the use of language is fundamental in the management of psychosocial health. Be that as it may, it is emerging further that there is a noticeable dominance of females within the community. However, this eventuality does not negate the naturally assigned roles of both men and women. This can be seen in the shared approach demonstrated in the management of psychosocial health.

This is even so, with *belief* being central to the way of life within the Khoisan community. The influence of Christian way of life is unavoidable. Evident is the reality of churches continuing to infiltrate and dilute what is known as the way of life within the Khoisan community. This is substantiated by the introduction of spiritual practices, such as trance dancing, found to be practiced within the churches.

All things considered, the holistic approach and interconnectedness of life in the management of psychosocial health are found in the substantive area of the theory, hereby referred to as the ***wheel of life***.

## **B. Intermediate phase** (see Table 1, Chapter Three)

For this phase of coding, the researcher continued with substantive (open) coding, with a particular focus on the data emerging through constant comparisons of constructs (see Table 1). This involved collapsing, fitting, and refitting the emerging meanings from the data. The table below (Table 3) summarizes the emerging conceptual categories. These are emerging conceptual categories, ***shared belief, communal lifestyle, post-colonial hegemony, and communal therapeutic techniques***. These conceptual categories are interrogated and related to the conceptual codes and conceptual subcategories.

#### 4.6 Discussion of the emerging categories (see Table 3)

**Table 3:** Emerging findings from Participant-group One

EMERGING FINDINGS FOR PARTICIPANT GROUP ONE		
CONCEPTUAL CODES	CONCEPTUAL SUB-CATEGORIES	CONCEPTUAL CATEGORIES
A-1.1. Holistic-continuity <ul style="list-style-type: none"> <li>• Communal person</li> <li>• Life is a circle (circlic)</li> <li>• Plant personification "kan nie dood"</li> <li>• Psychosocial health</li> <li>• Health</li> <li>• Illness</li> <li>• Healing</li> <li>• Delegation of roles</li> <li>• Gender posteriority</li> <li>• Those who were here before us</li> </ul>	A-1. Source of Life and Living	A. Shared Belief System
B-1.1. Humility <ul style="list-style-type: none"> <li>• B-1.2. Shared responsibility</li> <li>• B-1.3. Eating practices</li> <li>• B-1.4. Graveyard visit</li> <li>• B-1.5. !nxhabasas</li> <li>• B-1.6. Mpho ya badimo</li> </ul>	B-1. Day to Day Practices	B. Communal Lifestyle
C-1.1. Religionization -(Christianization) <ul style="list-style-type: none"> <li>• Trance-dance</li> <li>• Graveyard visit</li> </ul> C-1.2. Slavery And Labor Migration	C-1. Westernization and Colonization	C. Post-colonial Hegemony
D-1.1. Humility           D-1.2. Gender Roles (Conversations For Men And Conversations For Women)           D-1.3. Language Connotations <ul style="list-style-type: none"> <li>• Feminine, gentle, kind, caring, lively and sharing.</li> <li>• Boundary setting (big, strong, and masculine)</li> </ul>	D-1. Basic Therapeutic Technique/Communication Skills	D. Communal Therapeutic Techniques
D-2.1. Metaphors (covert speech)           D-2.2. Silence           D-2.3. Stories <ul style="list-style-type: none"> <li>• Self-resilience disclosure</li> </ul> D-2.4. Patience/Respectful Waiting <ul style="list-style-type: none"> <li>• Boundary setting</li> </ul> D-2.5. Fourth-right Honest Interventional Communication	D-2. Advanced Therapeutic Technique	

#### **4.6.1. Conceptual category A: Shared belief system**

This conceptual category emerged from the data after it was realized that participants constantly maintained their mention of the '*belief*' as a medium of life. Particularly, to appreciate the understanding of psychosocial health within the community, sensitivity to beliefs is warranted. Notably, this conceptual category is labelled '*shared*' because it comes from the data that members of the community mutually appreciate the way of life. Indeed, there is a *shared belief system*.

##### **4.6.1.1. Conceptual subcategory A-1: Source of life and living (not just existing)**

Regarding the weight of the data in the aspect of a belief system, it is emerging that this conceptual category is related to the '*source of life and living*' as a conceptual subcategory (see A-1. in Table 3). Looking at the fact that life is believed to be circlic, more data point to the appreciation that life needs a source of power for the *wheel of life* to be sustained. Equally, using a constant comparative method, all conceptual codes emerging from this subcategory were continually interrogated (see Table 3). To start with:

###### **4.6.1.1.1. Conceptual code A-1.1: Holistic-continuity**

- Communal person

What is emerging is that a person who is born into this community is inspired at an early age by humility and mutual respect grounded in the principles of Ubuntu. These principles are not only expressed to other communal persons in the community, but also to nature. Hence, the emergence of the belief that preservation and continued existence of cosmology equals the health and continued life of a person.

Under that understanding, a communal person is first a 'human,' before the recognition of a particular gender assigned. This means that every person within the community assumes equal responsibility for life and living in the community. Henceforth, a person is seen as a holistic entity (emotions, physics, mental, and spirit) that is interconnected with nature. On account of the data, it is then at this point that the gender identity of a person is introduced to the meaning of a person. Even with the eventuality of the latter, the

Khoisan community is emerging as a gender-neutral society. Rather, the communal nature of life takes more meaning.

On the weight of the emerging data, this gender neutrality is connected to the circle of life, wherein the roles of those who were here before are dedicated to those who are here now (living). For this to happen, the gender of the person who assumes the role of those who were here before is not considered. Instead, these characteristics are important in delegating roles. This can be evidenced by the weight of the data, as participants confirmed by saying (see quotes below):

Spoken word.

*“Yes... a woman can be called to continue the  
of a man.” (Participant M)*

*“...even a child can be called up to assume the role of an elder.” (Participant J)*

*“Before someone passes on, the family will look at the person with best suiting  
character to take the place.” (Participant J).*

Clearly, communality, holism, and continuity of life precede an understanding of gender within the Khoisan community. Above all, working together with men and women to achieve a common goal in life is emphasized. It was further noted that different families can be inherently led by a man (patrilineal) and some by a woman (matrilineal). That is, families are either matrilineal and/or patrilineal. Subsequently, on account of emerging evidence, this was labelled as **ambilineal descent**. This was induced as the participants continued to share (see the quotes below).

Spoken word.

*“Culturally, our aunts take the lead, not the uncles. It is the aunt on the mother’s side of  
the family.” (Participant X)*

*“In my family, I as a woman I cannot do certain things. That’s even during lobola  
negotiations I call the uncles of my children.” (Participant L)*

*“From my family, my father used to be the leader. But also, even when his was still alive his sister (my aunts) used take the lead of certain things.” (Participant J)*

- Life is a circle (Circlic)

Important to the notion of holism and continuity, it is emerging that a person in this Khoisan community is born into a world instilled with the belief that life for all those living in it is an everlasting entity. To wheel this circlic nature harmoniously, impartiality is inculcated in all living beings. This is to achieve a harmonious equilibrium of the cosmos, including, but not limited to, humans, plants, air, sky, water, and animals.

Spoken word.

*“...Yes... children are reprimanded when they kill anything, because every living thing is essential to us.” (Participant O)*

- Plant personification “kan-nie-dood”

Similarly, this harmonious balance was evident by the emergence of data when participants mirrored and interconnected their life to that of a plant – ‘**kan-nie-dood**’. First, the plant’s life cycle is compared to the belief that life is circlic in nature. Hence, it is emerging that the ‘**kan-nie-dood**’ plant is self-perseverative. Thus, on account of the data, the analogy of self-preservation is related to the phenomenon of delegation of roles, whereby after a family member passes away, there is a living household fellow who continues the life.

Furthermore, this is also related to the principle of Ubuntu in that, in this community, you are first a human, thus illuminating the philosophy. I am because you are. Consistently, as the plant life cycle continues, the findings suggest that death is a symbol of positionality rather than the end of life. This explains why there is the appreciation of ‘those who were here before us’ as opposed to the ‘dead.’ Moreover, the plant self-preserved itself by growing from the same roots alternatively throughout the year as the season changes. Based on this understanding, this can be related to the test of time that the cultural heritage of Khoisan has endured. Similarly, this signifies the resilience Khoisan has shown over the years, in that the next generation is stronger than the one before it.

Spoken word.

*“...it will grow from same root again but next time it grows it will be stronger version of its previous self, it will endure more in essence.” (Participant E)*

This established construct of self-preservation and the positionality of life brings about the appreciation of this Khoisan community on how they continue to be sustainable and develop their ways of life.

Furthermore, it is believed that plants have a psychological purpose in the circle of life that helps them with grieving. Considerately, the data points out that grieving this community becomes a process of continuity of life rather than hope. Ultimately, the life circle of the plant bares assurance to the Khoisan community that the one who passes over follows the process instead of pain.

- Psychosocial health

As dictated by data, holism and continuity are fundamental to the appreciation of psychosocial health. On that account, psychosocial health becomes indented with the meaning of life, communal person, good health, illness, and healing for its continuity. This means that a person living within this Khoisan community appreciates life as a continually never-ending process. This person exists with a shared belief that his/her mental, physical, emotional, spiritual, social, and/or communality is interconnected to nature and to those who passed on before her/him. Furthermore, you are continually striving for a harmonious balance between the self, nature, and those who passed on earlier. Thus, when an imbalance presents itself, continuity and holism take the lead in reuniting and restoring the circle. All else being equal, psychosocial health negates itself as a continual and never-ending process.

- Delegation of roles

There is the expression that communal persons are holistic and interconnected to nature and those who passed on, the emergence of data communicates that even with death, life continues, and positionality also arises with the delegation of roles. This means that the principles of communality are integral to the community's belief system. Mutually, the ultimate purpose of attaining a balance in life is a dedicated task for every member of the community. Essentially, those who are physically on earth continue to fulfil the role of

those who pass on. Hence, communal persons have equal responsibility for the workings of life and living within the Khoisan community. This is why it is emerging that a communal person is delegated and positioned to continue the lives of those who were here before.

- Gender Posteriority

Gender has become an important but latent aspect of holism and continuity because the delegation of roles and positionality has no bearing on gender identity. For this purpose, a man can be positioned and delegated to continue the roles of a woman who has passed on and vice versa. Above all, appreciation of holism and continuity preponderates the order of the day. Significantly, it is also emerging that when a person is born within this Khoisan community you are "human" first and is equal to the living, those who were here before and nature. Thus, gender identification is a delayed phenomenon, assuming latent meaning in the identity of a communal person. Hence, gender neutrality is a prospective phenomenon but not absolute.

Additionally, the prospect of gender neutrality is emerging with leadership roles within various families in the community. This reality is clear because ambilineality is widely accepted when either a family is patrilineally or matrilineally led. Furthermore, the children of a family can inherently identify with either or both.

However, notwithstanding the above, it is emerging that, even as a delayed phenomenon, gender identification by communal individuals is as important as gender impartiality. To bring this to context, the data led the research to discover how language is used among communal persons and how it personifies gender. To illustrate, the participants shared that there were words that were only male connoted and there were those that were female connoted (see quotes below).

Spoken word.

*“When its big, strong, great, strong and powerful is given male connotation.” (Participant J)*

*“...and when its gentle and caring it’s given a female connotation.” (Participant O)*

*“For example, the name Xhodas is female connoted.” (Participant M)*

Importantly, gender is also related to the circle of life through natural occurrences of existence. This emerged as participants continued to share that rain was understood to be female and thunder male (see quotes below).

Spoken word.

*“There are names used for certain natural occurrences... aaah Some have male connotation, and some have female connotation.” (Participant J)*

*“...it has to do with rain and thunder... Oh yes, the female connotation is the rain, and the clouds is male connotation.” (Participant M)*

*“For example, thunder is related to a male connotation.”(Participant M)*

- Those who were here before us.

It also came out from the data that the persons who have passed on are integral to the belief of holism and continuity of life. This construct can be appreciated in the following quotes:

Spoken word.

*“...when we go to the graveyard you don't pass the graves of your ancestors and not put a rock on there.” (Participant M)*

*“It shows that their gone, but their life still remain with us.” (Participant X)*

This can also be explained by the emergence of the belief that dying is seen as positionality in that a communal person is passing over to continue the circle of life. Therefore, the living and those who were here before remaining interconnected with each other and nature.

#### **4.6.2. Conceptual category B: Communal lifestyle**

Psychosocial health is a never-ending continuum of life. The management of psychosocial health challenges is sounded in the lifestyle of a communal individual living within the Khoisan community. Given this understanding, the conceptual category for this emergence is referred to as a communal lifestyle, with one conceptual subcategory

labelled day-to-day practices (see B-1. in Table 3). This was followed by an exploration of the following conceptual codes:

#### **4.6.2.1. Conceptual subcategory B-1: Day-to-day practices**

This conceptual category is realized because psychosocial health management is a continual practice embedded in the day-to-day life of communal individuals.

##### **4.6.2.1.1. Conceptual Code B-1.1: Humility**

This conceptual code came to be after the establishment that, before everything else, communal persons are humans conducting themselves with humility. It is understood that this is a generic phenomenon instilled by every communal person from birth. Moreover, humility supersedes gender identity. This means that communal persons must practice mutual respect and care, regardless of age, gender, and social status. Importantly, this mutual respect extends to those who were here before us and nature. Thus, it can be deduced that this is done to strive for harmony and balance between living, those who were here before, and nature.

##### **4.6.2.1.2. Conceptual code B-1.2: Shared responsibility**

It is also emerging that communal persons within the community see themselves first as equal, but also analogous to nature, including plants, animals, and the cosmos at large. Furthermore, this equality is similarly applied to the shared responsibility of continually working towards achieving a balance of life.

##### **4.6.2.1.3. Conceptual code B-1.3: Eating practices.**

It is equally emerging that this Khoisan community has a lifestyle that involves slaughtering animals for eating and rituals. Interestingly, the data points out that, first, the equality of the animals slaughtered, and the communal persons are always understood. In that regard, I am because the animal is. This is supported by the emergence of the belief that specific parts of slaughtered animals serve a significant purpose. For example, participants maintained that there were parts of the animal meant to be eaten by elders and some only by children.

Spoken word.

*“... Yes. The head of the animal is normally given to the elders and senior people in the family.” (Participant L)*

*“This is because the need the wisdom from the animal.” (Participant L)*

*“... with the cooked meat, the lower extremities are for children.” (Participant E)*

Based on the collected data, this practice was related to an understanding of self-preservation. This means that the communal person preserves the remains of the animal by eating it to continue the life of the animal. Thus, the life of an animal is integral to the life of a communal individual, even in an event where it has been slaughtered. Given these points, it is deduced that the practice fits into the belief of holism and the circular nature of life.

#### **4.6.2.1.4. Conceptual code B-1.4: Graveyard visit**

This conceptual code found life in the emergence of data, as participants emphasized the importance of visiting a loved one's grave. In essence, this is a day-to-day practice in the lifestyle of a communal person. Although this practice may still be common to many communal persons, some indicated that they no longer visited the graves of those who passed on.

Spoken word.

*“...Yes, I believe in the visiting the graveyard.” (Participant M)*

*“...For me, never go to the graveyard.” (Participant A)*

Even with the contrasting construct on the grave visits, some participants shared that they believe that this practice is integral to their life and meaningful towards solving their psychosocial health challenges.

Spoken word.

*“I go to visit my father's grave when I have problems, I talk to him, and my problems go away.” (Participant J)*

#### 4.6.2.1.5. Conceptual code B1.5: !nxhabasas

This is a rite of passage ritual for young women in the Khoisan community transitioning to womanhood. This ritual is one of the historical heritages preserved for the longest time within the community. It emerged that the ritual is used to achieve a balance of life for young women when they face psychosocial health challenges. The fact that it is a psychosocial challenge involving communal persons who are female due to biological makeup. It is appreciated by the community that women, especially the elderly, take the lead in the management of this challenge. Equally, there is a sharing of roles throughout the ritual process, where men in the community also play their part.

##### Spoken word.

*“...Yes, !nxhabasas involves the teachings of life for young girls celebrated by the men and women of the community.” (Participant O)*

#### 4.6.2.1.6. Conceptual code B-1.6: ‘Mpho ya badimo’

Directly translated into English the practice refers to a gift to those who were here before us. This emerged when the participants shared stories about their strong connections with those who were here before us and nature. Gifting those who were here before us can involve the slaughtering of an animal for ritual purposes, where parts of the meat are offered according to the stages of life. As already established, this signifies equality of life between the communal persons (those who were here before and those who are still physically on earth) and nature. Seamlessly, this relates to the emergence of continuity and the circlic nature of life. Ultimately, this practice is intended to achieve a balance of life in the management of psychosocial health challenges.

Significantly, there is a shared belief that attaining a balance of life through lifestyle is central to Khoisan communality. As discussed below, there is contrasting evidence of the consequences of westernization and colonization within this Khoisan indigenous community. This was unavoidably noted in the data and was labelled **post-colonial hegemony** as a conceptual category constructed through one abstract subcategory (Westernization and colonization) and a sundry of ideational codes (see Table 3).

### 4.6.3. Conceptual category C: Post-colonial hegemony

This construct came after differing views were shared by participants concerning the way of life of a communal person. However, there was a consensus in most aspects of the data concerning the shared belief system. It was equally noted that some participants are practising Western-inclined lifestyles in certain aspects of life. Consequently, it is emerging that colonialism has influenced the outlook of the Khoisan community. This conceptual category was convoluted into the following conceptual codes (see Table 3).

#### 4.6.3.1. Conceptual subcategory C-1: Westernization and Colonialization

##### 4.6.3.1.1. Conceptual code C1.1: Religionization.

It is emerging that the introduction of Christian faith within the Khoisan community has eventually influenced their ways of living. For instance, the spiritual practice of *trance dance* is important. It was noted that the participants were not hesitant to share that the *trance dance* had not been practiced by the community in recent times but was mimicked in churches. Instead, this pivotal spiritual practice has now been found across different sects of various churches within the community. Second, the practice of visiting a loved one's grave has been contradicted by some participants, who say that they do not engage in that practice.

##### Spoken word.

*"I do not visit the graveyard; I believe in Jesus." (Participant O)*

*"I believe in prayer; I pray to god." (Participant M)*

*"...Yes, trance-dance is now being practiced in the churches."*

##### 4.6.3.1.2. Conceptual code C-1.2: Slavery and migration

In addition to the historically undisputed truths, the emergence of slavery and migration has impacted the Khoisan community. Most importantly, this act resulted in an already constructed understanding that the Khoisan community is female-dominant. From the evidence of the data, the participants elaborated that:

### Spoken word.

*“Our culture is mostly female dominant because the female plays a crucial role than males do, I think part of the reason could be due to slavery. So.... Way back when... because some cultures were almost decimated most of the males were killed and the female would remain with the young males.” (Participant J)*

*“... So, females had to think of ways to preserve life... and in recent history males would have to go away from home to look for employment to sustain the family.”  
(Participant J)*

*"This pushed the woman to the forefront, However, in churches men are given the elevation than females because their being given the opportunity to being a preacher than women.” (Participant M)*

This emergence is related to the construct of the wheel of life. Hence, women have and still have the duty of holism and continuity of life, even in the absence of men within the community. Furthermore, a relationship can be established with the construct of shared responsibility and gender neutrality. In this regard, the preservation of the community and attainment of a balance of life are important to communal persons.

Amid this complex was the fundamentality of the livelihood of the Khoisan community. There are widely accepted communal therapeutic techniques for the management of psychosocial health (see Table 3).

#### **4.6.4. Conceptual category D: Communal therapeutic techniques**

With a special focus, this conceptual category came into being after the realization that there is importance placed on the primordial ways of being as a communal individual. However, there are precocious ways of being expected, especially from those involved in the management of psychosocial health challenges. This emergence was conceptually categorized as communal therapeutic techniques constructed by one conceptual subcategory and a myriad of conceptual codes (see Table 3).

#### **4.6.4.1. Conceptual subcategory D-1: Basic therapeutic techniques/communications skills**

##### **4.6.4.1.1. Conceptual code D-1.1: Humility (Gentleness)**

This concept is also sound for therapeutic skills because it is equally at the centre of the management of psychosocial health challenges. Humility precedes the order of day among communal persons within the Khoisan community. Thus, humility is the discernment of a communal person in whom you are all equal in the community.

##### **4.6.4.1.2. Conceptual code D-1.2: Gender-aligned roles (conversations for men and conversations for women)**

In that everyone is equal and genderless, there is acknowledgement that for psychosocial health management, there are incidents that need women in the community to take the lead and vice-versa. For instance, during '*Mpho ya badimo*' it is expected that the leader of the family (either a man or a woman) takes the lead in the deliberations of the practice. But also, even when the family is matrilineal, it came out that during the '*lobola*' negotiations it is widely expected that men particularly, uncles in the family take the lead. Most importantly, it is practiced with the common goal of achieving continuity and balance of life.

#### Spoken word.

*"...As much as I am the leader as woman in my family, I always call the uncles' during lobola negotiations."*

##### **4.6.4.1.3. Conceptual code D-1.3: Language and Gender Connotations**

Equally, this is an inherent therapeutic skill in that, across members of the community, there are words connoted as male and some as female. This is applied continually in the day-to-day life of a communal person to address psychosocial health challenges (but not limited to). For example, communal persons involved in the management of a particular psychosocial challenge. They are inclined to show skills in the form of femininity, gentleness, kindness, caring, loving, patience, respect, and sharing (but not limited to). Thus, with these basic therapeutic skills, the communal person will demonstrate female

connoted spoken words. Simultaneously, the boundary setting should be integrated in the process. This means that words that are big, strong, and masculine demonstrate the male connotation of the spoken word. Eventually, this is to achieve a balance between being firm and gentle for the counselee in the management of psychosocial health challenges.

At this point, the importance of advanced therapeutic skills has emerged. That is, beyond humility, communal people are expected to display a higher level of communication skills. This construct is labelled advanced therapeutic/communication skills related to a variety of conceptual codes, as discussed below (see Table 3).

#### **4.6.4.2. Conceptual category D-2: Advanced therapeutic techniques/communication skills**

##### **4.6.4.2.1. Conceptual code D-2.1. Metaphors (covert speech)**

Mostly, this skill is seamlessly demonstrated by the elders of the community but also by communal persons with experiences of life. This skill is important, as it offers an element of teaching and learning for the care user. It is emerging that the spoken word instilled with the teachings of life in the form of a metaphor is enunciated by a sense of softness and firmness.

##### **4.6.4.2.2. Conceptual code D-2.2: Silence**

Silence becomes an important part of spoken words or advanced communication skills. This is because there is always meaning in silence, as per communal persons. Spoken words and silence form an important aspect in the management of psychosocial health challenges.

#### Spoken word.

*"...Yes indeed, silence carries a lot of meaning." (Participant X)*

##### **4.6.4.2.3. Conceptual code D-2.3: Storytelling**

Stories intertwining the history, traditions, and culture of the Khoisan people have sounded as an empirical element of healing in the management of psychosocial health. For the most part, the stories involve resilience and the ever-present test of time that

Khoisan culture has endured. Hence, self-resilience disclosure becomes integral to storytelling. The care giver demonstrates openness and empathy towards the communal counselee. This was then used as a mirror to the counselee for self-correction and attainment of a balance of life. Thus, these stories were told and transferred from generation to generation for the betterment of the Khoisan people and culture.

#### **4.6.4.2.4. Conceptual code D-2.4: Patience and respectful waiting**

As far as the data point out, the concept of patience and respectful waiting for the attainment of balance in the life of a communal counselee becomes unavoidable. This is realized by the emphasis on the fact that healing starts with the 'human' part of the communal counselee. Hence, the individual is allowed a space for healing. This was achieved through boundary setting.

##### Spoken word.

*"People always need to be given their time for healing." (Participant L)*

#### **4.6.4.2.5. Conceptual code D-2.5: Forthright-honest and Interventional Confrontation**

Even though patience and respectful waiting are prioritized in the balance of life, honesty and focused interventions are equally needed. On account of the data, this can be related to the understanding that everyone is equal in the circle of life. Hence, no one's psychosocial health challenges are more important than those of others. This is why a reprimand that is either gentle or firm is used when needed, and it is to balance life.

##### Spoken word.

*"There is no one who is more important than the other." (Participant E)*

*"No problem is bigger than a community." (Participant J)*

#### 4.6.5. Inductive Synthesis

In conclusion, the intermediate phase of substantive coding was realized by collapsing, fitting, and refitting emerging categories into concepts. As has been demonstrated, the result of this phase of coding uncovered shared beliefs, communal lifestyle, post-colonial hegemony, and communal therapeutic/communication skills as conceptual categories. Overall, in their order of tabling, these conceptual categories are constructs of five conceptual sub-categories: source of life, day-to-day practices, Westernization and colonization, basic therapeutic/communication skills, and advanced therapeutic/communication skills. Altogether, these categories and subcategories are related to a myriad of conceptual codes (see Table 3).

This was done by summarily diving deep into the meaning of the first conceptual category (shared belief) with its conceptual subcategory (source of life and living). It emerged that having the understanding and appreciation of life being circlic and ever-lasting further requires indebtedness of living. This means that it takes the wheel of life to be propelled. Hence, holism and continuity are inductively emanated as conceptual codes. From here, it becomes clear that a communal individual who is born into this circlic life is from a young age engaged with the belief and culture of life for living. Central to this is the significance of the appreciation of the mutual belief system. Humility is fundamental to your being as a communal person, and gender takes a latent meaning. Thus, the eventuality that one is rather meaningfully holistic (mental, physical, emotional, spiritual, and social) and interconnected to the cosmos than to your gender. This is referred to as gender posteriority. Relatedly, the data then inform us that this grounding gives meaning to the understanding of gender roles and positionality. Furthermore, the ambilineal nature of family identity is unavoidably connected to the understanding of gender neutrality. Overall, continuity and holism are foundational to the wheel of life to be orbited. Even more to this is the drawing of strength for preservation, positionality, grief, and the harmonious balance of life from nature wherein, a plant "kan-nie-dood" is central to the elemental equation and belief that life is circlic.

Equally important is the fact that psychosocial health becomes a rudimentary phenomenon in the belief of holism and continuity. Hence, the mutual approach of striving

for a harmonious balance in life is central to the management of psychosocial health. Congruently, psychosocial health has continual and holistic meaning. The unpacking of the communal lifestyle as a conceptual category heightened the importance of humility within the Khoisan community. Therefore, achieving a balance of life is a shared responsibility among communal individuals.

Even with this alluring rendition of shared beliefs manifested in the lifestyle of the Khoisan community, there is evidence of an unavoidable contrast emerging from external cultural impositions and the consequences of colonial hegemony. This is embodied in the introduction of religionization, where spiritual practices imitate the West in such spaces. Adding to the latter, the consequence of slavery and labour migration becomes an issue of substance, considering the complexity of cultural beliefs coupled with colonial hegemony within this community.

It further emerged that a communal individual, who is involved in the management of psychosocial health, requires the inherent humility found in every communal person to complement the necessary advanced therapeutic skills.

#### **4.7. SECTION B: Discussion of findings from the *Makgotla* of the community in Malawi (Participant-group Two).**

##### **4.7.1. Substantive (open) coding** (see Table 1, Chapter Three)

###### **A. Initial phase**

For consistency in collection, analyses and coding the data, the same data collection schedule used in Participant-group One (see Section A) was used for Participant-group Two. The data presented herein were collected from two separate sessions of *makgotla*. Hence, the unfolding of *makgotla* was centred on the following questions: ***What is good health? Healing? Psychosocial health? Person? Management of psychosocial health?*** and ***lastly, the role of persons. What is life? Is life linear or a circular process?*** This was preceded by central questions ***What is the source of life? Lastly, the end goal?***

- What is good health? (**what**).

At the onset of the findings, the participants enumerated the concept of good health in their direct response as a compartmental entity accounting for physical health (see quotes below).

Spoken word.

*“Free from illness, injury or disease.” (Participant 1)*

*“State of being free from illness, injury or disease.” (Participant 5)*

MEMOING #G2/01

These responses are related firstly to;

Manifestation of a strong sense of sacredness within indigenous African contexts. Indigenous communities guard against intellectual property. This has become a defence mechanism employed by African indigenous communities against exploitation and prostitution of knowledge by western paradigms.

However, this can also be a demonstration of the consequences of the mass destruction of culture and self-identity as a community in the hands of colonialism. Thus, the interpretation of reality is diluted by Western ways of knowing. This reflection became apparent when the community leader who conducted Lekgotla began to probe more in the question.

In probing further, the deliberation started to enumerate provocative contributions to the understanding of good health in the context of Participant-group Two. Thus, the participants shared good health means the following:

Spoken word.

*“State of one is psychologically okay, physically okay, mentally okay, in terms of doing your function within the community.” (Participant 5)*

*“The state of complete physical, mental, and social wellbeing. It is usually determined by the standard of a particular community.” (Participant 7)*

*“When one is Well.... physically, mentally, and also socially.” (Participant 6)*

*“Associating with people rightly.” (Participant 5)*

*“...spiritually and emotionally aligned, or well.” (Participant 1)*

*“It means Physically, mentally, socially well.” (Participant 7)*

#### MEMOING #G2/02

Implicitly, it is emerging that, in this African indigenous context, health is intertwined and is a multidimensional phenomenon. This involves;

Mental, emotional, physical, spiritual, social, and economic

This means that all these facets cannot be separated from your ‘health.’

Furthermore, in untangling the meaning of good health, the participants deliberated on the understanding and importance of mental health in their reality. The unearthing of this understanding brings about a fundamental element in the appreciation and interpretation of good health in this context. Hence, the emergence of the finding that, to one, making the meaning of reality certifies a sound mental state.

#### Spoken word.

*“Health is determined by mental health.” (Participant 7)*

*“Mentally sound – able to make decisions. Being able to make decisions concerning their health.” (Participant 7)*

#### MEMOING #G2/03

Thus far, the data points that mental health becomes an important aspect of health. Therefore, you cannot understand the meaning of your reality if you are not mentally sound.

Furthermore, concerning mental health, participants deliberated on the extent to which mental health is essential to the production and interpretation of reality. The responses are as follows.

Spoken word.

*“.....You’re able to reason properly.” (Participant 3)*

*“Having the capacity to interact with people.” (Participant 3)*

*“.....when one is mentally sound....., able to make decisions. Being able to make decisions concerning their health.” (Participant 6)*

*“If you are mentally sound you are able to make informed decision.” (Participant 1)*

MEMOMING #G2/04

- In this indigenous community, mental health is emerging as an important element of reality.

Thus, reality is conceptualized through time by the people of the community being mindful of contextual paradigms. As a result, knowledge is produced and interpreted through way of life. Mental health is essential to this process.

-Given this understanding, people of this indigenous community rely on mental health for their production and interpretation of reality and praxis thereof.

Ultimately, the people of this indigenous community appreciate mental health as being at the centre of the meaning of health.

*“There is no health without mental health” - WHO.*

Moreover, in exploring what 'physical' means within the concept of good health, participants responded with a unique contribution, adding that the availability of resources or lack thereof contributes to the meaning of good health.

Spoken word.

*“One is physically present, able to interact with others, have a home (shelter/accommodation) and food, being that you are not sick.” (Participant 3)*

*“Socially, meaning that you interact with people around within the community.” (Participant 6)*

## MEMOING #G2/05

This brought about an interesting contrast in the understanding of health in the substantive area of theory. Herein, the phenomenon of good health is extant to the socioeconomic standing of an individual within the community.

Importantly, the interpretation of society and how it relates to everyone within the community was deliberated by the participants to mean:

### Spoken word.

*“Associating with people rightly.” (Participant 4)*

*“Being able to interact with other.” (Participant 7)*

*“.....contributing to the life of the community.” (Participant 2)*

## MEMOING #G2/06

It became clear that a person within the community cannot exist as a single entity to have good health. Interactions and relationships among community members are essential. This related to the way in which life is embedded in the principles of *ubuntu* principles – I am because you are.

It became clear that a person within the community cannot exist as a single entity to have good health. Interactions and relationships among community members are essential. This can be related to the way of life embedded in the principles of *Ubuntu* – I am because you are.

In essence, it can be deduced that sacredness forms an integral part of the life of Participant-group Two. This was noted by the participants’ elemental responses at the beginning of the session. However, there is insufficient evidence to reach this conclusion. Elemental engagement can also be related to the consequences of deculturizing the people of Malawi through the intentional project of colonization.

Be that as it may, it is emerging from the data that health is a holistic phenomenon involving one's mental, social, emotional, and economic aspects of life. Therefore, the good in it caters to the completeness or equilibrium of all its elements based on holism. However, mental completeness is integral to the meaning of good health.

- What is illness? (**What**)

In the same way, it is materializing that illness is understood and appreciated as the opposite of what is good health by Participant-group Two. At the same time, some participants sounded compartmental in their definitions of illness as a phenomenon. Thus, participants shared the following:

Spoken word.

*“When one is not physically, mentally, socially well.... an opposite of good.” (Participant 3)*

*“State of not feeling well. The person is not able to do some things, behaving in a certain that is not normal.” (Participant 7)*

*“Problems with your mental and physical, psychological well-being. You’re unable to function properly in your society.” (Participant 5)*

*“Illness has to do with the incompleteness of what is good health.” (Participant 3)*

*“The state of being sick, having a condition.” (Participant 7)*

*“.... fighting with everyone their meeting. Deviating from normality.” (Participant 4)*

MEMOING #G2/09

It became clear that illness is understood and appreciated as the complete opposite of good health. Hence, good health and illness are seen as interconnected, whereas, as conceptual entities, one cannot exist without the appreciation of the other. Although this may be the case, at the praxis level appears to be what the community strives to achieve.

At the same time, some responses deemed by the researcher to be influenced by colonial hegemony were noted. To the end, the response is compartmental in nature but also goes against the holistic understanding established earlier.

Important to note.

- The definition compares with the substantive area of research.
- The contrast is seen in the compartmental soundness of the definition by participants.

Furthermore, amid the findings that illness is interconnected to good health, there also aroused the need to explore the understanding of 'who' defines normality. As it emerged that illness has to do with "deviation from normality," one of the participants shared.

#### Spoken word.

*"..... normality which is determined by the community."* (Participant 3)

*"Society puts the standard."* (Participant 7).

*"...yes, I fully agree."* (Participant 0)

#### MEMOING #G2/10

Thus far, it has emerged that it is rudimentary to appreciate that the community itself determines the means of knowledge production, and the reality or interpretation thereof. It is clear that time, context, place, and people matter the most in the exploration of reality. All four elements warrant appreciation in knowledge and practice interpretation.

Important to note.

Time, context, and people

As in the aforementioned cases, it is emerging that good health and illness are intertwined. This means that for one to understand the other, one must appreciate the other. This finding relates to the substantive area of research in that illness is applied as the opposite of good health. To this extent, the notion of who determines normality on the account of evidence standards are set and accepted by the community itself.

- What is healing?

Understanding healing is fundamental to the appreciation of emerging findings. Hence, the emergence of evidence indicates that healing is an actionable process that distinguishes illnesses from good health. The responses from the participants were as follows:

Spoken word.

*“An act of becoming normal from deviations. The state of coming back to normal.”*

*(Participant 2)*

*“Process of getting better.” (Participant 0)*

*“Coming together with your community. Interacting with your community.” (Participant 4)*

*“An act of getting better from the illness.” (Participant 5)*

In probing further, it came out that a typical process of healing in the context of a grieving person is to restore deviations from normality, which involves the following:

Spoken word.

*“To support someone who is grieving, .....people will be present with you. Comforting you. Is a process of comforting for emotional healing.” (Participant 0)*

MEMOING #G2/11

The appreciation of healing in this indigenous community needs sensitivity towards the understanding of health and illness. Healing emerges as the process of reversing the incompleteness resulting from an illness into a hole or an equilibrium state.

Important to note;

- Healing is emerging as an interconnected holistic nature – physical, emotional, mental, social, socio-economic, and spiritual.
- Healing involves a process that corrects all the above-mentioned elements.

It is unfolding that healing is an insulator between “good health” and “illness”. Therefore, it becomes a shared actionable process in managing the imbalances of one’s wholeness into completeness.

- What is psychosocial health? (**What**)

The participants discern themselves in this regard to the effect that psychosocial health is appreciated within Participant-group Two as interconnected to the meaning of ‘good health,’ illness,’ and ‘healing.’

Spoken word.

*“well-being in terms of emotions, realizing your ability to cope with normal stresses of life.” (Participant 2)*

*“... when you are able to make healthy choices, mmhhh... interact with people.”  
(Participant 7)*

*“Is being healthy socially and psychologically..., socially in terms that one is able to interact with others, and psychologically .... where is free of stress.” (Participant 5)*

*“Being emotionally and socially well, even spiritually.” (Participant 2)*

MEMOING #G2/12

Fundamentally, psychosocial health appraises internal persona and how it relates to the surroundings. Ultimately, this means that all the rudiments of the understanding of good **health, illness, and healing** as a concept in this community have become inevitable.

That is, one has to maintain a balance between emotions, physical, spiritual, mental, socioeconomic, and social to attain psychosocial health.

With the emerging finding that psychosocial health is interconnected with the meaning of good health, illness, and healing, the participants continued by sharing that mental health is also significant in this regard. Notably, this meaningful attachment of mental health to the meaning of a conceptual entity is not unique as it was also found to be important in the meaning of good health. In addition, the inclusion of the availability of resources for sustainable livelihood in the meaning of psychosocial health is also consistent with what

is found in the concept of good health. However, this remains a unique finding compared with the substantive area of theory. However, one's meaningful contribution towards the community is equally emerging as integral to the meaning of psychosocial health.

Spoken word.

*“Your mental health affects your social health.” (Participant 0)*

*“.....socially, the things that affects you are whether you have food, any means of living (financial income).” (Participant 5)*

*“...yes..., being able to participate meaningfully within the community – interacting with others result in a healthy psychosocial being.” (Participant 1)*

*“Yes, I agree.... When your mental and social capacity is welcoming, it means that your behaviour and reasoning is good, .... Then you are able to interact with others.” (Participant 3)*

MEMOING #G2/13

- Mental health is integral to psychosocial health.

Availability of resources (food and other means of living) is equally important to the meaning of psychosocial health.

- A person's meaningful contribution towards the community is important to the psychosocial outlook.

All considered, this understanding can be related to the appreciation of holism.

On the other hand, it is on account of data that the findings emerged on the phenomenon of behaviour and association. This advancement in the meaning of psychosocial health within this community arose based on discussions on meaningful contributions to the community. Thus, participants shared the following:

Spoken word.

*“Behaviour and association are important.” (Participant 7)*

*“When you Behave according to your age.” (Participant 5)*

*“When you’re older you are expected to act than someone who is younger. If their acting contrary to the expectation that the community holds than that person raises concern about his/her psychosocial health.” (Participant 7)*

Be that as it may, the findings emerging led the research to explore the question of - *Can one achieve a complete balance of psychosocial health?* The responses were:

Spoken word.

*“No..., one cannot be completely psychosocially healthy.” (Participant 2)*

*“...yes, I agree (with participant 2), continual maintenance of the state of mental and socio well-being is important.” (Participant 7)*

The findings of this study suggest that psychosocial health cannot be completely attained. Furthermore, it was found that your contribution and/or lack thereof within the community can be used as a measure to determine your state of psychosocial health.

Spoken word.

*“...in some instances, we use the parameters of association, in my village we don’t expect someone to be withdrawn where they don’t interact with others. The understanding will be that the person is not psychosocially healthy.” (Participant 3)*

MEMOING #G2/14

Interestingly, it is emerging that “health” or attainment of completeness is a life-long process that requires a constant upkeep.

Physical, emotional, spiritual, economical, and most important mental well-being.

Thus, one is invited to reconcile with the reality that, in this community, work towards a good state of mental and social well-being. There needs to be continued care for one’s

internal environment (emotions, spirit, physics, mental, and socio) and surroundings (how you relate to others).

What emerged, therefore, was that psychosocial health is a lifelong process involving meaningful participation and contribution to the meaning of life within the community. Hence, the findings of this research point out that psychosocial health is not an isolated entity; instead, it is interconnected with the meanings of health, illness, and healing. Interwoven refers to the pertinence of spiritual, mental, economic, emotional, and social well-being. This means that one can make healthy choices and interact with others. However, for mental well-being, it is of central importance to the meaning of psychosocial health. This means that one can conduct himself/herself appropriately with the expectation of his/her age. At the same time, the availability of resources, such as food and any other means of living, contributes to the continuousness of psychosocial health.

Given this emergence, the need to understand the 'who' is involved in the management of psychosocial challenges within the community becomes inevitable. Thus, the following is proposed:

- What is the meaning of a person? (*What* and *Who*).

Primarily, it is emerging that a person's meaning is sounded by the fundamentality of belonging. Accordingly, within this community, a person must belong to a precinct and/or kinship wherein there is a shared belief system. Granted that the person belongs, the person must be conscious of oneself and show the ability to reason in the process of demonstrating meaningful participation in the life of the community.

Spoken word.

*“a person is a conscious individual, able to reason, they belong to a community.”*

*(Participant 2)*

*“...yes..., a person is someone who is able to engage themselves in activities within the community.” (Participant 4)*

*“....as someone who belongs, they live together wherein you can share common ideas, and beliefs.” (Participant 7)*

*“a person is someone who belong to a Kingman ship.” (Participant 4)*

*“a person is a human being who belongs to a community and is able to make decisions by participation and contribution.” (Participant 2)*

#### MEMOING #G2/15

It became clear that a person within this indigenous community was someone who belonged. In this way, he/she identifies with people. Furthermore, contributes to the production and interpretation of the reality.

Given the understanding of the 'person' within this indigenous community, there is a need to explore the role of persons in the management of psychosocial health. The question asked by the participant was as follows:

How do you manage psychosocial health challenges at the community level? (Who is involved, of 'who is saying/doing what to whom, when and why and how they are saying/doing it').

- Who is involved? (*Who*).

First, it is emerging that people within the community involved in the management of psychosocial health challenge are those with experience in life. These include chiefs, elders, religious leaders, family members, friends, and traditional leaders. Moreover, the findings emerging from the data indicate that the management approach within the community is organized in levels. It starts at the family level, the community, and lastly, traditional leaders and faith-based healers.

#### Spoken word.

*“Those with experiences in life.” (Participant 2)*

*“.....religious leaders and elders within the community are involved in the management of psychosocial health challenges.” (Participant 7)*

*“..... family, friends and traditional healers.” (Participant 5)*

*“Yes, it’s the people within our community, such – Chief, local courts.” (Participant 3)*

*“...the management structure has levels, in that, it starts first at the family level (elders), followed by community level and then lastly traditional healers, faith-based healers.”  
(Participant 5)*

## MEMOING #2/16

It comes out that those who are involved are those who “belong” to the community and share the same belief. In particular, those with experiences in life.

At the same time, it emerges that there are levels of care where it starts first with the family. Thus, if the psychosocial challenge is not resolved at that level, it is referred to as the community. Finally, if the challenge persists, traditional healers and religious-based healers are entrusted with management.

### ▪ *When?*

Not only did the research establish previously that psychosocial health is a life-long process, but also that the participants went further to innumerate common psychosocial challenges within the community. Hence, the intention of the 'when' part of the question unfolded with participants mentioning some of the psychosocial challenges the community experienced.

### Spoken word.

*“... poverty, marital issues.” (Participant 5)*

*“Inability to socialize.” (Participant 1)*

*“.. bereavement.” (Participant 5)*

*“Depression and anxiety.” (Participant 2)*

*“Sexual abuse.” (Participant 2)*

*“...drug and substance abuse.” (Participant 3)*

- **Why** and **how**?

The 'why' and 'how' of the management of psychosocial health challenges involved the active roles of the persons involved. Fundamentally, psychosocial management is emerging as a shared process involving a sense of comfort, positive feelings, praying, and support.

Spoken word.

*"... because during bereavement a person would be sad, the family and the broader community will support the person."* (Participant 1)

*"Yes...this is done by people praying."* (Participant 7)

*"Some by talking and counselling the affected person."* (Participant 5)

*"Some people of the community will share positive feeling with the affected person."*  
(Participant 2)

*"Providing a sense of comfort."* (Participant 5)

Furthermore, it was explored by the community that if a person within the indigenous community presents with aggression, irritable behaviour, or even anxiety-related manifestation that person will be managed by a medicinal plant called 'kuleza.'

Spoken word.

*"... at a community level or by a traditional healer a person will be given a medicinal plant called "Kuleza" to calm them down."*

*"...yes..., we use medicinal plants to manage our challenges in the community."*

MEMOING #G2/17

There are myriad psychosocial health challenges faced by the community. However, it can be deduced that there are different ways to manage psychosocial health, depending on the nature of the problem.

There are myriad psychosocial health challenges faced by the community. However, it can be deduced that there are different ways to manage psychosocial health, depending on how the problem manifests itself.

Thus far, the meaning of the previously explored conceptual entities (*what, why, whom, how*) within an indigenous community has been explored for the management of psychosocial health challenges. Furthermore, the emerging data were explored closely to understand that time, context, place, and people matter. Hence, the following explorations from the participants were centered on the question: What is life?

- What is life from beginning to end? (**What**)

This question brought about interesting insights into the meaning of life within a community. Thus, not only is it emerging that the reproduction of life is essential to the meaning of life, but also the ability of people within the community to produce and contribute is as important. Further, interaction and association among people within the community are essential to the understanding of life. This accounts for the functioning of each person towards the betterment of the community. Hence, people in this indigenous context anticipate meaningful contributions towards the community as a way of life.

#### Spoken word.

*“.... life is when one is able to produce, interact and associate with others within the community.” (Participant 6)*

*“Life is when you are able to reproduce.” (Participant 1)*

*“Yes..., being able to function within the community, and being able to reproduce.”*

*“Yes..., indeed.” (Participant 7)*

## MEMOING #G2/18

Interestingly, it is emerging that life occurs when a person within a community interacts with others. One is involved in, and contributes to, decision-making within the community. However, life is when one is productive, in that one contributes meaningfully towards the community. Additionally, life is when one can associate with others. This is appreciated in line with the understanding of “a person,” and therefore, the one who belongs.

Furthermore, it is unfolding that the reproduction of life is an important facet in the deliberations of what life is.

This means that life is when the one who belongs contributes meaningfully to the decision-making process and reproduction of life within the community.

- When does life begin and does life end? (*Where and When*)

It is worth noting that when looking at the emerging findings regarding the beginning and ending aspects of life, a sense of sacredness and/or the influence of colonialism was noted by the participant. It is evident that responses began with a compartmentalized approach. For instance, it is emerging that life is an aspect of physicality that accounts for one's experiences. This indicates that life begins when one is born and ends with death.

### Spoken word.

*“Life begins at birth and ends with death.” (Participant 4)*

*“Yes... life ends, when you die.” (Participant 3)*

*“Yes, I concur, when life ends one is no longer able to associate.” (Participant 2)*

*“Life..., I could say it’s the experience of a person from where one is born. Experiences, whether there is love or hatred where one could be affected any other way. Whether*

*bad or good... and one is able to overcome the challenges that come by in life.”*  
(Participant 1)

#### MEMOING #G2/19

It is emerging that life is only what we experience at a physical level on the earth's face. In other words, life begins after a child is born and ends when one dies.

Participants started with deliberations with a sense of sacredness, which could be a sign of the protection of their knowledge. However, this can also be a sign of colonial influence.

On the contrary, in probing further, the participants started to bring deeper meanings by immersing themselves in their indigenous context. In contrast to the responses above, more participants enumerated the following:

#### Spoken word.

*“Life doesn't end when we die, because those who are left behind tend to resemble the behaviour and traits of those who passed on. It is when our elders would say – you are exactly like your uncle/aunt/mother etc.”* (Participant 7)

*“...yes, that is understood to be continuity of life.”* (Participant 3)

This emergence indicates that life is continual even in the event of death, and one's life always persists. This is presented by the understanding that family members inherently carry on with the behaviour of those who were here before. This emergence is consistent with the findings in the substantive area of theory.

Congruently, this emergence has led to the excavation of more insights into the question of when life begins and whether it ends. The participants deliberated more by saying,

#### Spoken word.

*“When one die in the community, you are buried with your ancestors. The reason is you are continuing to commune even in your death.”* (Participant 2)

*“... there is a communal understanding that we have to be buried together.” (Participant 1)*

*“Yes..., we commune, even in our death.” (Participant 7)*

*“Yes, we have that culture of burying our people at the same place.” (Participant 5)*

Under the appreciation that life is a continual phenomenon, the theory is advancing in that there is a communal element in life within this community, even throughout the circle of life. Hence, the culture of those who were here before being buried together in the same space continues with their communal way of life. Therefore, where one is born, where one is to be buried. Be that as it may, one participant acknowledged,

#### Spoken word.

*“In some instances, it is a challenge to bury people at the same place, as people are scattered for various reasons.” (Participant 3)*

#### MEMOING #G2/19

Notably, the participants started deliberations with a modernized perspective of life. In this case, life can only make meaning if proven by physical evidence. Although the latter may be true, on the other hand, most of the participants later gave countering insights from the perspective of communality – what life means.

It is emerging that, within the indigenous community wherein communality is a way of life, people continue to build a community by burying those who have passed on at the same place. Therefore, it is emerging that life has not ended.

Given the advancement that communality is upheld throughout the circle of life, emerging findings further attach meaning to the continuity of life by transferring the names of those who were here before to those physically living on earth. This is based on the understanding that the spirit of those who were here before is transferred to living. Moreover, it is emerging that this understanding can be manifested by living showing the exact behavioural character of those who were here before. This also demonstrates the preservation and continuation of the legacy found in the substantive areas of theory.

Simultaneously, one's name can be changed for the legacy of those who are here to continue. The transfer of a name from those who passed on to the living is a practice performed at the moment of the burial or even years after the burial. Moreover, it is not consistent whether a specific cultural ceremony is performed for the transfer of a name. However, the name given to a person always has significant meaning. This emergence was realized when the participants started to explore the following:

Spoken word.

*“.... when I was at a funeral, during the funeral there was a transfer of a name they give it to a young girl. The sermon is that we are transferring the spirit from the dead to the living one.” (Participant 3)*

*“.... So that the life that was lived can continue.” (Participant 3)*

*“Yes.... This happens during the funeral, before the burial.” (Participant 7)*

*“Yes.... It happens where a child is named after a dead family member to assume his/her life in continuity.” (Participant 5)*

*“When they name someone else after the dead, the behaviour becomes exactly as that of the one who’s dead.” (Participant 3)*

*“Sometimes they name the child after the dead just to maintain the legacy of the person. For example, my name was changed to grandmother’s when I was eight years old to continue her legacy after certain similar attributes were noted.” (Participant 7)*

*“In my culture there is no ceremony performed when a child is named”. It’s just the family will decide to name the child from either the mother’s or father’s side.”  
(Participant 5)*

*“In my community there is always a particular cultural ceremony that goes along with naming of the child. Furthermore, there’s always meaning attached to a given to a child.” (Participant 6)*

*“... mhhhh...alright for instance, the name Masambelo, which means education directly translated to English. I am told that the meaning is that the meaning is attached to a moment that symbolize a graduation from school.” (Participant 6)*

- Is life a linear or cyclic process? (*What and How*)

The findings thus far lead research to the expression that life is circlic and not a linear process. Therefore, with this indigenous community, life is an interconnected phenomenon that becomes cyclic through the reproduction of life.

Spoken word.

*“It is a circle. Because it does not end, as we have already explored - life does not end, because it goes around – with yourself, family, and community. Whereas it is connected to the next one”. (Participant 1)*

*“Life is circlic in such a way that we venture into marriages and produce, and then those offspring will later in their life’s reproduce – it keeps on going and going” – “it doesn’t end, it keeps on going”. (Participant 4)*

*“Once someone has died physically, the spirit still goes on to live”. (Participant 8)*

*“Even when that person does not have offspring, the spirit lives on maybe until Jesus comes or something like that”. (Participant 1)*

*“I believe it keeps on reliving”. (Participant 8)*

Consequently, another follow-up question pertinent to the premise of ‘believe’ as mentioned by *participant 8* above arose – ‘By believe you mean from a Christian perspective or culturally?’ The response was that:

Spoken word.

*“No. Culturally. Because we are from diverse communities, our views in this might differ. Obviously, it differs. I don’t want to say its modernization, but today we tend to lack knowledge, or we never seek clarification as to why certain cultural things are done. The generation of today will see things/practices happening in the community and they don’t*

*take time to learn why certain things are done. As I shared previously, when there is a funeral and there's a transfer/naming of a child. I took it up on me to learn why that cultural practice took place. Essentially, I learned that there was a transference of life.*

*Therefore, all the characteristics of the dead still remain with us. This was new knowledge to me, and when I asked why people of the same clan tend to be buried together – I was told they commune deep down there. That is why in Malawi, people refuse to bury their family member away from their clan – for communality reasons. Because if this doesn't happen you will be isolating one of our own. That is not allowed. Down in the villages where we come from, they still strongly believe in these practices”.*

*(Participant 8)*

What is coming out of these findings presents a complex outlook on the ways of life in this community. In this community, cultural practices have been transferred from one generation to another. Even so, it lies in an individual seeking knowledge and learning the indigeneity of life. However, it appears that it is becoming less important to young people today within this indigenous community.

- Are there any structural components or layers in life? How are they connected?  
*(What and How)*

It is quite illuminating that the structural components of the phenomenon of life within this community are emerging from the data to have communality of central importance. First, the community solves the challenges faced by the community.

#### Spoken word.

*“Yes, there are, there are some systems. For example, when someone has a problem, they share it with the community, and they can be assisted. So, there is a system of supporting one another in the community”.* (Participant 2)

*“Yes... in the community there are social gatherings that can be managed by the Chief. These gatherings entail issues affecting the community at large to come up with a solution”.* (Participant 5)

- Spirituality concerning life, cultural practices, and psychosocial health challenges?

Comparatively, it is emerging that with Participant-group Two, spiritual practices embedded in dance and music still exist in their purest form. This is less influenced by Western doctrines of life, as distinguished in the Khoisan community of South Africa. This is evident in the revelations that the *Vimbuza dance* from the Tumbuka tribe stood the test of time. Simultaneously, the respective dances maintain similarities of divination, singing, clapping of hands, and the formation of a circle.

#### Spoken word.

*“There are some families who believe that way. By making noise to manage psychosocial health challenges in that when they hear the drums, they become better.”*

*(Participant 11)*

*“Music and dance are used for psychosocial health management, even for people who manifest with seizures”. Because it is understood that epilepsy is a spiritual illness that needs to be managed in that way.” (Participant 21)*

*“Me I originate from the Tumbukas that’s in the north part of Malawi. In our tribe I have noticed anything unless a traditional dance for psychosocial health challenges called Vimbuza. You find that a person has a long-standing problem that is well managed by the dance. The patient will perform the dance and they will get better.” (Participant 15)*

*“There is a traditional healer or someone who inherited from his grandparents who knows how to dance. In most cases is the traditional healer, who performs some rituals and can know what someone is suffering from. So, it’s like a Sangoma. Sometimes its him who does it, sometimes they invite the patient, sometimes they add some traditional herbs just like a Sangoma but before they perform all the prescriptions there is that dance which they call it Vimbuza.” (Participant 15)*

*“With Vimbuza we normally have an entrust person who is believed to have the knowledge and powers to conduct the dance. If we have psychosocial challenges in the community then the village heads will get those problems to that person so to prepare for such occasions. For example, a girl has signs and symptoms of conversion*

*disorders then they will take this girl to that particular person to prepare the medicinal herbs and the dance.” (Participant 12)*

*“But I think in the system there is also counselling skills involved. Even with rite of passage the women in the community will be tasked to handle the matter.” (Participant 11)*

*“The vimbuza dance have drums made from a tree, with goat/cattle skin on top, tighten it to make sound. A minimum of three drums. And then you make a circle, the rest of the people help with singing, clapping hands. The dancer put on an attire/cultural attire -skin of an animal in the legs, around the legs, on the head and the hands. Then they hold a stick. Even the client is dressed that way. So, when their singing the client will dance with the healer.” (Participant 15)*

*“The dances are done at night so their attributed to spirituality. But is in a jovial mood. But normally their scheduled in relation to the behaviour of the moon/full moon, dry seasons. Otherwise mostly is on emergency basis as per the need.” (Participant 15)*

- Is life related to cosmology/ is it connected to the surroundings? (*What*)

Spoken word.

*“Life is always connected to your surroundings. Everyone else live with what they are surrounded with - resources – food, air, farming.” (Participant 2)*

*“It is true, we are always connected with our surroundings.” (Participant 4)*

*“Life goes with what we are surrounded with, whether good or bad. Even how we behave from day-to-day is influenced by our surroundings. For example, if you have never smoked in your life and you are surrounded by people who smoke cannabis you can be influenced to smoke.” (Participant 1)*

*“Surroundings forms an integral part of knowledge production and how do we understand our reality.” (Participant 2)*

To this end, the emergence of the research findings concerning the interconnectedness of oneself to one's surroundings and nature contributes to consistency with the substantive area of the theory. The words above from the participants maintained holism and connectedness. The emerging findings further advance this reality of interconnectedness through the appreciation of local knowledge and its application to everyday life.

- What is the source of life? (*What*)

It comes out that not only is life interconnected to the surroundings, but over and above that, the source of life is found within the surroundings. Chiefly, surroundings include your internal persona and those living around you.

This was realized as participants shared that:

Spoken word.

*“I think source of life can be from our surroundings, the people we live among, and even within ourselves. The behaviours that we project can be a source of life.” (Participant 3)*

*“By being surrounded by people, that could be the source of life. Whether the people treat you well or vice versa. That is the source of life. Even how we give out to others that is a source of life.” (Participant 7)*

Be that as it may, an outright consistency between the Khoisan community in South Africa (Participant-group One) and Participant-group Two was the weight of the data on how significant nature was to the source of life. Thus, in the community of Malawi, it is a baobab tree that is interconnected with the life of the community.

*“Like in my culture from Karonga district (Lake Side Malawi, Bordering Tanzania) normally our health in the community is symbolized with a baobab tree. Ahhhh in African context we all know that baobab tree normally in the ecosystem keeps the soil a little bit wet. Our ancestors believe that if they problems of hunger etc – they would assemble at a baobab tree and do their rituals. Even though policies health policies do*

*not encourage this and is more curative in nature, but we still continuing with the practice.” (Participant 7)*

Along with how interconnected life is, the active contribution of one who belongs towards oneself, the family, and the broader community becomes an important element to the source of life. Essentially, this means that, for the wheel of life to be powered, every person within the community plays a role. Integral to the active contribution of the community, the sense of sharing is further realized to bestow the source of life. In addition, it came to light that the source of being is a component that cannot be separated from life.

Spoken word.

*“What a person does for a living, in that if you’re a man and you don’t have a source of income you’re considered life-less.” (Participant 5)*

*“In my community, I am looked as to what I do, and what I am contributing to my family and to the community. That’s what defines life and its source.” (Participant 3)*

*“For life to wheel, I have to contribute myself within my community.” (Participant 3)*

*“Even our capabilities to do things – for examples how we get our support maybe our employment.” (Participant 7)*

*“The sense of sharing among the community stands as a source of life.” (Participant 6)*

*“Life comes from within a life, that union of a wife and husband is a source of life.”*

*(Participant 8)*

Importantly, a spiritual domain emerges to play an equally integral role in the source of life. This advancement was illustrious when the participants explored cultural and religious beliefs about the existence of God and the source of life. Even so, contrasting views emerged on the meaning of God concerning culture and religion. Hence, it is unfolding that even though similarities exist, there is God in cultural terms that can be

traced back to before the introduction of the Christian God. Be that as it may, it came out that ancestors gave energy to life, thereby empowering a new life.

Spoken word.

*“Spiritually, God gives the source of life.” (Participant 3)*

*“From a cultural perspective there are Gods, and religiously there is God. Therefore, I mean it both.” (Participant 3)*

*“For me their different, the western God came in and found our cultural beliefs in existence. However, you still find overlapping practices. For example, earlier on I said when we die, we are buried in the same area for communal reasons. The new religion came in and also there are practices of communion of the dead or communion of the saints. Hence, it is not very different from the ancestor’s belief in. But obviously they differ in different aspects. The problem here is that when the white man came with the bible, he condemned everything that is cultural to us and also, we were made to believe that these practices are wrong by nature. But I think we can still draw lessons from some aspects. Therefore, my answer to your question is that the religious God and our ancestors (God) beliefs, think they are different but there are also a lot of similarities.” (Participant 8)*

*“Ancestors give energy to life; they empower new life.” (Participant 8)*

*“For example, people in our community would say you are exactly like your uncle, meaning that you are living that life of your uncle – you are getting source/energy from the life of your uncle. Therefore, your ancestors give you the power of life.” (Participant 5)*

*“For example, if you are successful people will always attribute it to someone who lived before you. Similarly, if you are a failure. That is why I am saying your ancestors gives you drive to your life.” (Participant 8)*

#### 4.7.2. Inductive synthesis

Discernibly, the emerging findings point not only to the appreciation of local knowledge production and interpretation of reality in unique contexts such as Malawi. However, central to the belief system is the premise of life being circlic, continual, and interconnected to the surroundings. Moreover, it has been established that communal ways of life extend themselves, even after death. Those who belong continue to commune by being buried together at the same burial site. Equally, it is understood that life can be transferred from those who were here before to those living physically on Earth for the continuation of life. Above all, communality seems to be fundamental to the ways of life but also central to the source of life.

Evidently, within the context of Participant-group Two, one's personhood is implanted into the indebtedness that one belongs to a community and shares common beliefs. The upshot is that, for the appreciation of good health and illness, a person is seen as a whole, interconnected to cosmology and spirit. Equally, a person is conceived as a whole, founded by physical, mental, social, emotional, and economic foundations. Hence, healing becomes a process that distinguishes illness from good health by restoring the balance of one's foundations. Therefore, psychosocial health is understood as integral to good health and healing. Thus, psychosocial health management becomes a life-long process shared by the family, community, traditional healers/leaders, and faith-based healers. It is achieved not only by a sense of comfort and support, but also by using medicinal plants.

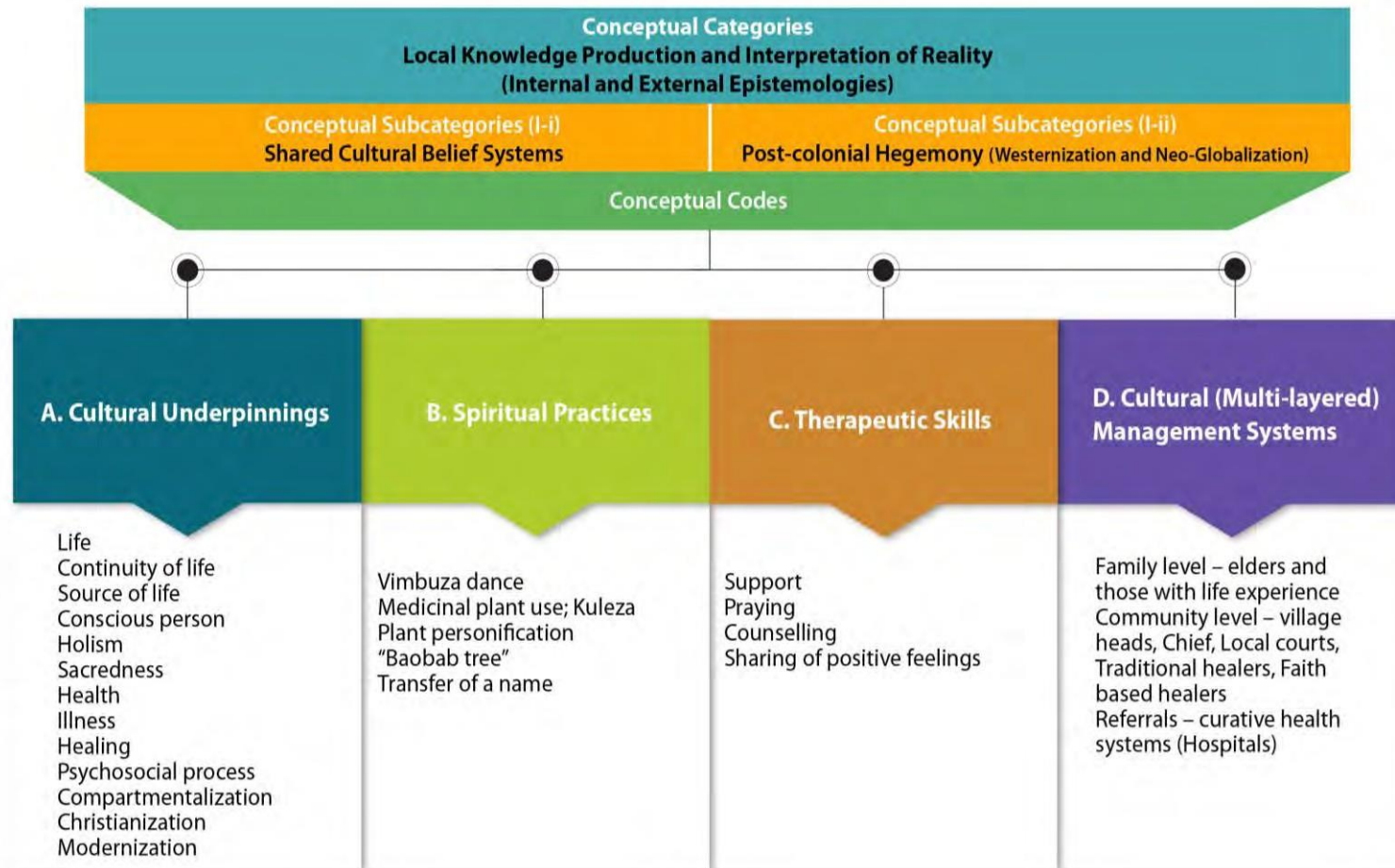
However, notwithstanding the deep-rooted communality and cultural beliefs emerging from the data, the influence of Westernization and religionization is unavoidable through the crux of the ways of life within this community.

## **B. Intermediate phase** (see Table 1, Chapter Three)

For this phase of coding, the researcher continued equally with substantive (open) coding with a particular focus on the data emerging through constant comparisons of constructs, just as with Participant-group One, by collapsing, fitting, and refitting emerging meanings from the data (see table 1, Chapter Three). The tabulated below is the emerging conceptual category further interconnected to conceptual codes and conceptual subcategories (see Table 4).

#### 4.8. Discussion of the emerging categories (see Table 4)

**Table 5:** Emerging findings from Participant-group Two



#### **4.8.1. Conceptual category I: Local knowledge production and interpretation of reality**

It is evident that psychosocial health management is a multifaceted phenomenon interconnected with where you belong, what you are, and ways of living. On this account, time, context, and people warrant weighty appreciation. Relatedly, time denotes the circumstances in which a community finds itself. Context attaches to the meaning of space. People construed living and those who were here before. This explains the obedience to the principles of Ubuntu "I am because you are." Significantly, the appreciation of praxis is a valuable outcome of those who belong to this conceptual category.

Hence, the conceptual category I (one) emerges because of the established ways of knowing and how much is understood by the community in achieving communality. Thus, internal and external epistemologies are bracketed as part of the conceptual category, as they manifest in a context in which there are local and non-native realities on how knowledge is construed. Local realities are realized through sacredness, a common sense of communality, shared beliefs, and belonging. On the other hand, external influences appear to include the destruction of culture and self-identity, religionization, modernization, westernization, and colonial hegemony. Therefore, conceptual category I (one) is presented by two of the intertwined conceptual subcategories fundamental to the realization of the existing communal cultural belief, but also diluted by post-colonial hegemony.

##### **4.8.1.1. Conceptual subcategory I-I & I-ii: Shared cultural belief system and post-colonial hegemony**

This conceptual subcategory (I-I) emerges first because of the common way of life demonstrated by Participant-group Two. This is associated with culture, as it construes how the community has functioned over many generations. However, even under rooted cultural beliefs, the consequences of colonial dominance still present itself through ways of life. Hence, the two conceptual subcategories jointly emerged from the conceptual

codes to be unpacked, which explains the merging of the two conceptual subcategories. The intercept is shown below.

#### **4.8.1.1.1. Conceptual code A:** belief and cultural underpinnings

This conceptual code emerges as the understanding that beliefs and cultural principles are central to the ways of life within the context of Participant-group Two. This fundamentality includes life, person, holism, sacredness, health illness, healing, psychosocial processes, Christianisation, modernization, and compartmentalization.

- Life

Certainly, a contrast has been established between Participant-group One and Two with the outright emergence of the reality that the reproduction of life among those found in Participant-group Two is inseparable from the meaning of life. However, it is evident that how people relate and associate with one another compares with Participant-group One. Communality is essential to the livelihood of the natives, wherein one's belonging can associate and contribute meaningfully to the life of the community.

Contrary to shared cultural beliefs connoting the meaning of life, a manifestation of colonial hegemony cannot be avoided. This was realized by the founding that life denotes a physical existence on Earth; therefore, life starts when one is born and ends with death. This intercept between the deep-rooted cultural and subdued meaning of life was noted by the participants:

#### Spoken word.

*“Life ends when you die, I don't know what happens when you die, ... we have buried the person, the person is gone.” (Participant 7)*

*“I would say is the existence of you on earth.” (Participant 6)*

This compartmentalization of the meaning of life by Participant-group Two as a context is interrelated by the researcher to the aftermath of colonialism and Westernization over time within African communities.

- Continuity of life

Compared to Participant-group One, it is emerging that life is a circlic-holistic conception that is continual and everlasting. Consistently, life is found to be a holistic notion that involves one's persona, physical, and spiritual presence, but also, circlic in that life is continual. First, it was realized that when an individual passes away in this community, he/she is not considered lifeless; rather, the persona of the one who was here before spiritually passed to the one physically living on earth. This can be achieved naturally, or by transferring the names of those who were before, to those physically living on earth.

Equally important, it is emerging that life is circlic through reproduction by men and women in the community. Equal to holism and continuity is the understanding that life continues even during death, where those who were here before are buried in one place for the communality and continuity of life. Thus, dualism in the meaning of life is both circlic and holistic. However, post-colonial hegemony comes into play as it is becoming a growing challenge to commune and continues the circle of life during death since, in recent years, people have migrated all over for different reasons.

Spoken word.

*“Where your navel is, that's where you are buried.” (Participant 5)*

*“(life)It doesn't end, it keeps on reliving.” (Participant 1)*

Comparable to Participant-group One, this circlic-holistic notion is strengthened in ways of life by a sense of belief. It is the cultural belief that one is interconnected with living (mankind, plants, and animals), those who passed away, nature (resources), and the cosmos. However, equally, there is an intercept of post-colonial hegemony that should not be ignored, as some participants attached their belief to Christianity.

- Source of life

This conceptual property is comparable to the understanding achieved with Participant-group One that the circlic nature of life demands the element of power to wheel, but also where the power originates. Based on the data, it is revealed that the source of life arises

from the surroundings, including but not limited to people living within the community. Therefore, this compares with the emerging understanding of Participant-group One that there is a collective responsibility bestowed on each member of the community for the life and living of the community.

The data further point out that nature, as part of the surroundings, plays a significant role in the source of life. This emerged as the data indicated that a **baobab tree** is an essential phenomenon in the life of Participant-group Two. The baobab tree represents the health of the broader community. This interconnectedness to nature and life was seen to be comparable with the "**kan-nie-dood**" plant wherein, Participant-group Two personifies the plant to the circlic nature of life. Similarly, the baobab tree resembles the continuity of life found within Participant Group Two as it is important to the ecosystem. The tree is known to preserve the life cycle of the soil as part of nature, which in turn interconnects with the life of members of Participant-group Two.

Even further, the source of life is also found in one's socio-economic standing, but also in your meaningful contribution towards yourself, your family, and the broader community. Consistently, it comes out that the sense of sharing within Participant-group Two is itself a source of life. This understanding is considered comparable to the sense of communality found in Participant-group One. Moreover, it is emerging that life is sourced from the life itself. Therefore, without it, there would not be life.

- Conscious person

This conceptual property finds meaning in what a person living within the community of Participant-group Two is understood to be. It is emerging that a person has a sense of self-awareness of oneself, surroundings, and other people. With this consciousness, one must have an identity of belonging to a community and/or kingship. Thus, with that sense of awareness and belonging, the data lead to the idea that one must bring meaningful contributions towards the self, family, and the broader community. Furthermore, the conscious person assumes a shared responsibility for knowledge production and practice for the community. This complete understanding of a person is comparable to that of

Participant-group One, with the emergence of an individual conceived as a communal person.

- Holism

Comparable to Participant-group One, holism is central to ways of life, with its meaning attached to the appreciation that the ways of life are interconnected. First, conceptual property is interrelated to the understanding of a conscious person who is a complete phenomenon (mental, spiritual, physical, social, economic, and emotional) interconnected to those living physically on earth, those who were here before, and the cosmos. Moreover, as found in Participant-group One, holism is integral to and continuity thereof. Therefore, not only for the continuity of life, a holistic balance is warranted between conscious persons and nature, but also in the fullness of the source of life. The harmonious equilibrium between the interconnectedness of health, illness, and healing is achieved through appreciation of the holistic nature of living life itself. Fundamentally, this completeness and interconnectedness of life are the purpose of people living within this community in striving for a harmonious balance of living for continuity.

- Sacredness

This conceptual property emerged through observations and deductions by the researcher during data collection. It was noted that the community of Participant-group Two envelopes their knowledge and ways of life with pride. Pride was observed through the gratitude and fulfilment of the participants.

Spoken word.

*“Thank you for doing this kind of study.” (Participant 7)*

*“We are grateful.” (Participant 1)*

Be that as it may, a sense of protection towards knowledge and heritage was equally noted. This observation was understood by the researcher as protection of intellectual property. This knowledge has been continually reproduced over many centuries. It is also

through reflection that this research appreciates the complexity of belief systems. For the most part, it is daunting to reduce the century worth of knowledge to simple terms.

Even as much, the sacredness emerged from multiple points of data collection and analysis. This protection of intellectual property became evident when participants deliberated on the meaning of *health*, starting with the frail meaning of the phenomenon. This emergence is deduced in this research in a two-fold way: as a sense of sacredness, but also as a sign of colonial hegemony evidenced by a compartmentalized way of life.

- Health

In contrast to Participant-group One, the emerging meaning of this conceptual property is conglomerated by the obvious intercept between shared cultural beliefs and colonial hegemony. The meaning of health initially presented a compromise to deep-rooted cultural beliefs in which a compartmentalized elucidation weighted by colonial hegemony was offered. Notwithstanding, the emerging meaning continues to take a revolutionary shape that is holistic, but aims for completeness with mental health, assuming a fundamental role. In comparison to Participant-group One, this holism involves mental, social, emotional, physical, and surrounding factors. Even so, unique to Participant-group Two, an economic aspect emerges to form part of the meaning of health in that one's physical nature encompasses resources such as, but not limited to, food and shelter.

Therefore, this research deduces that the ways of life amid the dilation of time have been inexcusably stultified by the unforgiving colonial project. Hence, time, people, and context are given credence.

- Illness

It is realized in this research that Participant-groups One and Two are inclined to acquiesce to the meaning of illness in that illness is the opposite of what is good health. Emerging from this is the notion that illness is the outcome of the imbalance between one's physical body, mind, emotions, spirit, surroundings (cosmos, the living, and those who were here before), and economic circumstances. More importantly, it is emerging

from the data that this imbalance in oneself is a reality that is determined and interpreted by the community itself consistent with the metaphorical truth that "I am because you are."

- Healing

It is equally appreciated by Participant-groups One and Two that healing is not just a meaning that exists between good health and illness. However, the data yield a shared actionable process that is interconnected to one's physical body, mind, emotions, spirit, surroundings (cosmos, those physically living on earth, and those who were here before), and economic circumstances. This explains the harmonious balance of life. This understanding correlates with a sense of belief.

- Psychosocial health process

The data thus far show the psychosocial process as a life-long voyage that is never complete, demonstrated by not only one's contribution towards oneself, family, and the broader community. It goes beyond one's internal persona and is just a mere relationship with the surroundings. Therefore, it becomes a multifaceted and evolutionary phenomenon interconnected to one's physical body, mind, emotions, spirit, surroundings (cosmos, those physically living on earth, and those who were here before), and economic circumstances. Thus, it is integral to health, illness, and healing within a community. However, it is also unique to Participant-group One, which is equal to the multifaceted and evolutionary meaning of psychosocial health and is the unavoidable weight carried by mental health in the interpretation thereof. Consistently, this advancement has also emerged in the meaning of good health as a conceptual property.

What is thus an emerging means to achieve a harmonious balance between one's physical body, mind, emotions, spirit, surroundings (cosmos, those physically living on earth, and those who passed on) and economic circumstances, there is a need for life-long care for all faculties of oneself.

- Compartmentalization

For this conceptual property, the overt intercept between the shared belief system and postcolonial hegemony was immediately noted. This emerged when compartmental construal was primarily in the order of the *makgotla* session. This interpretation was anecdotal to participants, referring to health within their context, as follows:

Spoken word.

*“When you are free from illness, injury or disease.”* (Participant 7)

In addition, Christianization was also noted in the *makgotla* sessions, deliberating on the management of psychosocial health management as a significant player that tends to compartmentalize its approach to religious interpretations and meanings.

This is deduced in the research as the outcome of colonial hegemony, presenting itself as a well-crafted, modernistic portrait.

#### **4.8.1.1.2. Conceptual code B: Spiritual practices**

Giving credence to a shared cultural belief system is the spiritual practices among those who belong. Spirituality is central to the makeup of a conscious person as it is to the broader community in the management of psychosocial health challenges. This understanding is consistent with that found in Participant-group One. This conceptual code emerges through the following conceptual properties: *Vimbuza dance*, medicinal plant use, plant personification, and name transfer. These spiritual practices emerge to be of importance in achieving a harmonious balance between one's physical body, mind, emotions, spirit, surroundings (cosmos, those physically living on earth, and those who were before), and economic circumstances.

- *Vimbuza dance*

Spoken word.

*“Music and dance are used for psychosocial health management”.* (Participant 21)

The latter quote resonates with participants sharing an undivided spiritual belief that *Vimbuza dance* is innately integral to the management of psychosocial health challenges.

This spiritual dance emerges compared to the trance dance found in Participant-group One. Primarily, both spiritual practices involve dance, singing, clapping hands, divination, and the formation of a circle. In particular, the *Vimbuza dance* is a communal practice performative in circles involving a knowledgeable leader who, most of the time, is a traditional healer leading the process. By comparing incidents within the emerging meaning, circlic formation is deduced in this research to signify the belief that life is never-ending. The circle is formed by singing, playing drums, and clapping hands in sync. Furthermore, drums are made of goat and/or cattle skin, representing the interconnection between nature and those who belong. The purpose of *Vimbuza dance* is to manage spiritual-related psychosocial health illnesses. This includes, but is not limited to, epilepsy/seizure. Furthermore, traditional healers may at times use medicinal plants for treatment. In particular, a medicinal plant referred to as 'kuleza' has been used for the treatment of aggression. At the same time, it has been established that there is an element of counselling composed of *Vimbuza dance*.

- Plant personification: The baobab tree

Significant to spiritual practices is the appreciation that surrounding nature, in particular, forms an integral part of life and living. Thus, achieving a harmonious balance in the management of psychosocial health challenges is fundamental. An example of this emerging meaning is the belief that health is signified by a baobab tree. This emergence is comparable to what is found with Participant-group One as much as the '*kan-nie-dood*' plant is concerned. In this conceptual category, when the community is experiencing periods of hunger and drought, they use the baobab tree as a ritual site. It has been reported that this is because trees are important to the ecosystem of life in that they nurture the soil. This meaning amounts to the holistic nature of a person and the circlic nature of life.

Furthermore, when comparing incidents in the data, this emergence can be related to the understanding that health is not a mere understanding of injury and/or absence. Additionally, the appreciation of a conscious person as a holistic being is correlated with the practice of plant personification. Hence, a person is complete with a physical body,

mind, emotions, spirit, surroundings (cosmos, those physically living on Earth, and those who were here before), and economic circumstances.

- Transfer of a name

It is emerging that, in agreement with Participant-group One, the transfer of a name is a practice also found with Participant-group Two. Essentially, it is reported that this is a communal practice of the transfer of life from those who were here to those physically living on earth. This is related to the emerging meaning of the delegation of roles found in Participant-group One. Central to this development is the establishment of life as a never-ending reality.

#### **4.8.1.1.3. Conceptual code C: Therapeutic skills**

In this research, it also emerged that therapeutic skills are an innate technique found within Participant-group Two as a community in achieving a life-long harmonious balance when managing psychosocial health challenges. This is comparable to an establishment achieved with Participant-group One, where it was advanced that there are basic and advanced therapeutic skills. Consistently, therapeutic skills are meant to achieve a harmonious balance between one's physical body, mind, emotions, spirit, surroundings (cosmos, those physically living on earth, and those who were here before), and economic circumstances. These therapeutic skills include, but are not limited to, support, praying, counselling, and sharing positive feelings.

#### **4.8.1.1.4. Conceptual code D: Cultural management system (multi-layered)**

The genesis of this conceptual code became an eminent development from the data, as it emerged that there is a multi-layered structure in the management of psychosocial health. Fundamentally, this involves conscious persons with experiences in life. Hence, at the family level, elders, and other family members with experience with the concerned psychosocial challenge. If the challenge escalates to the community level, village heads, chiefs, local courts, traditional healers, and faith-based healers are involved. With the emergence of Westernization and religionization influencing the way of life. Therefore, if

there is no solution at the community level, the challenge will be referred to as a curative-inclined institution, such as a hospital.

#### **4.8.2. Inductive synthesis**

Central to these findings is the contextual nature of knowledge production and interpretation, which is influenced by time, people, and space. It is predisposed to both external and internal realities. Hence, the influence of Westernization and neo-globalization is an eventuality that is not ignored within the deep rootedness of shared cultural beliefs emerging as foundational to the management of psychosocial health challenges. It is becoming evident that indigenous ways of life are not static, but evolutionary, particularly over time.

With a focus on the emergent findings thus far, it has been advanced that belief and culture underpin ways of life. Hence, the emergence that life is more than just a physical existence. Overwhelming evidence has posited life is an outcome of communality that is circlic, holistic, and everlasting. On that note, the data indicate that life is communal, as those who belong inherently contribute to the life of the community. Certainly, life is circlic as it is a never-ending phenomenon in which persons continue to commune even in death. At the same time, it is also holistic, as it is interconnected to one's physical body, mind, emotions, spirit, surroundings (cosmos, those physically living on earth, and those who were here before), and economic circumstances.

Therefore, it is important to realize the meaning of good health, illness, and healing as central in the management of psychosocial health challenges. Hence, psychosocial health emerges as a multifaceted developmental process that is life-long and never complete. This culminates in its management as a shared process meant to achieve a harmonious balance between one's physical body, mind, emotions, spirit, surroundings (cosmos, those physically living on earth, and those who were here before), and economic circumstances. This balance is achieved by employing cultural management systems that are armed with therapeutic techniques.

## **4.9. SECTION C: A joint discussion of the emergent constructs from Section A and B (Table 5)**

### **4.9.1. Theoretical coding (see Table 1, Chapter Three)**

#### **C. Further development**

To advance the material constant emergence of Grounded Theory, this research endeavoured a befitting refinement through the immersion of categories. This process includes the integration and collapse of emerging core categories to form new ones (see Table 1, Chapter Three). Therefore, the researcher embarked on theoretical coding to interrogate the relationship between the emerging meanings as well as to integrate the categories into the emerging theory, as stated by Glaser and Holton (2004). With a great sense of theoretical understanding, this was further realized through careful literature integration, guiding the emerging theory into a formal thesis. This cautious literature integration is pursued to avoid excessive use of literature, prevent blinding of the researcher on the new emerging meanings, and therefore, maintain theoretical sensitivity (Glaser & Holton, 2004).

Thus, crucially circumventing the disregard for data dependence of the emerging theory was sometimes caused by undue literature use. Hence, this process of analysis and coding was undertaken while safeguarding against forcing the emerging theory by allowing raw data to dictate the process (Glaser & Strauss, 1967:41). The jewel in the crown is the meticulousness in the theory development by methodically following the coding process. Accordingly, the refitting, refinement, and immersion of developing constructs for further development are integrated carefully with indigenous knowledge systems literature across disciplines.

Under these circumstances, the Table and the Figure below present the emerging constructs corroborated by the emerging theory of the two participant groups. Substantial to these emerging constructs is the core category of Communal Psychosocial Lifestyle (CPL). Essentially, psychosocial management is a lifestyle associated with psychosocial well-being and communal principles. Important to CPL are shared cultural belief systems,

co-living systems, and communal therapeutic techniques. This emerging meaning is discussed below.

**Table 5:** Emerging findings from Participant-group One and Two

EMERGING CONSTRUCTS			
Core Category Communal Psychosocial Lifestyle (CPL)			
Category 1 Shared Belief System	Category 2 Co-living Systems	Category 3 Communal Therapeutic Techniques	
Co-categories	Co-categories	Co-categories	
1.1 Communal Person 1.2. Gender Posteriority 1.3. Linguistic Intentions 1.4. Communal Roles 1.5. Holistic-circlic Life 1.6. Plant Reification 1.7. Sacredness 1.8. Food and Eating Culture 1.9. Health 1.10. Illness 1.11. Healing 1.12. Psychosocial Health	2.1. Colonial Hegemony <b>Co-concepts</b> Westernization Religionization Compartmentalization  2.2. Multi-layered Management System (MMS) <b>Co-concepts</b> Family Community Curative Care	3.1. Basic Therapeutic Interactions <b>Co-concepts</b> Humility Sharing Positive Feeling Soft Feminine Nature Masculine Nature Support Counselling Praying Comfort  3.2. Advanced Interactions <b>Co-concepts</b> Stories (storytelling) and Metaphors (covert speech) Meaningful Silence Self-resilience Disclosure Patience and Respectful Waiting (boundary setting) Fortright Honest Interventional Conversation	3.3. Basic Therapeutic Interventions <b>Co-concepts</b> Graveyard Visit.  3.4. Advanced Therapeutic Interventions <b>Co-concepts</b> Mpho ya badimo (Thanksgiving to those who were here before us) !nxhabasas (Rite of Passage) Plant-medicine Use Trance-dance Vimbuza Dance



Figure 10: Emerging constructs

#### **4.9.2. Core category: Communal Psychosocial Lifestyle (CPL) (Figure 10)**

The findings of this research indicate that African indigenous culture is as important as psychosocial health management. This importance is emphasized by the communal way of living. This is when the interests of the collective supersede those of the individual. Fundamental within the emerging constructs of this research, as evidenced by the core category 'Communal Psychosocial Lifestyle (CPL),' is the ornaments of communality to the holistic functioning of an African community. Communality is emerging at the centre of the management of psychosocial health challenges.

Grounding this core category evidence that communality is an embodiment of the ways of life in managing psychosocial challenges found in the two indigenous Southern African communities explored in this research. Above all, but not limited to communality, manifests itself in this research by first, the sense of belonging among the people living within the community. Second, it is through the shared understanding and appreciation of the knowledge generation and interpretation of the denoted reality. This emerged as a substance with attention to the dilatation of time and the evolution of space and its people. Fundamentally, is the realization that this knowledge generation and interpretation is cushioned by a sense of sacredness. Third, shared responsibility and accountability through meaningful contributions towards the life of the community by its people. Lastly, co-living systems are grounded in internal and external epistemologies found within the evolutionary context.

In essence, the findings of this research thus far align with Bondarenko, (2015:64) and Onebunne (2019:36), who argue that communality distinguishes the African paradigm from other worldviews. This is specifically because it exceeds the meaning of the community. Thus, the emergence of this research indicates that communality originates from a sense of belonging among people living within the community. This view was advanced by Bondarenko, (2015:66), who proverbialized that personality is not an outcome of individualism but rather collectivism. Thus, collectivism supersedes individualism.

Confirming the assertions of Columbus (2014:216), this research submits that communality accentuates that one's identity mirrors the community. This is because the

meaning of identity is delineated within, by, and for the community. This author makes this argument by demystifying communality as a sense of consciousness beyond individuality but a collective whose life depends on the functionality of others (Columbus, 2014:209). Therefore, they have the same roots.

Essentially, given the sense of belonging within the research findings, the imperativeness of mutuality among those living within the community emerges. This finding is further proclaimed by Benson (2011:99) that African communities pride themselves in interpersonal mutual sharing, caring, interdependence, and harmony. This interdependence knits the sense of communality intact in the process of ontologically obliterating individuality and egotism. Those belonging assume an inherent shared responsibility, appreciation, and understanding of life. Hence, Onebunne (2019:33) expresses that this inherent mutuality is devised through mutual participation, selfless relationships among people, mutual sharing, and social orientation. Purposefully, for the circlic nature of life to wheel, everyone belonging within the community collectively contributes to the positive outcome of all.

Empathic to the previous finding, Ikuenobe (2018:597) emphasized that communality requires a moral attitude of contributing to the betterment of the broader life of the community. This further elevates the fundamentality of duty in its importance in collectivism for the material well-being of all. Hence, in this research, the expression of communal living is realized as a model of good for all members of the community. Be that as it may, Onebunne (2019:35 & 38) positions this as 'communal strength,' for one is only sufficient in communion with others. Additionally, this research realizes that this shared accountability begins with the generation of knowledge and its interpretation to construe reality for those living within the communal context. Further, it is the appreciation and respect towards cosmology as a communal establishment.

Behrens' (2012:183) pronouncement is consistent with this finding. The author posits that African communities' surroundings are considered communal spaces that are needful of shared mutuality by the living, those who passed on, and those to be born. Interconnected with these developments, primarily to the accentuation of knowledge generation and the sense of communality, is the principle of ubuntu, which ties together the ways of life.

Therefore, communality begins with the stripping of individualistic personalities and elevating the sense of belonging with the duty to achieve harmony for all.

This understanding of the imperativeness of communality has been established across the social sciences. Therefore, in the field of psychology, where communality concerning social cognition was interrogated, it was found that communality assumes the superiority of its own (Abele and Wojciszke, 2014:242). Furthermore, Higgs (2010:2416) emphasizes the importance of communality, even within higher education, as a primacy of research and learning. A communal lifestyle can materialize when we pay attention to certain educational practices in our communities. Hence, Radebe (2019:183) recommends the integration of the African Indigenous Health Knowledge System (AIHKS) with particular emphasis on psychosocial health knowledge for learners with special needs. The author accentuates the fundamentality of Ubuntu and holism in the didactic environment. It is important to note that Schultz *et al.* (2018:2952) heightened the strong correlation between education, health, and well-being for most indigenous communities. However, Rampho (2019:51) argues that when the didactics of *ukhuthwasa* are incorporated into the education and training of nurses in South Africa, the gap between theory and practice will significantly reduce. Given these corroborations, (Olweean, 2019:15-16) avows that if people lose their sense of communality, the results are disastrous to collectiveness, resulting in disorientation, demoralization, and loss of connection.

Equally important and unique to the emergence of CPL as a core category is the finding that psychosocial well-being is indispensable for the management of psychosocial health challenges. Psychosocial well-being is important since it is integral to the belief in holism and continuity of life. This is because psychosocial well-being is a continual development shared by the community with the desire to achieve a harmonious balance between the holistic and circlic nature of life. This harmonious balance is emerging as an arch between good health, illness, and healing. Hence, psychosocial well-being becomes a shared, purposeful, life-long endeavour meaningful to a communal context.

Thus, communality in this research is fundamental to the management of psychosocial health challenges. Holism and circlic nature cords are musical, where both the 'white and black' cords matter. For instance, the emergence of the meaning and application of

health, healing, illness, and psychosocial health share an interconnected meaning towards the cirlic nature of life. Then, the sense of belonging heartens the shared duty and accountability construed by cultural beliefs to manage psychosocial health challenges manifesting within the community through communal therapeutics.

In listening and attending to the findings, communality, belief, and therapeutics encapsulate CPL. Hence, the communal psychosocial lifestyle (CPL) is a core category. To this end, it can be argued that what becomes obvious is the understanding that the management of psychosocial health challenges is inherent to the lifestyle of communal contexts embroidered in shared cultural beliefs.

#### **4.9.2.1. Category 1: Shared cultural belief system** *'I am because you are, and you are because I am.'*

Enshrined in CPL as a core category is the shared cultural belief system, which emerges as a medium for the meanings and workings of life. The appreciation that health is fundamental to that development is important to the meanings and workings of life emanating from shared cultural beliefs. This connection is delineated after demonstrating the intricacies of a shared belief system.

Owed to the fundamentality of communality is mutuality among the people; hence, a cultural belief is shared by each person for all. The data show that ways of life within the community are ordered by the sharing of principles in life. This cultural belief system is emerging as imperative, as it shapes the life of the communal space for the living, those who were here before and yet to be born. Incisively, this cultural belief system curtails the devoted credence given to the 'belonginess of each, to all' cementing the grounds of communality.' However, important to this is the principle of **Ubuntu** – 'I am because you are, ' which has been achieved in most African worldview literature (Chisale, 2018; Nzimakwe, 2014; Gade, 2011; Mangena, 2019; Molefe & Ngcongco, 2021; Mwipikeni, 2018 & Murove, 2012). At the core, **Ubuntu** in this research presupposes humanity, communion, respect, sharing and a way of life sustainable to all (Mokgoro, 1998:2; Nussbaum, 2003:2 & Letseka, 2012:57). This is because it is the finding of this research that a person living within a communal space is grounded in the principles of **Ubuntu**. Understandably, this belief emerges from the data and is at the heart of a communal

context (Nussbaum, 2003:2). Important to this finding is the realization that the principles of **Ubuntu** are shared reciprocally within the communal environment.

This is done by preserving nature through an appreciation of the existence of cosmology for continual life. This is because all that is part of the communal environment is seen as equal to a circlic life interconnected to one source. This is why the realization of life's interconnectedness is significant. That is, if one is suffering from a psychosocial health challenge, it is appreciated as a challenge for all that is interconnected (Bartholomew, 2016:106). Hence, the emergence of the management of psychosocial health challenges is attuned to the principle of Ubuntu. Epistemologically, this shared belief system is also found in knowledge generation and its interpretation within communal spaces. Hence, within the reality of a psychosocial health challenge, one has to believe that health, illness, and healing are intertwined entities, where, in all their meanings, the expression is within one another (Bartholomew, 2016:112). This emergence is confirmed by Bearskin *et al.* (2016:24) who state that the Inuit and Métis communities of Aboriginal origin maintain health and wellness through interaction with indigenous knowledge and practices that shapes cultural beliefs.

In essence, shared cultural belief systems jealously guide the functionality of a community (Bartholomew, 2016:112). For instance, if the ways of founding cultural belief systems are not followed by the people, this results in an imbalance in life manifesting itself as an illness that could be restored by therapeutic interventions. Hence, the management of psychosocial health is a lifestyle embedded in shared cultural beliefs. Therefore, a holistic ontological approach striving for the balance between health, illness, and healing (Bojuwoye & Moletsane-Kekae, 2018:94) is paramount. This understanding was advanced by Harfield *et al.* (2018:7), pronounces the rootedness of culture within the healthcare and wellness of indigenous communities. Importantly, the embodiment of culture within healthcare promotes community participation, cultural competence, self-determination, and capacitation (Harfield *et al.*, 2017:7).

History has proven that the relationship between culture and health bears efficient outcomes. Cementing this argument is a brief chronological confirmation presented below, which demonstrates that the inclusion of shared cultural beliefs in healthcare

approaches is a crucial undertaking. This finding was established in the early 2000s by Van Dyk (2001:65) who postulated that the fight against HIV and AIDS in Africa is only to bear good results if cultural beliefs and values are respected by the Western paradigm. Comparable to the current times, Malherbe *et al.* (2021:447), together with Osei-Tutu *et al.* (2022:17), advocated for the prioritization of African-calibrated approaches in psychological care. Coherent in this research is the understanding of psychosocial health; psychosocial health challenges and their management are steered by a shared cultural belief among all living within a communal space (Bartholomew, 2016:108).

Fourth, a deep analysis of the body of research findings thus far demonstrates the footprints of shared cultural belief systems found in the day-to-day life of a person living within a communal space (Communal Psychosocial Lifestyle) for the betterment of all. This emergence is realized through interrogating relational meanings between shared cultural beliefs and co-categories: communal person, gender posteriority, language intentions, communal roles, holistic-cyclic life, plant reification, sacredness, food and eating culture, health, illness, healing, and psychosocial health.

#### **4.9.2.1.1. Co-category 1.1: Communal person**

In this research, it is emerging that a communal person has a sense of belonging (Ndlovu, 2010:118), to a community/kingship in a communal space of ambilineal origin. This sense of belonging stems from common cultural beliefs. Fundamental to this shared cultural belief is the indebtedness to the interconnectedness of life and, therefore, life being holistic, circlic, and continual.

A communal person is one with life preceding physical existence, death being a substance of positionality, where one assumes a different role in the continuity of life. Significant to shared cultural beliefs is the common appreciation that a communal person is a holistic entity in that one's mental, spiritual, physical, social, economic, and emotional faculties are interconnected to the communal space, the living, those who were here before, and the yet to be born (cosmos). Humility is the primacy of communal person. This is premised on the realization that one is born first a 'human', inserted with a strong value of humility presupposing gender as a latent occurrence. In this it is prioritizing the principle of **Ubuntu** – 'I am because you are.' Inherently, this positions a communal

person as one who is conscious of oneself, others, and space (Columbus, 2014:209 & Mbaegbu, 2016:12).

Thus, one must mutually respect, share, be gentle, and be caring and compassionate for/to others, space (cosmos), and those who were here before and yet to be born. This means that a communal person assumes equal responsibility for life and living of all within the community by striving for a balance of life. This is achieved through innate mutuality to preserve nature for the betterment of life for all, including those who were here before and those yet to be born (Bondarenko, 2015:69). Unique to the findings, however, is that important as it is to the functionality of the communal space, gender is recognized as a latent positionality in the identity of a communal person. Otherwise, a communal person's name carries an integral meaning to the communal space, living, and future.

#### **4.9.2.1.2. Co-category 1.2: Gender posteriority**

Gender remains an important aspect of the life and functionality of communal spaces. It is embedded in the demystification of a communal person in the position and meaning of gender within the communal space. Above all, this research is alive to a contrary argument upheld by Mapara and Thebe (2015:202 & 211) of the same discoveries as Chiliza and Masuku (2020:66), demonstrating a storied history of how gender is currently a divisive tool across societies. However, in this research, it is emerging that gender remains a unifying tool in a communal context in that 'all' within the communal space remain equal.

This finding resonates with that of Besong (2021:99), advancing the balance of equality between men and women. Consequently, the emergence of gender as integral to communal space, holism, and continuity of life becomes manifest. Thus, communality, holism, and continuity of life precede an understanding of gender. Unique to this research is the emerging finding that gender assumes a latent position in the personality of a communal person. Post the cementing of belongingness, humility, and holism with shared accountability towards the communal space, the assignment of gender arises. However, the ambilineal nature of communal space found in this research renders gender a neutral concept.

#### 4.9.2.1.3. Co-category 1.3: Linguistic Intentions

Important to language use per the shared belief system is the connotation found within a language. To the extent of the complexity of the African language, these findings are consistent with Asante (2011:150) however, maintaining the existentialism of communality with language use. This is at least with the understanding of the communal space found in this research. The expressions and names given to communal persons are connoted in the linguistics of culture and belief. In reality, the meaning found within the name is big and strong and is given to a male person. Similarly, when gentleness reverberates, the name is assigned to the female. Bearskin *et al.* (2016:24), found that for Aboriginal people, the naming of a child holds an endearing meaning to culture. This practice is closely linked to the future and lives of individuals. This is because the essence of the Aboriginal people's upbringing is immersed in the family ancestral line, which shapes the present and future of reality. However, Schultz *et al.* (2018) also submit that indigenous languages tie indigenous Australian societies to their land, community, and family.

Furthermore, unique to this research is the establishment that gender and language are interconnected to the communal space as they relate to the circle of life as natural occurrences. Rain is understood to be female and thunder male in nature. In connection with this, Chin *et al.* (2019:8-9) found that thunderstorms come because of a variety of variables in a cyclic form. In this research, the variability of women being gentle and caring, together with the powerful nature of men, can be related to the association of rain and thunder. This understanding can relate to the fundamentality of holistic life that rain brings hope and a new life, just as females bring life to the world by giving birth to a new generation of life.

Equally, this construct can be corroborated with the naturality of life in which rain and thunder go hunting together just as much as a male and a female join to create a new life. Again, the focus is not on gender but on the common goal of attaining a circlic balance of life. The dual modus of rain and thunder concerning male and female meanings is articulated in the works of Lewis-Williams and Pearce (2004:215). They advance the

interconnectedness of rain to the life of the San people in the Southern African region between the two kinds of rain (male and female rain).

Surely, indigenous language practice emerges in this research as intentional in its preservation of life, creation of the immediate world, and safeguarding of the culture for indigenous people. This understanding seems elemental to the functioning of a communal society enshrined with shared cultural beliefs.

#### **4.9.2.1.4. Co-category 1.4: Communal roles**

As understood from the findings, the roles of communal persons within a communal space are informed by the fundamentality of communality, holism, and the continuity of life. Hence, communality dictates the shared obligation to the functionality of the communal space, regardless of gender. This emergence is in accordance with Nare (2016:71) who avers that healing is a communal role.

Life and living in a communal space are attained by a continuous desire to achieve a harmonious balance between the interconnectedness of life. Innately, it is also the role of communal persons in reproducing life through relationships between men and women in the community. Furthermore, communal persons are duty-bound to continue the life of those who were here before utilizing the transference of life and responsibility. This is achieved through delegation, employing a gender-neutral process.

The living, regardless of gender or age, are delegated to carry on the lives of those who were before by assuming the role that was occupied by those who passed on. This is further understood as the positionality of life, as those who have passed on also assume a new role in the circle of life. In addition, men and women have inborn communal roles, such as the leading role that women take during rites of passage for young girls. However, men play a leading role in psychosocial challenges involving men. Simultaneously, men and women jointly work in communal roles.

#### **4.9.2.1.5. Co-category 1.5: Holistic-circlic life '*precious and everlasting*'**

Meaning of life draws from the deep rootedness of a shared cultural system. Life is believed to not only be an experience of physical existence (Attoe, 2019:34). Its meaning

is also essential to the overlaps of communal space, those physically living on Earth, those who were here before us, and the yet-to-be-born (cosmos); hence, the preciousness of life. In this way, life is everlasting, based on its circular nature. Conversely, after rigorous undertaking, Attoe (2019:186) concludes that life is meaningless.

In this research however, important to the emerging meaning of life is that it is not defined by singularity, but by its essence of continuity, communality, and holism. Demystifying continuity of life is the belief that life does not end, becoming everlasting (Okoro, 2019:7). Thus, life is endured even in the event of death. This is evidenced by the commonality found between the living, those who passed on, and the eventualities of the future (the yet-to-be-born), even though Attoe (2019:186) begs to differ.

In this research, communality takes the lead of life, where, even during passing on, those who passed on are buried at the same place for the continuity of life. Extending belongingness to communion during the afterlife hence, those who passed on are buried with their ancestors within their communal space. However, it is also emerging that continuity of life is achieved by naming the living or yet-to-be-born after those who passed on for the continuation of the legacy.

In the meantime, life is communal in that the living can, when called up, carry on the life of those who were here before. This is because of the rootedness and interconnection of life to the communal space, those physically living on Earth, those who passed on, and the yet-to-be-born (cosmos). Similarly, the living can, when called upon, carry on the life of the one who passed on. As already noted, communality is shown in the preceding ways of life. By not dulling the sword, it is realized that to maintain the cyclic nature of life, the interaction and association of belonging are fundamental.

This emerges through the reproduction of life by men and women, a meaningful contribution towards the life of the community for the better of all. This association and its meaningful contributions are engulfed by a sense of sharing. All in all, life is holistic, as it is interconnected to one's physical body, mind, emotions, spirit, surroundings (cosmos, those physically living on earth, and those who were before), and economic circumstances. It sources its power from the communal nature of the space and the

interconnectedness of the living and those who were here before. This is concluded by Okoro (2019:13), as a way of life also found with the Igbo people, with the belief that all within the universe is connected to one. Above all, the meaning of life denotes the fundamentality of time, space, and people. This undertaking is understood by Marava, (2015:96), who agitated the conceptuality of time concerning belief, life, and those who passed on.

#### **4.9.2.1.6. Co-category 1.6: Plant reification**

Important to the cultural shared beliefs found in the communal psychosocial lifestyle in this research is the reification of nature, particularly plants. This emergence is related to the overlapping interconnect of communalistic, holistic, and circlic life to the communal space and all within. This is especially so when there is a realization that those living are all equal before communal space. Linked to this emergence is the realization that in a communal space, there exists shared accountability to preserve and bestow meaning to the surroundings. Further, mutual respect is extended to all within the communal environment.

This practice is important for survival through resilience building in the communal context, as it is ingrained in the source of life. Moreover, this practice is important to the psychosocial health of communities.

The plants mentioned in this research are the “kan-nie-dood” plant and baobab tree. These plants provide evidence of the psychosocial health of communal spaces. Hence, health is beyond the scope of physical illness. Indeed, plant reification has emerged as an integral part of psychosocial health challenges, such as grieving, hunger, and drought. Thus, it is fundamental to achieve a harmonious balance of life in the management of psychosocial health challenges.

The baobab tree was found by Lisao *et al.* (2017:453-454), to be of fundamental importance to the ways of life of the Herero, Ovambo, San, and Masubiya people for spirituality, treatment of cough, and day-to-day life. Across the body of literature, it is clear that there is much more that nature brings to life ranging from climate change, nutrition,

treatment for diseases and shade for animals (Sanchez *et al.*, 2011; Msalilwa, 2020 & Krishnamoorthy *et al.*, 2022).

#### **4.9.2.1.7. Co-category 1.7: Sacredness**

As onerous as it sounds, the concept of sacredness cautiously separates itself from its sister concepts (secrecy, confidentiality, etc.) in this research, as it is applied in its comfort of cultural context. Importantly, this research shares the meaning of sacredness with Haidt and Graham (2009:378) in that its fundamentality is found beyond the physical meanings of the ways of life given a specific cultural space, time, and people.

The modality of sacredness emerged in illuminating the underlying meaning of the data. This modality is an integral tool of life used in the communal context in this research. Hence, psychosocial health management can discern these realities. The sense of protection of local knowledge and heritage by communal persons is significant to this finding. Handfield (2020:253) states that sacredness is a valuable yet priceless act of belief. Thus, across the African literature, this understanding has long been established.

It is generally agreed that sharing traditional knowledge requires trust in relationships (Lisao *et al.*, 2017:454). Equally, this study appreciates the complexity of cultural belief systems, particularly in the African context. It has been noted throughout the points of data collection that participants begin sharing surfaced information with the questions, but with further probing, delicate insights are shared.

#### **4.9.2.1.8. Co-category 1.8: Food and eating culture.**

Intrinsically, food and eating culture are found in this research to form an essential part of psychosocial health and lifestyle. Furthermore, food culture is rooted in the belief in holism and continuity of life. Commonly, food is obtained from the slaughtering of an animal for either everyday eating or ritual purposes, which in any way is offered to be eaten. At the centre of this emergence is the shared understanding of equality between people and animal/food. This is because of the interconnectedness of life within the communal space. Hence, food and eating culture are closely related to the self-preservation of life, wherein consuming the animal is a method of continuing the life of the animal.

#### **4.9.2.1.9. Co-category 1.9: Health**

In this research, health is realized as a holistic notion knotted into the communal space by a sense of belief. The meaning is especially disposed to belief because one must appreciate its interconnectedness and the harmonious relationship a communal person has with the surroundings, inclusive of those who were here before, those physically living on earth, and the yet-to-be-born (cosmos).

This finding is eloquently revered by Nare (2016:58) and Nare *et al.* (2018:5), who found that health is a psychosocial epithet, since health is a holistic entity involving not only the individual but also the family and the community. It derives its meaning from a sense of belief advancing the principles of Ubuntu – 'I am because you are.'

Accordingly, the emergence of health is synonymous with nature and communal space is found herein. This is based on the realization that the whole community (all that is within, including the cosmos) is responsible and accountable for the health of the broader society (Nare, 2016:60 & Osei-Hwedie, 1997:9).

However, the importance of mental well-being in health has been noted. This is due to the mutuality shared by all in striving for the betterment of all through meaningful contributions towards the communal space. Furthermore, mental well-being is of significance in the ability of communal persons to associate and interact with others, and in that understanding, health encompasses one's physical body, mind, emotions, spirit, surroundings (cosmos, those physically living on earth, and those who passed on), and economic circumstances. In terms of fundamentality, health is a communal lifestyle. Therefore, the good in it prioritizes the harmonious equilibrium of all its elements for the continuity of life.

#### **4.9.2.1.10. Co-category 1.10: Illness**

Given the meaning of health, illness emerges as the whole opposite of what is good health. Aligning with Bila and Carbonatto (2022:556) arguing that illness is integral to cultural belief systems in Africa. Thus, illness emerges in this research to denote the irreconcilability between one's physical body, mind, emotions, spirit, surroundings

(cosmos, those physically living on earth and those who were here before) and economic circumstances.

This results in the imbalance of life which may manifest itself in different forms affecting how one relates with others and the cosmos (Nare, 2016:60; Nare *et al.*, 2018:6 & Madzhe *et al.*, 2014:324-325). Therefore, health and illness remain intertwined as psychosocial embodiments provided a communal space.

#### **4.9.2.1.11. Co-category 1.11: Healing**

In this research, healing is realized as a lifelong shared cultural process with the sole intention of locating a harmonious balance between one's physical body, mind, emotions, spirit, surroundings (cosmos, the living, and those who were here before), and economic circumstances. Therefore, one must relate better to others and the cosmos.

This finding is confirmed by Madzhe *et al.* (2014:327), who noted that the significance of healing mental health illnesses is to restore good relations with others, as communality is important. However, Nare (2016:68-69) concurs that healing in primal health care is holistic and ingrained in the principles of communality where the process of healing is shared by the communal persons. Thus, healing in this research is appreciated as a process beyond the elevation of individual suffering, but a collective undertaking. As found in this research, healing discovers the meaning between good health and illness through its interconnectedness to the communal space inclusive of those who were here before, the living, and the yet-to-be-born (cosmos).

Thus, Nare (2016:68) and (Mphuthi, 2015:66) find this interconnectedness by submitting that resources found in the communal space, such as medicinal plants, are being used to facilitate the process of healing.

#### **4.9.2.1.12. Co-category 1.12: Psychosocial health (*a never-ending process*)**

To better understand the psychosocial health phenomenon in African communal contexts, one need to appreciate health, illness, and healing. This appreciation is the rise of multidimensional meaning in psychosocial health. At this juncture of the theory, health, illness, and healing are interconnected with the functionality of a communal space.

Therefore, the psychosocial aspect of mental health and healing is emerging in this research. In the monolithic nature of psychosocial health, the inseparability of health, illness, and healing cannot be ignored. This explains the significance of health, illness, and healing in terms of psychosocial health. This finding was also in agreement with Nare *et al.* (2018:5), who postulated that health, illness, and healing are interconnected to African ways of care and belief systems.

Importantly, psychosocial health has become a rudimentary phenomenon in the belief of holism and continuity. Hence, the mutual approach by communal persons in striving for a harmonious balance in life is central to the management of psychosocial health.

Psychosocial health has a continual and holistic meaning. This is why psychosocial health is upheld as a life-long mutual process in striving for harmonious balance within the interconnectedness of life. The physical body, mind, emotions, spirit, surroundings (cosmos, those physically living on earth, and those who passed on), and economic circumstances. However, it is also a never-ending process of harmonious interactions and relations between a communal person and others and the communal space.

Shared cultural belief systems are an important part of communal psychosocial lifestyle. Even in established development, the findings of modernized ways of living because of colonial hegemony are unavoidable and important to this research. Hence, the discourse on co-living systems as a category involves colonial hegemony and multi-layered management systems as co-categories (see Table 5).

#### **4.9.2.2. Category 2: Co-living systems "From co-existence to co-living between two distinct worldviews"**

Among the deeply ingrained shared cultural belief systems, the findings illuminate Africa as a dichotomy. The obvious examples of capture by the two participant groups in between two worldviews attested to be between the Western worldview and African worldview. Even though there is a clear dominance of emerging African ways of life, the impact of colonial rule on African indigenous communities should not be underestimated (Lowe and Montero, 2021:46; Ogar *et al.*, 2019 & Heleta, 2016:6). Thus, in the table above (see Table 5), the co-living system emerges as a core construct that sheds light

on the underlying meaning of the core category, Communal Psychosocial Lifestyle embedded in the findings. Fundamentally, the findings acknowledge that colonialism radiates its influence in contemporary ways in the context of African communities. Hence, co-living systems emerged as category 2 (two), under which colonial hegemony was a co-category and co-concept such as Westernization, religionization, and compartmentalization discourse through careful literature integration. Finally, a multi-layered management system inclusive of family, community, and referrals will be afforded the same respect for discourse.

#### **4.9.2.2.1. Co-category 2.1: Colonial hegemony**

Colonial hegemony was established in this research by the emerging Westernized, religionised, and compartmentalized realities of life in African indigenous communities. This argument is made by Bulhan (2015:240) about colonial hegemony in that this rule was painstakingly intentional in eradicating African ways of knowing. This was achieved by not only occupying the land but also the African being. For example, the eventuality of Christian churches within communal communities have been found to influence spiritual practices. Spiritual dance, such as trance dance, is now found in religious settings. The research found that, in recent years, trance dance has not been practiced in its original form in South Africa's Khoisan community.

At the same wavelength, it was also noted that some participants did not visit cemeteries like many others did because of conflicting belief systems. The contradiction of this belief system was further proven by the mention of Jesus Christ as Savior. Equally, the emerging Christian belief informs trust in faith-based healing of psychosocial health challenges.

Furthermore, the negative effects of colonialism are displacement, slavery, and migration. The killings and displacement of men by colonial rule were found in this research to recalibrate the culture of the Khoisan in South Africa as female dominant. This has led women to fend themselves and find ways to preserve the life of communality. Certainly, it is realized that displacement and migration are predicating holism and continuity of life. Those who passed on are now finding it a challenge to communicate with their ancestors, as some are buried in cities and elsewhere.

Correspondingly, a compartmentalized way of viewing life (Bulhan, 2015:240 & 252), instead of holism, was evidenced through the language used by some participants (Wolf, 2017:8 & Kalusa, 2021:73-74). For example, health and life were first defined by the participants as mere physical phenomena.

*“Life begins at birth and ends with death.” (Participant 4)*

*“Life ends when you die, I don't know what happens when you die, ... we have buried the person, the person is gone.” (Participant 7)*

*“Free from illness, injury or disease.” (Participant 1)*

Given colonial hegemony, another emerging finding on African knowledge systems is hardly documented, making it difficult to transfer knowledge from one generation to the other. However, the youth of today due to Westernization have been found in this research not immersed in African ways of life.

These findings are based on the imperativeness of culturally shared beliefs and the co-living systems influenced by colonial hegemony within communal spaces. A multi-layered approach in the management of psychosocial health challenges emerged as a core concept (see Table 5). The core concept is discussed below.

#### **4.9.2.2.2. Co-category 2.2: Multi-layered Management System (MMS)**

Life in African indigenous communal context is informed by the extent of the findings of both African and Western worldviews. Although this may be true, a holistic approach to psychosocial health management is paramount. A holistic approach inclined to no separation of physical health from mental, emotions, spirit, surroundings (cosmos, the living, and those who passed on), and economic dimensions of life is important from an African perspective. Thus, MMS has emerged as a befitting approach in the management of psychosocial health challenges. This approach is multi-layered because it involves family, community, and curative institutions.

This multilayered management approach in health services demonstrates accessible and affordable health services, community involvement, continuous quality and efficiency improvement, culturally congruent and competent health services, and holistic health

care. The reciprocal nature of this system, evidenced by communal ways of knowing and biomedical sciences, shows a reciprocal process in which the two schools of thought educate and learn from each other. Therefore, these two systems with a history of contradiction and disharmony are within this research presented as mutual engagement where the genuine outlook of communal space is inescapable.

Accordingly, at the family level, MMS involves communal persons with experiences in life, such as elders and other persons, to manage psychosocial health challenges. For example, if a psychosocial health challenge involves a married couple, elders within the family, together with other married family members, will be the first line of care. Even though Bearskin *et al.* (2016:26) deliberated on the somewhat severe damage the tyrant colonial and Christian rule has had on the Inuit and Métis families, the authors still position the indigenous family structure at the heart of the healthcare service, as much as the findings of this research. Hence, in this study, family refers to people who are related to oneness. As a mosaic, this approach was proposed by Grabowski *et al.* (2022) and Nare (2016:60) by positioning the family as an environment in which health- and illness-related behaviours can develop, be maintained, and change. Family involvement was further advocated by Im and Kim (2021:89), who found its effectiveness in the management of psychosocial health.

Subsequently, if psychosocial health challenges perpetuate, the matter escalates to the community level. This is because community is regarded as fundamental to the worldview of indigenous communal spaces. This is further considered beneficial for cultural promotion and continuation bearing capacity in indigenous contexts (Bearskin *et al.*, 2016:27). Boyd-MacMillan *et al.* (2016) also promote community involvement in psychosocial health management. Hence, the solutions to the health challenges of a given community are located within the community. That is why traditional healers, faith-based healers, community leaders, village heads, chiefs, and local courts are involved at this level. If the community level fails to manage the challenge, the matter is referred to as a curative setting (i.e., a hospital).

This holistic approach is strengthened by both African and Western worldviews; hence, the imperativeness of therapeutic interactions and interventions found within indigenous

African communal contexts emerge. Henceforth, the discourse engages basic and advanced therapeutic techniques employable for the management of psychosocial health challenges (see Table 5).

#### **4.9.2.3. Category 3: Communal therapeutic techniques** *"Holistic-Continual Process of healing"*

Communal therapeutic techniques are an integral part of MMS in psychosocial health management. This is because of the recognition that health, illness, and healing are fundamental to the functioning of communal spaces. However, there is also the interconnectedness of life due to its wholeness, continuity, and circlic nature. Therefore, everyone desires a harmonious balance between physical, mental, emotional, spiritual, environmental (cosmos, living, and those who pass on), and economic conditions. Additionally, a never-ending process of interaction and building relationships is desirable. This is where each meaningfully contributes to life based on a mutual understanding of individual responsibility and accountability for the good of all.

Consistently, this finding has been uncovered in many studies (Towns *et al.*, 2014:6), that African indigenous people's first line of care is usually within the family and community, either with a healer, indigenous practitioner, or pastoral care. On this basis, some further argue that there is more to human health than modern science has come to avail (De la Porte, 2016:8). Hence, without understanding indigenous Africa, the health-seeking behaviour of human beings will always remain a conundrum to modern ways of life.

These communal therapeutic techniques are categorized as basic or advanced (see Table 5). The discourse commences with basic therapeutic interactions, followed by advanced therapeutic interactions. The discourse will then be closed with the basic and advanced therapeutic interventions.

##### **4.9.2.3.1. Co-category 3.1: Basic therapeutic interactions**

###### *Humility*

Humility is realized as a basic therapeutic interactive skill, as it is supposed to be an inborn ability expected of each communal person. It informs the day-to-day life of the

communal environment. Importantly, humility equips each person in the communal space to appreciate the equality of life for all. This accentuates the impartiality upheld in the functionality of the community. Therefore, humility is a guide for those involved in the management of psychosocial health challenges. Furthermore, humility is demonstrated by a sense of gentleness and compassion in behaviour and language. This is achieved by the softness of feminine nature, coupled with the strength of masculinity for boundary setting. Similarly, modern medicine argues that humility should be a quality ingrained in healing and that openness, self-disclosure, avoidance of arrogance, and a patient-centred approach should always take the lead (Coulehan, 2011:214). Arnold (2013:335) argues this finding by submitting that the power to heal is inspired by humility.

#### *Sharing positive feelings and providing support*

As psychosocial health is understood as a collaborative process, those involved in managing mental health tend to support and share positive emotions with those affected. This can be achieved through physical, spiritual, and emotional support; counselling; and praying, which provide comfort for people with impaired health. This approach was also used by Lala *et al.* (2014), in which a program was developed to share positive messages and offer support in the management of psychosocial health challenges faced by Rwandan genocide survivors.

#### **4.9.2.3.2. Co-category 3.2: Advanced therapeutic interactions**

##### *Storytelling and Metaphors (Covert dialogue)*

Storytelling and metaphors are used as advanced therapeutic skills. Stories are often informed by the culture and traditions of communal contexts, which sometimes demonstrate resilience. This skill is acquired through life experience; hence, it is mostly demonstrated by elders within the community. This skill is important because it provides an element to teaching and learning, as the information is in a form that is easy to remember and at times humoristic yet provides useful guidance through openness and empathy. It is becoming apparent that such softly and firmly pronounced spoken words, imbued with life lessons in the form of stories, are important, as they offer appreciation and understanding of health, illness, and healing. The joint articulation of the benefits of

storytelling and metaphors in the management of psychosocial health has been largely achieved (Burns, 2012 & Hammel, 2018).

### *Meaningful Silence*

The findings indicate that silence cannot be separated from what is being said (i.e., storytelling and metaphors). This is because silence has a therapeutic meaning in spoken words. Therefore, silencing plays an important role in psychosocial health management. The finesse of giving voice to silence and making use of it as a therapeutic tool is mostly found among the elders of the community, as well as those with life experience.

### *Self-resilience disclosure*

Self-resilience disclosure is an essential part of therapeutic interactions in the management of psychosocial health challenges as it provides opportunities for openness, empathy, and rapport. This is usually demonstrated through storytelling, in which the affected individual is encouraged by the communal psychosocial health care giver to reflect on what is being said. This is important for therapeutic skills, as it provides clarity and guidance on the shared process of healing.

### *Patience and respectful waiting (boundary setting)*

Patience and respectful waiting are important because restoring the balance of life begins with the self for the betterment of all. Therefore, the communal counselee is afforded space and time for the clarity of health, illness, and healing. While psychosocial health management is a shared process, a harmonious relationship between others and communal space is always encouraged. In the meantime, the communal counselee is allowed the opportunity for readiness. Equally, forthright honest interventional conversations are used to set boundaries between patience and respectful waiting. This is because everyone is aware that no one's challenges are greater than those of the collective.

#### 4.9.2.3.3. Co-category 3.3: Basic therapeutic interventions

##### *Graveyard visit.*

Graveyard visits to African indigenous communities have been practiced since time immemorial. This relates to the continuity and positionality of life. Because those who passed on do not cease to exist but assume the sacred role of overseeing the life of the family and the broader communal context, they need to be communed with. This continues through a circle of life. This is a basic therapeutic intervention used to manage psychosocial health challenges. This is done with the belief that remembering and visiting the resting places of those who have passed on will bring luck into life and therefore restore the balance of life.

#### 4.9.2.3.4. Co-category 3.4: Advanced therapeutic interventions

The sole purpose of these advanced interventions is to aspire to balance life in the management of psychosocial health challenges. These practices can be led by a traditional healer or an elderly person within a family. As found in this research '*Mpho ya badimo*' is one of the advanced therapeutic interventions used in psychosocial health management. '*Mpho ya badimo*' is a Setswana word which means gifting those who passed on. This is realized as an advanced therapeutic intervention that involves the slaughtering of animals for ritual purposes. Different parts of the meat serve sacred purposes.

Another advanced therapeutic intervention found in this research was *Inxhabasas*, a ritual for a rite of passage for young women who, by age and experience, transition into womanhood. This is a ritual where women in the community, particularly the elderly, play a leading role. For instance, providing communal teachings of humility, respect, sexual health, and womanhood to young women come of age. Furthermore, spiritual practices are found in this research to be advanced therapeutic techniques employed in the management of psychosocial health challenges. This includes the *Vimbuza dance* found in Malawi, and the *trance dance* found in the Khoisan community in South Africa.

##### *Plant medicine use*

Plant medicine has been used in the management of psychosocial health challenges. It is emerging that a medicinal plant called '*Kuleza*' is used for the management of aggressive and irritable behaviours. This is consistent with the findings of Bock (2015:99) that there is medicinal use of plants in the management of aggression by indigenous healers. This finding is better placed in the works of Mphuthi (2015:67-70) and Taaka (2016:36) who argued that healing is a sacred process within African indigenous communities, which necessitated prolonged engagement with nature and medicinal plants. This therefore explains, the special bond with the 'all' in the communal space (Nare, 2016:60).

#### **4.9.3. Inductive synthesis**

The findings of this research confirm the existing literature that communality is fundamental to the realities of African indigenous communities. The 'Communal Psychosocial Lifestyle' emerges to be fundamental to the management of psychosocial health challenges. This is because communality is an embodiment of the ways of life in indigenous communal contexts, which centres around belongingness, mutuality towards the betterment of all, and the co-living systems influenced by African and Western world views, respectively.

Furthermore, it has been found that shared cultural belief systems and the unavoidability of colonial hegemony are important to the management of psychosocial health challenges. Therefore, it influences the co-living systems of the communal context, which then informs the ways of life. This is to say that the approach of emerging psychosocial health management is informed by the African and Western world views, respectively, with some dominance of African ways of living. Hence, in its monolithic nature, psychosocial health is deemed to be inseparable from health, illness, and healing. This is why psychosocial health is upheld as a life-long mutual process in striving for harmonious balance within the interconnectedness of life.

Eventually, MMS emerges, which involves family, community, and curative systems for a holistic approach to the management of psychosocial health challenges. At family and community levels, this approach is self-equipped with communal therapeutic

interventions and interactions. This can range from elders of the family counselling the counselee to an indigenous practitioner prescribing medicinal plants.

#### **D. Theory** (see Table 1, Chapter Three)

To achieve the ***parsimonious, scope and modifiability*** of the theory the researcher and the main supervisor continued to fit the “in vivo” concepts by reflecting on the meaning and pattern, on its relevance. Thus, at this phase of coding, the substance and outcome of the emerging phenomenon is unearthed. Hence, the emerging outcome below.

**4.10. Emerging outcome:** A formal theory for psychosocial health management among Southern African indigenous communities

#### *The scope and parsimony of the theory*

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In an attempt to demonstrate the emerging Grounded Theory, the following are preliminary conceptual definitions:

- **Axiom:** A self-evident reality or statement.
- **Theorem:** A proposition.
- **Connatural equilibrium:** Obtaining the balance of life through natural or cultural means.
- **Equilibrium of choice:** means having a free will to obtain a balance of life.
- **Four-Dimensional Inclusive Communal Psychosocial Health Management for Southern African Indigenous Communities (4IC-PHM-SAIC):** The emerging formal theory.
- **Euclidean geometry:** a mathematical system attributed to the Greek mathematician Euclid of Alexandria.
- **Straight angle:** A geometrical straight line with an angle that is of the value of 180°.
- °: A degree symbol.

Overall, the amassed, comprehensive findings of phase one of the research emerged as Grounded formal theory. This formal theory justifies itself through extensive data constantly compared to different areas of the emerging theory. As demonstrated by Glaser and Holton (2004), the conceptualization of data through coding is the foundation of the Grounded Theory process and development. The four interconnected phases include initial and intermediate coding, further development, and theory. It was through extrapolation from a two-coding process of substantive (open) coding and theoretical coding that this formal theory developed.

As much as the outcome of this phase is a formal theory, Glaser and Strauss (1967:32) highly revere theory as first, a process followed by a process that is never-ending in its formation. That is why going forth, 'formal theory' is referred to interchangeably as theory, Grounded Theory, emerging theory, theory in development, and/or emerging approach.

Thus far, with the emergence of formal theory, the first part of the overall aim of research has been achieved. This was to 'develop' a communal holistic therapeutic approach for psychosocial health management among Southern African indigenous communities. This is measured against the objective of the research (see Chapter One), since Glaser and Strauss (1967:31) give latitude on the presentation and form of the emerging theory. The emerging formal theory is discussed through a theoretical discourse involving four dimensions, comprising four core categories. The researcher commences the discussion with the first, second, third, and fourth dimensions, followed by their crystallization, as presented in the different theoretical discourses under each dimension as grounded in the findings. Below are two diagrammatic representations of the theory of development:

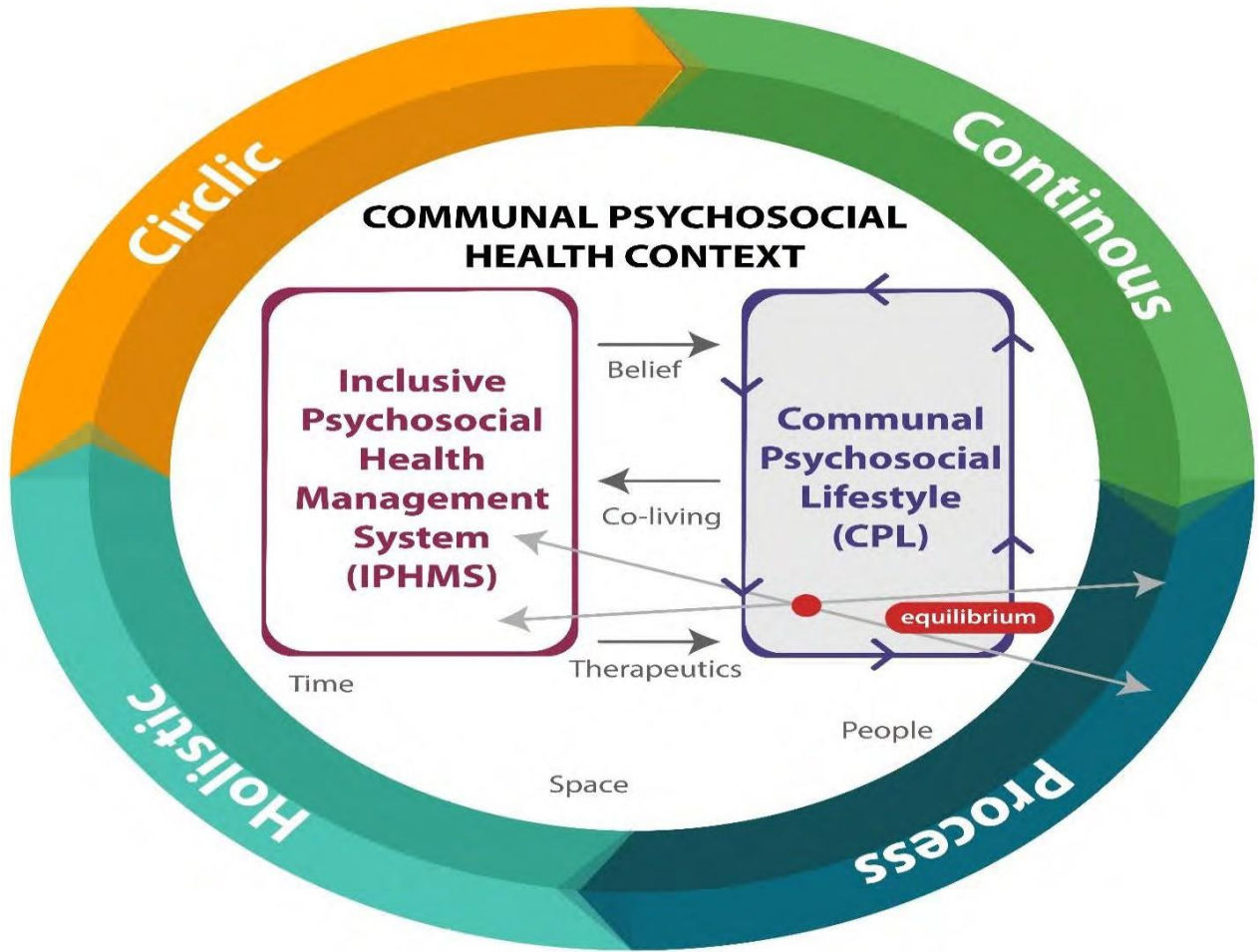


Figure 11: A proposed conceptual map of the formal theory.

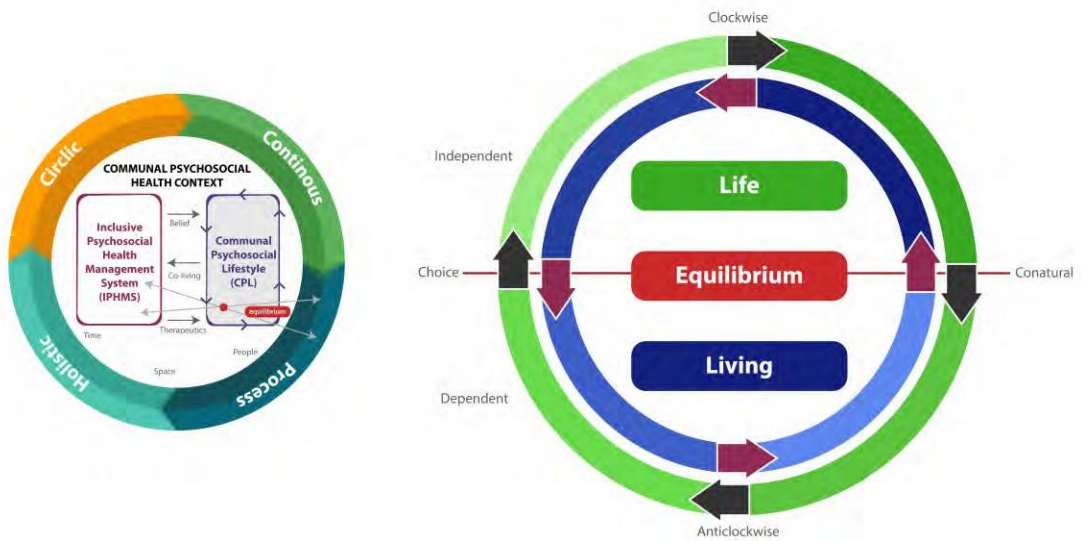


Figure 12: Dimensions of the formal theory.

## 1. FIRST DIMENSION: MEANING OF LIFE

### ***CULTURAL-AXIOMATIC STATEMENT I: LIFE IS A HOLISTIC-CIRCLIC CONTINUOUS PROCESS. THEREFORE, INDEPENDENT.***

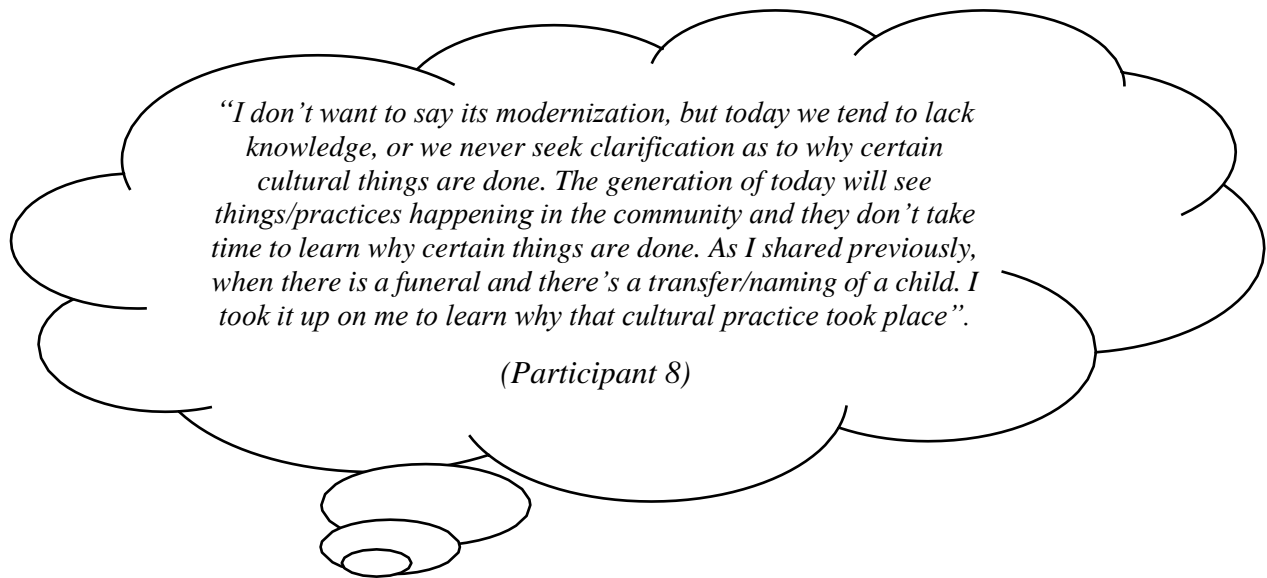
*Life happens even if we are not living it.*

As demonstrated above, Dimension One: Cultural-Axiom I. It is represented by the green colour (see Figure 12), as seen in the outer circle of Figure 11. This theoretical discourse cements the philosophical standing of the theory in development by referring to life. This illustrates that psychosocial health management in communal spaces cannot be separated from meaning of life. Hence, life is described as imperative and interconnected to one's communal being sourcing its circlic energy from the communal nature and the interconnectedness with the living and those who were here before.

Essentially, this dimension elongates the inescapability of the cultural axioms found in communal spaces. As defined by the Cambridge Dictionary, an axiom is a self-evident truth found in mathematics and other areas of science that is widely accepted as the premise upon which other truths can be built. Furthermore, the Merriam-Webster dictionary states that this truth is self-evident; therefore, it is nonprovable. In addition, based on Cantù, (2022:3), Goldberg (2022), Bernardo and Nalipay, (2016:110-111) and Burgess, (2011), this research synthesizes the meaning and application of axiom as a founding principle of sets of beliefs used for order and relations between those who were here before us, the living, and the environment for beneficial outcomes. Therefore, they are critical in forming foundational grounds for a community's worldview, knowledge, and practices.

Hence, life, according to this cultural axiom, is understood to be independent. Cultural realities do not change with time or people in such communal spaces. Thus, life as a dimension of the theory of development emerges to explain this befittingly. Therefore, whether a person is knowledgeable about the meaning of life, or the epistemic undertaking of life remains intact. For instance, the connection between those who have passed on and living is an eventuality that locates the cultural realities of a communal

space. Therefore, whether an individual is aware or not, his/her physical presence on Earth is in solitary sync with those who have passed on.

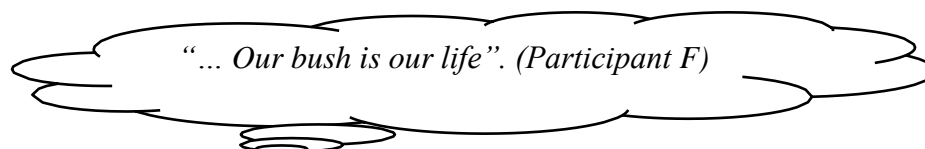


Equally, the source of life among communal persons is found in, but not limited to, the divinities, reification of nature, and the communal self. However, this is regardless of episodic interruptions or whether communal people are aware of the doctrines of life. Hence, in psychosocial health management, whether a communal person is aware or upholds the belief that life is a holistic-circlie continuous process, life continues accordingly. Nevertheless, it remains the mutual responsibility of the broader community to pass this knowledge from generation to generation. Hitherto, as stated in the conceptual framework, one's choice is to maintain harmonious balance with the circle of life.

Similarly, Dimension One of this theory in development seeks to position itself as embedded in the findings, independent of other dimensions. This position is further exemplified through the appreciation of the *wheel of life* in that life independently circles clockwise, and living dependent on this circle anticipates anticlockwise. As already established, life continues in its holistic-circlie nature, independent of one's life choices. However, this dimension is also of fundamental importance in etymological, epistemological, and ontological practices in psychosocial health management.

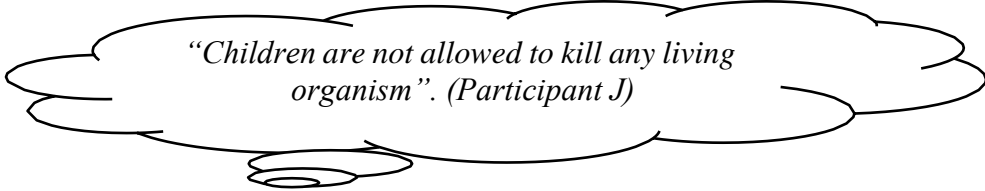
### **Theoretical discourse: Holistic-circlic continues process.**

In accentuating the fundamentality of Dimension One further, the holistic-circlic continuous process emerges as a theoretical discourse (see the Figure 11). This outer circle forming the diagram of the theory epitomizes the emerging meaning that life is a holistic-circlic continuous process. Its diagrammatic positioning represents its independence and principal importance (see Figure 11). Essentially, this explains the ontological meaning of life and how it relates to other dimensions of the theory, as well as how important the meaning of life is to psychosocial health management, particularly in a communal space. Life, as it was compared to the different areas of the data concerning the management of psychosocial health within indigenous communities, has emerged as a holistic, circlic, and continuous process. First, the theory of development emphasizes that life within a communal space is holistic. This is because it is interconnected with all that is found in a communal space, inclusive of the living, cosmology, those who passed on, and the eventualities of the future (yet-to-be-born). For example, in the management of psychosocial health, the importance of plant reification is heightened and relates to the meaning and everlastingness of life. It is, therefore, evident that nature carries a significant meaning towards a communal person's psychosocial well-being and resilience.



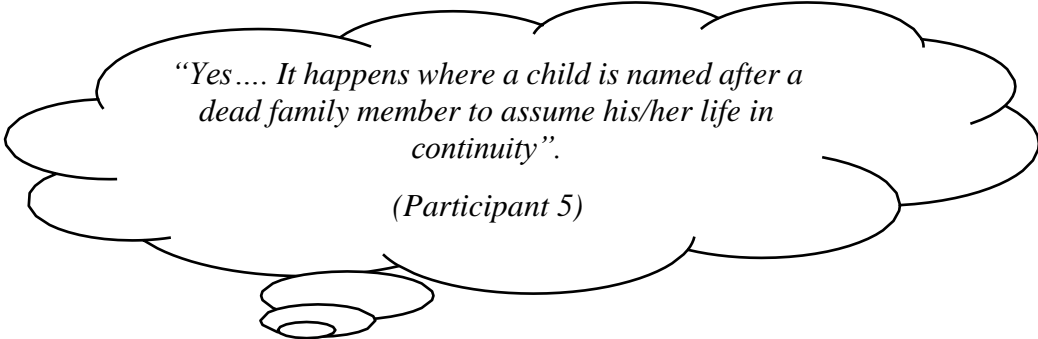
*“... Our bush is our life”. (Participant F)*

Second, life is a circlic process, as the data illuminates its ever-lastingness yet, a precious eventuality. This development demonstrates the sufficiency of data on how life circles within the communal space (the living, cosmos, those who were here before us, and the yet-to-born) place less weight on physical existence. For instance, communality during death, where communal persons are buried together to continue to commune. Important to this circlic nature of life is its preciousness, where regard of the highest order is reserved for the communal space and all that is inclusive of it.



*“Children are not allowed to kill any living organism”. (Participant J)*

Finally, the continuity elements of life related to psychosocial health management were compared in different areas of the data. This demonstrates that life is continuous precisely because, when a communal person passes on, they only lose their physical existence to assume a different role in life. For psychosocial health management, this is significant, as communal persons grieve the passing over with the understanding of positionality and following the process of life instead of the pain generally attached to death. However, the delegation of roles is as important as the continuity of life, where the transference of life and mutual responsibility take precedence.



*“Yes.... It happens where a child is named after a dead family member to assume his/her life in continuity”.*

*(Participant 5)*

Hence, in no uncertain terms, this theoretical discourse informs the emerging approach that the meaning of life in psychosocial health management is a fundamental issue. This is because the health management approach should aim to achieve a harmonious balance between life and living to achieve good health.

## **2. SECOND DIMENSION: EQUILIBRIUM OR BALANCE OF LIFE AND LIVING**

***CULTURAL-AXIOMATIC STATEMENT II: IF LIFE IS INDEPENDENT; THE POINT OF EQUILIBRIUM IS THE SENSE OF BALANCE BETWEEN LIFE AND LIVING.***

*Genuine living interconnects balance with Life*

Dimension Two is referred to as the equilibrium (see Figure 11 & 12). Dimension Two of the theory in development constitutes the second theoretical discourse of the emerging theory. This theoretical discourse builds on the philosophical outlook of the theory in development. Fundamentally, Dimension Two is where the ontological meaning of life meets the choices of living (lifestyle) and anticipates harmonious balance (good health). Therefore, this dimension acting as an insulator is dependent on both the living choices of a communal individual and the cultural axiom of life.

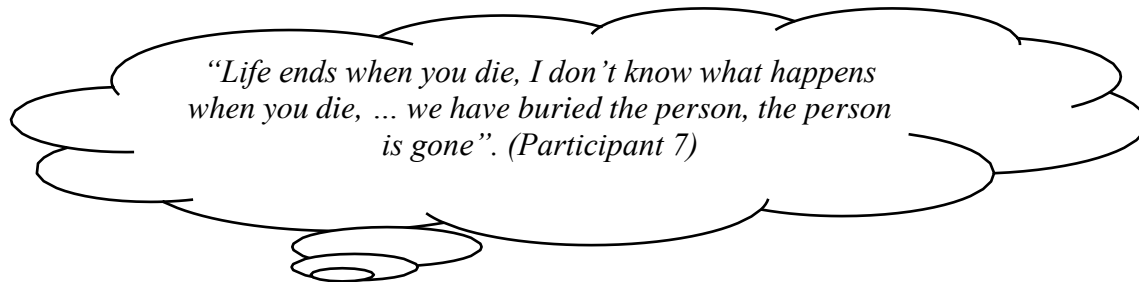
This dimension of the formal theory is intricate in two ways. First, connatural equilibrium is manifested by the innate mutual responsibility of communal persons to balance life and transfer it to the next generation. For instance, practising communal therapeutic interventions and interactions for the betterment of the communal space (inclusive of all). In doing so, knowledge and practices are mutually transferred to young people within the community.

Lastly, the equilibrium of choice is another facet of the dimension in which communal persons stand to find other means of attaining balance with life. For instance, Western-inclined practices include pastoral care, faith-based healing, and curative care services. This dimension demonstrates that the attainment of a harmonious balance between life and living is of central importance. Therefore, the theory of development focuses on a balance of life to achieve good health.

### **Theoretical discourse: Inclusive Psychosocial Health Management System (IPHM)**

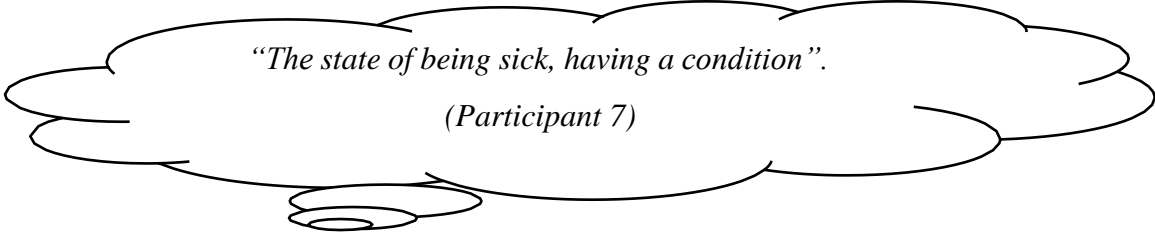
This theoretical discourse is found in the inner circle of the diagram of the theory in development, coloured in yellow (see Figure 11). This discourse represents the fundamental ontological and etymological importance in the management of psychosocial health. There is a large amount of confirmatory data on communality and shared belief systems concerning psychosocial health management. The unavoidable emergence of Westernized, inclined realities within the communal psychosocial health context impedes in some cases. They may seem benign, but their polarizing dichotomy of worldviews is inescapable. Hence, the theory in development seeks to advocate for the inclusion of

both cultural experiences in the management of psychosocial health among indigenous communities (Pinkoane *et al.*, 2012:18 & Harfield *et al.*, 2018:8).



Ontologically, the theory in development argues that the Western worldview realizes life as compartmental eventuality. This view posits that life is a product of one’s physical existence. However, the intersection of communal therapeutic techniques between the two worldviews is an important ontological development of the formal theory. Such spiritual practices imbricate faith-based churches by communal individuals because of religionization. Furthermore, the developing theory is sensitive to the finding that some communal persons do not practice basic therapeutic interventions for the management of psychosocial health challenges. For instance, not visiting the graveyards. The formal theory is further appreciative of the brutal effects of colonialism, slavery, and the migration of communal persons to cities. Evidentially, these have influenced the ways of life within communal spaces.

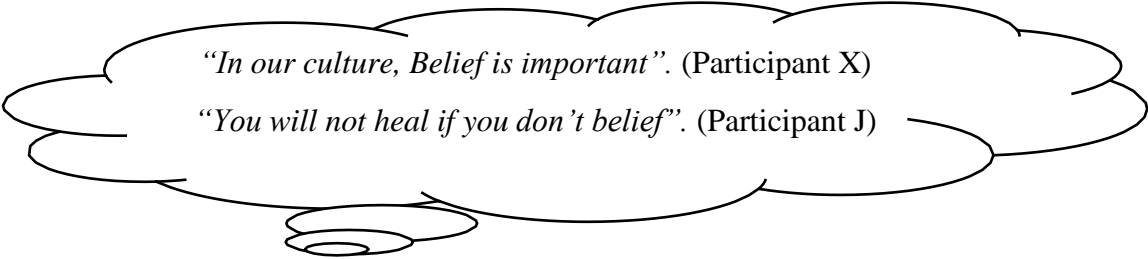
Similarly, etymologically, the findings demonstrate that the use of language and the meaning thereof represent a compartmental phenomenon. For example, the findings inform the theory in development that some within the communal space understand illness as mere physical injury. In such cases, individuals have the choice to seek curative-inclined health services. All-encompassed, IPHM seeks to be respectful, sensitive, appreciative, and inclusive of all within the communal psychosocial health context.



*“The state of being sick, having a condition”.*

*(Participant 7)*

On the other hand, there is an overwhelming confirmatory finding on the African worldview that demonstrates life as a holistic-circlic continuous process. First, its ontological meaning relates to rootedness in the reality of communality and shared cultural belief systems among communal persons. This is significant in offering a sense of meaning to the workings of life in a communal space. The principal of this shared belief is the appreciation of the developing theory that the interconnectedness of life to the communal space, the living, those who passed on, and the yet-to-be-born (cosmos) is essential. Therefore, inclusion of a belief system is fundamental to an emerging approach in the management of psychosocial health.



*“In our culture, Belief is important”.* (Participant X)

*“You will not heal if you don’t believe”.* (Participant J)

This inclusive approach identifies the philosophical underpinnings of a communal psychosocial health context, prompting etymological injunctions. This dictates the emerging theory to uphold the utmost holistic and interconnectedness of life, communal person, health, illness, and healing in the meaning of psychosocial health. Thus, psychosocial health is a fundamental phenomenon in the shared belief of a holistic-circlic continuous process. Hence, mutual responsibility among communal persons on striving for a harmonious balance of life is central to the management of psychosocial health. Given this foundation, the formal theory in its inclusive nature receives psychosocial health as a never-ending interaction between the holistic and interconnectedness of life in striving for a harmonious balance between life and living.

### 3. THIRD DIMENSION: GENUINE LIVING OF LIFE

#### ***CULTURAL-AXIOM III: IF LIFE IS INDEPENDENT AND EQUILIBRIUM IS INTERCONNECTED TO LIFE AND LIVING; LIVING IS DYNAMICALLY INTERDEPENDENT ON LIFE***

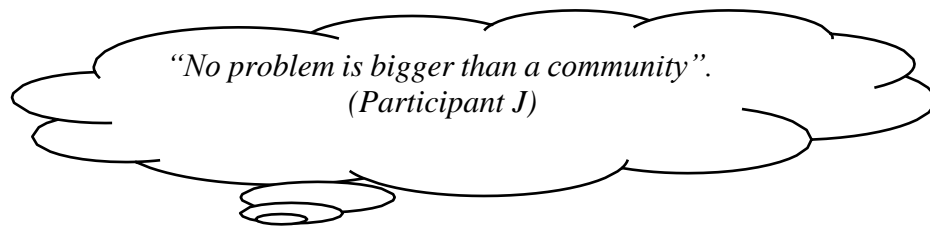
*To genuinely Live, we need to balance ourselves anticlockwise with the clockwise circle of Life to gain the power to push against the challenges of life.*

Dimension Three of the formal theory is referred to as living (see Figure 12) comprising the third theoretical discourse on the psychosocial health management system of indigenous Southern African communities. This dimension positions the importance of ways of living as far as the management of psychosocial health is concerned. This is based on the established philosophical standing of a communal context of life as not independent of its holistic-circlic continuous process. Therefore, living is dependent on the clockwise motion of life to eventualize its anticlockwise movement. Under these circumstances, the choice of way of living remains the prerogative of a communal individual. Hence, ways of life concerning psychosocial health management depend on the individual's application of the meaning of life. This is knitted upon together with the appreciation of the connatural equilibrium and equilibrium of choice. For example, an individual can agree with the Western worldview that life remains just evidence of physical existence. Therefore, to that believer, illness is merely a physical injury. However, another individual can uphold the opposite side of the cultural reality by upholding the African worldview. Hence, illness is a manifestation of the imbalance between life and living. As already established, the developing theory is sensitive, respectful, and competent in enveloping opposing ways of life in its psychosocial health management approach.

#### **Theoretical discourse: Communal Psychosocial Lifestyle (CPL)**

This theoretical discourse is referred to as the Communal Psychosocial Lifestyle (CPL). Diagrammatically, CPL is represented in the inner circle of the diagram, as can be seen in its grey colour (see Figure 11). Based on the data, the developing theory posits that communality is a central phenomenon in managing psychosocial health challenges. In so doing, the developing theory appreciates the importance of communality in the holistic

functioning of indigenous communities. Hence, the inclusion of ways of life in the management of psychosocial health is justifiable.



It is clear that the management of psychosocial health challenges is inherent in communal lifestyles. Important to this theoretical foundation is the shared belief systems and communal therapeutic techniques that are inseparable from lifestyle. Further, it is the mutual duty among communal persons to attain the equilibrium (connatural or by choice) of life to achieve good health.

However, the theory in development is alive to the reality that CPL is also informed by the co-living systems found in communal contexts. As already alluded to, living systems appreciate life from polarizing dichotomous worldviews. Hence, within the CPL, some individuals may, by choice, agree with Western worldviews as opposed to African ways of life. Even in that eventuality, the emerging approach is inclusive of all within the communal psychosocial health context.

In addition, to the finding that psychosocial health management is a matter of lifestyle, the theory in development demonstrates its cultural competence and congruence by managing psychosocial health challenges at the family level. This level involves communal individuals with experiences in life, such as elders and others, with the needed communal therapeutic skills. These include humility, support, and respectful waiting. If the challenge is not resolved at the family level, the problem is referred to the community. This level may include indigenous healers, faith-based healers, community leaders, village heads, chiefs, and local courts. Therapeutic interventions applied at this level include, but are not limited to, plant medicine and ‘*Mpho ya badimo*’.

Western-qualified, culturally competent, or Western therapists are also referred to at this level, but still based in the communal setting. The latter emphasizes the inclusiveness of

care in this emerging theory. Similarly, if psychosocial health is not resolved, the challenge is referred to as the curative setting (i.e., a clinic or hospital). However, because psychosocial health management is a mutual duty of all, even at the curative level, families and communities are involved in the care of their people. For instance, the theory in development advocates for the co-existence of indigenous and Western health medicine within the curative systems, where these communal therapeutic techniques form part of the care; therefore, they are inclusive-holistic.

#### **4. FOURTH DIMENSION: COMMUNAL PSYCHOSOCIAL HEALTH CONTEXT (CPHC)**

***AXIOMATIC STATEMENT IV: A BELIEF SYSTEM IS SHARED AND APPRECIATED BY ALL WITHIN A GIVEN COMMUNAL CONTEXT.***

*The power of the belief is embedded in the communal unity and sharing.*

This dimension is positioned within the cyclic structure of the formal theory (see Figure 11). The dimension is coloured brown and is referred to as the Communal Psychosocial Health Context (CPHC). Dimension Four encompasses the fourth theoretical foundation for the theory in development. CPHC seeks to allot context by delving into the position of the formal theory as far as time, space, and people are concerned.

In doing so, the theory in development appreciates this within the communal context. When a psychosocial health challenge arises, it is understood that the challenge is the result of an imbalance between life and living. Thus, in this context, a psychosocial health challenge is understood as a shared event among communal persons. In this case, its management is communal therapeutic techniques, and it commences from the family to the curative level where needed. Importantly, this shared process is for the community, and by the community.

#### **Theoretical discourse: Time, space, and people culture**

*Belief systems are influenced by internal and external ontologies, epistemologies, and practices.*

The emerging approach finds it important to contextualize the current times, space, and people in which the developing theory finds itself. Even though evidence of African indigenous ways of life has stood the test of time, it is not an issue of debate. First, emerging formal theory demonstrates the ability to concede the finding that Africa has suffered the influence of Westernization and Christianization. This has been evident in this research to cause dilution and loss of culture (Cumes, 2013:65) but also, the evolution of culture for invention and adaptation (Idang, 2015:106).

However, it is not the intention of the theory in development to determine whether this influence is positive or negative. At the same time, it is of paramount importance to bring forth these emerging findings. For instance, communal persons are unable to continue to commune because of migration and dispossession when they pass on. Equally, for several reasons, the existing dichotomy of the two worldviews brings about doubt about the authenticity of African science. However, this polarizing dichotomy opens the opportunity to choose one's preferred way of life. The latter is equally important as the emerging approach in the management of psychosocial health challenges. For this reason, the developing theory is inclusive and culturally competent to all that is within a communal context. Essentially, this is also a mechanism for the emerging approach of self-updating over time.

Importantly, the theory in development finds it fit to delineate the space in which it finds itself. As these findings emerge, communality takes the lead in life and living embedded in a shared belief system. This is realized when people live life with humility and shared responsibility to restore a harmonious balance of life. Equally, psychosocial health within this space is an interconnected, shared, purposeful life-long endeavour that is meaningful for maintaining a harmonious balance between life and living to achieve good health in a communal context. Therefore, psychosocial health management is rooted in lifestyle. At the same time, however, the space presents evidence of Westernization, religionization, and post-colonial hegemony. As already admitted, the emerging approach is alive to this, and therefore, is adaptive to opposing cultural realities.

#### 4.11. Theoretical Assumptions and Conclusions

The preliminary assumptions of this emerging theory corroborate the empirical evidence found in biomedical sciences since the 1700s, where probability theorems were used for medical diagnosis informed by mathematical principles (Bayes, 1763). This was also substantiated by Robert Koch through the 1800s by providing evidence of what is now known as Koch's postulate (Fredericks & Relam, 1996:18). Koch argued that there is existence of a relationship between a pathogen and a disease in every event of an infectious disease (Fredericks & Relman, 1996:19). Since then, throughout the years, this establishment, meaning the fundamentality of theorems in medical diagnosis, is currently being pursued by many other scholars in medical sciences, and in recent times this can be traced in the works of Ayim-Aboagye (2019).

Therefore, in this research, it can be assumed that the emerging theory finds confirmatory meaning with mathematical expressions grounded by axioms through mathematical reasoning. Hence, with the theorem of Euclidean governing geometry, axioms articulate self-evident statements. These include, for instance, the theorem that the distance between two parallel lines is always constant because they have no common point. Therefore, if the distance between the two lines remains constant, the lines will be parallel (Morino, 2021:186). From this, sets of mathematical rules are built. For example, a straight angle always constitutes a straight line with a value of  $180^\circ$ .

Similarly, this explains the four dimensions of the theory emerging in this research, which are dependent on the belief that life is a holistic-circlis continuous process. Therefore, from this self-evident truth, the theoretical discourse forming the theory aligns with a mathematical-like order. For example, the shared belief that a psychosocial health challenge is a manifestation of the disharmony between life and living. It provides this cultural axiom in a communal space, restoring that imbalance to a harmonious point of equilibrium remains a communal role. This is where a shared belief models the appreciation that health, illness, and healing locate their holistic and continual expressions from the holistic-circlis continuous process of life.

Thus, emerging from this research with axiomatic statements and sets of rules expressing cultural meanings for societal order is a ***Four-Dimensional Inclusive-holistic Communal Psychosocial Health Management for Southern African Indigenous Communities (4IC-PHM-SAIC)*** theory.

Holistically, psychosocial health is understood as an interconnected, shared, purposeful, life-long endeavour, meaningful to maintain a harmonious balance between life and living, to achieve the wellness of a communal context. Embedded within the established chorus of the shared belief system is the cultural truth that life is holistic-circlie and continuous. With this foundation comes the appreciation that time, people, and space are important to the effectiveness, adaptability, and culture-competent psychosocial health management approach.

Importantly, this emerging approach prides itself in the inclusion of both African and Western worldviews. This unique appeal of the developing theory posits that it is a culturally competent and congruent approach to psychosocial health management. This emerging approach is accessible and cost-effective because it is designed as the first line of contact for psychosocial health care, inclusive of the curative system. Hence, a ***Four-Dimensional Inclusive-holistic Communal Psychosocial Health Management for Southern African Indigenous Communities (4IC-PHM-SAIC)*** theory is proposed.

This emerging theory is inclusive first in its etymology, where fundamental meanings of health, illness, healing, and psychosocial health are interconnected, with the difference being the attainment or lack of a harmonious balance of life. This fundamentality aids in achieving a harmonious balance of life within a communal context in psychosocial health management. Central to this is the ontological inclusion of a shared belief system among the persons living within communal contexts. However, the epistemological inclusiveness of its communal persons with gender takes a posterior position with significance in humility and Ubuntu. Thus, shared belief systems and communal therapeutic techniques are devoted to lifestyles. It is at this point that the mutual responsibility of achieving a harmonious balance of life takes precedence in achieving good health for all.

Furthermore, this theory in development demonstrates ontological inclusiveness. This is because psychosocial health management is first approved and accepted by the community. The approach focuses holistically on physical health, mental, emotions, spirit, surroundings (cosmos, living, and those who passed on), and economic dimensions of life. However, it is also the never-ending process of harmonious interaction and relations between a communal person and others and the communal space.

This emerging approach is holistic, cost effective, and accessible. This system includes all the available resources in the communal context. Resources such as medicinal plants, indigenous healers, elders, and faith-based healers are readily available in the communal context, except for curative care, which may require logistical costs for travelling, and at times with the private sector, a service fee is imposed. What is unique in the emerging constructs of this research is that psychosocial health is attached to the meaning of life, the lifestyle of an individual, and, importantly, the context within which one finds themselves.

## Chapter Five

# *QUALITATIVE STRAND*

## PHASE II:

### Critical, Integrative Review

*The emerging Middle-range Theory: From Formal Theory to Hypothetical Models.*

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#### 5.1. Introduction

This chapter advances the emerging Middle-range theory of psychosocial health management from the formal theory level to a hypothetical models. The previous chapter discussed the emerging Middle-range theory, utilizing a rigorous Grounded Theory process (Phase I). The findings of Phase One of the research were used to carry out this chapter (Phase Two) by advancing from formal theory into a hypothetical models. Thus, this chapter expands on the qualitative strand of the research by conducting a critical integrative review to develop and form hypothetical models for the progression of the emerging middle-range theory.

The overall aim of this research was to develop, confirm, and validate a communal holistic therapeutic approach for psychosocial health management among Southern African indigenous communities. This chapter, however, continues to address the development aspect of the overall aim, including Objective Two of the research by conducting a critical, integrative literature review to compare and contrast the constructs that emerged from the formal theory against alternative models found in the existing literature. This undertaking followed the inductive-deductive theory generation process, as illustrated in Figure 3 (see Chapter Two).

## 5.2. Preliminary considerations

This chapter achieved the inductive and deductive theory generation approach (see Chapter Two, Figure 3) by following the guidance of Elo *et al.* (2013), Torraco (2005), Torraco (2016a), Torraco (2016b), Snyder (2019), and Glaser and Strauss (2006:21-43). The inductive-deductive theory generation process used in this research, as demonstrated in Figure 3 (see Chapter Two), involves Processes One to Four of theory generation. This chapter focuses on Process Two, which is inductive, and Process Three, which is deductive. Therefore, Process Two was achieved through the development (inception) of the hypothetical models, whereas Process Three is demonstrated in this chapter by the formation (conceptualization) of the hypothetical models.

Following the aim and Objective Two of the research (see Chapter One), the topic herein is *The communal holistic therapeutic approach for psychosocial health management among Southern African indigenous communities*. Therefore, the need and purpose of this critical, integrative review, and eventually the development of hypothetical models, is to confirm and generate new knowledge about the communal holistic therapeutic approach for psychosocial health management among Southern African indigenous communities (Torraco, 2016b:65 & Elo *et al.*, 2013:3). Thus, the development and formation of the hypothetical model was achieved through a joint process of inductive and deductive drawing strength, as reported by Torraco (2005), Torraco (2016a), Torraco (2016b), Snyder (2019), Elo *et al.* (2013), and Glaser and Strauss (2006).

A critical, integrative literature review was employed in this phase of the research as it **reviews, critiques, and synthesizes** representative literature on a phenomenon in an integrated manner, aiming for new frameworks and perspectives (Torraco, 2005:356; Torraco, 2016a:1 & Torraco, 2016b:62). Accordingly, the research achieved the **review** standard expected methodologically (see 5.3 to 5.4) by identifying and sampling the relevant literature for the review, utilizing a clear criterion for retention and discarding (Torraco, 2016b:65). This competent review avoided conveniently sampling the literature by allowing search limitations to be guided by the aims and objectives of the research (Snyder, 2019). Therefore, **critical** analysis of the relevant sampled literature ensued by identifying the strengths and key contributions of the literature as well as expounding on

deficiencies, omissions, inaccuracies, and other problematic contentions of the literature (Torraco, 2016b:63 & Torraco, 2005:361).

Additionally, a competent review and **synthesis** were achieved through an inventive and pragmatic generation of new knowledge to advance the field through new meanings and assumptions. All of these were carried out through rigorous integration of arguments on the phenomenon. To further advance the critique and synthesis, this research employed constant comparative analysis, as guided by Glaser and Strauss (2006:101-113).

Finally, as suggested by Torraco (2016b:65) and Elo *et al.* (2013:3) the phenomenon under research has been reasonably demystified as a new emerging theory. During extensive literature searches, the primary researcher found limited literature regarding this research topic. However, because this research sphere is new, it is valuable to compare and contrast the available literature with emerging theory. Henceforth, Snyder (2019) advises a four-phase process of conducting a literature review, namely, designing the review, conducting the review, analysing, and writing up the review. Torraco's (2016a) advice is for logical flow, which is referred to in this research as parts one, two, three, and four. This is discussed below:

### **5.3. Methods**

#### ***Part One: Designing the review.***

Primarily, keywords and phrases for the search strategy were informed by the developed core constructs from the previous phase of the research (Phase I). These keywords were further revised through consensus discussion with two independent reviewers. This undertaking was achieved by carefully aligning Aim and Objective Two of the research with the constructs from the previous phase.

The search began with clarity, seeking conceptual consistency through a pilot search informed by the main constructs that emerged from the previous phase of the research (see Phase I). The pilot study produced a large, uncontrollable sample, even after narrowing the search strategy. This led the researcher, in consultative consensus of the independent reviewers, to limit the sample to randomised controlled trials (RCT) in mental or psychosocial health management across worldviews. This informed change was to

achieve the intended objective of the chapter, as it is to compare and contrast the constructs that emerged from the formal theory against alternative models from existing literature (see Objective Two of the research).

*Part Two:* **Conducting the review (Sampling and Data collection).**

**Table 6:** Databases searched.

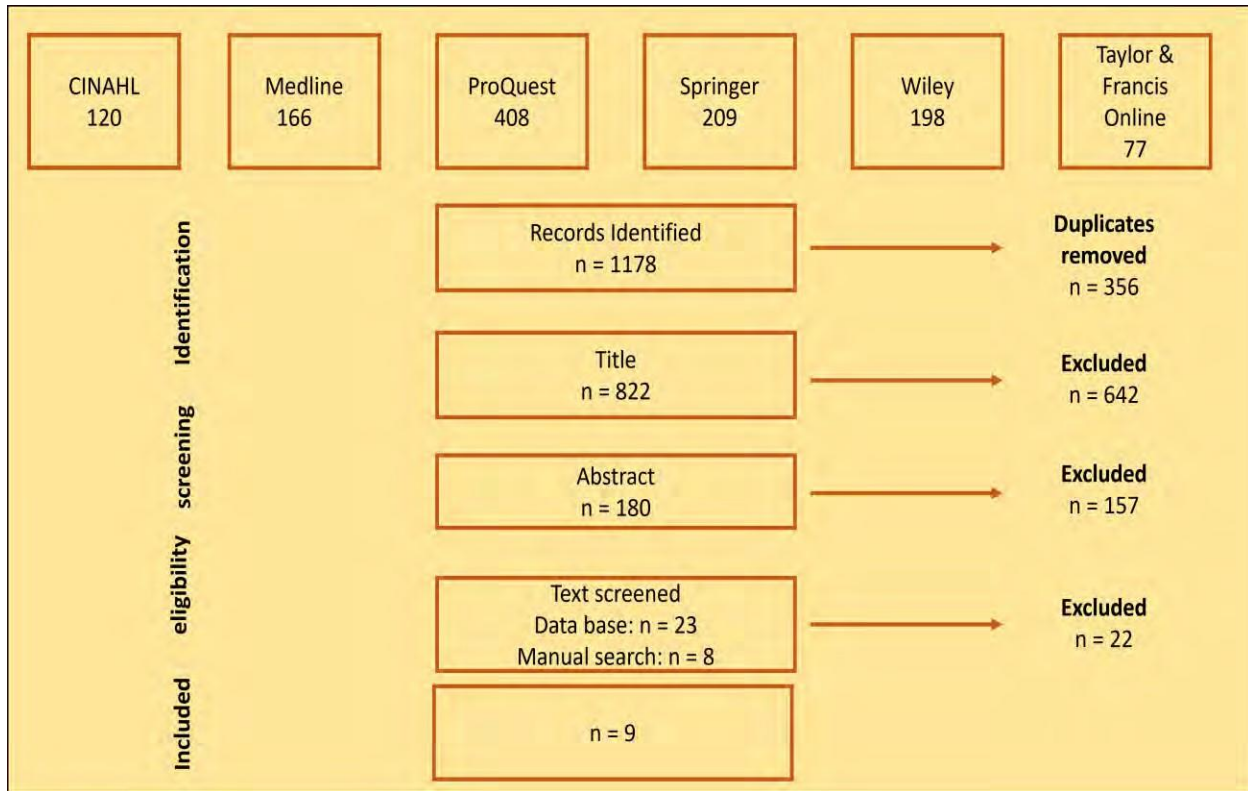
<b>DATABASES SEARCHED</b>	
<b>Data Bases Searched</b>	<b>Relevant Results</b>
CINHAL with full Text (via EBSCO host web)	Yes
MEDLINE (via EBSCO host web)	Yes
ProQuest	Yes
Springer Nature	Yes
Wiley Online Library	Yes
Taylor & Francis Online	Yes

Data were sampled from tabulated electronic databases. This was followed by surfing and excluding duplicate samples (Ruiz *et al.*, 2021:3). To offer as much quality of sampling as possible, a manual search through Google Scholar was performed using the reference list of the papers sampled. Search expanders and subject headings were applied consistently as the different databases were used. This was achieved with the databases used through the EBSCOhost web. Table 6 shows the databases that yielded the relevant results. The time frame of the search was unlimited. Therefore, the search terms and phrases that yielded the results most relevant to the objective are as follows:

*(“mental OR psychosocial health management approach OR theory OR program OR model”)*

*AND (“Mental health management theory”) AND (“psychosocial health theory”) AND (“community mental health programs”)*

Samples were included based on the following criteria: accessible and available in English, samples from an accredited and peer-reviewed journal, a primary source presenting original research findings of RCTs and the research aim, or objectives or questions containing psychosocial/mental health management with no time limitation. The criteria also included RCTs presenting results within the context of community mental health or primary healthcare. Exclusion criteria were as follows: unpublished manuscripts, review articles, secondary sources, books, and reports. Also excluded were conference works, opinion works, articles from unaccredited journals, articles from non-peer-reviewed journals, editorial papers, publications of the same original work, and research that did not involve psychosocial/mental health management.



**Source:** Adjusted from Al Thobaity and Alshammari (2020)

**Figure 13:** Article selection process

The figure above demonstrates the initial identification process to the final included sample (see Figure 13). The retention and discarding process ensued by methodically assessing the compliance of each paper against the inclusion and exclusion criteria. This involved a process whereby papers were screened based on title, then abstract. Samples were excluded if they showed no compliance. However, a full assessment of the manuscript was attempted prior to initially excluding or including the paper even where the title or abstract showed little or no relevance (Steel *et al.*, 2015:227). In addition, to advance the scope of the search and the final sample, references in the selected articles were scrutinized to identify other referenced articles that may add great value to the review (Snyder, 2016:337).

**Part three:** Analysis (**Data analysis**).

**Table 7:** Emerging findings from the review.



The Table above provides a summary of the findings that emerged from the review. The analysis of this review involved critical analysis, where deconstructions of the main findings of the literature ensued by carefully studying the relationships between the concepts to advance the emerging theory and critique where needed. Furthermore, a comprehensive synthesis and constant comparative analysis guided by Glaser and Strauss (1967:101-113) were performed for the development and formation of hypothetical models.

#### **5.4. Writing a review that is integrative, definitive, and provocative.**

##### ***Part Four. Description of the review***

The main finding of this review is the significance of community involvement and meaningful community participation in psychosocial health management, directly strengthening the construct of 'communal ways of life.' In this chapter, this is coined as a

core concept that emerges from the findings. This core concept is labelled increased community involvement and participation. The discourse for the description of this review follows various conceptual properties that form the core concept. Eight randomized trials and one pilot study sampled, critically reviewed, and synthesized in this study were conducted in eight (8) different countries. The summary table below demonstrates the settings of the studies, titles, and authors of the selected articles.

**Table 8:** Summary of the sampled literature

**SUMMARY TABLE OF THE SAMPLE**

S. No.	Authors, Date	Title	Setting
1.	Chibanda et al. 2011	Problem-solving therapy for depression and common mental disorders in Zimbabwe: piloting a task-shifting primary mental health care intervention in a population with a high prevalence of people living with HIV.	Zimbabwe
2.	Bolton et al. 2003	Group Interpersonal Psychotherapy for Depression in Rural Uganda a Randomized Controlled Trial.	Uganda
3.	Rahman et al. 2008	Cognitive behavior therapy-based intervention by community health workers for mothers with depression and their infants in rural Pakistan: a cluster-randomized controlled trial.	Pakistan
4.	Boisits et al. 2021	Developing a task-sharing psychological intervention to treat mild to moderate symptoms of perinatal depression and anxiety in South Africa: a mixed-method formative study.	South Africa
5.	Araya et al. 2003	Treating depression in primary care in low-income women in Santiago, Chile: a randomized controlled trial.	Chile
6.	Vanden Bossche et al. 2021	Community health workers as a strategy to tackle psychosocial suffering due to physical distancing: a randomized controlled trial.	Belgium
7.	Rahman et al. 2019	Using technology to scale-up training and supervision of community health workers in the psychosocial management of perinatal depression: a non-inferiority, randomized controlled trial.	Pakistan
8.	Malt et al. 1999	The Norwegian naturalistic treatment study of depression in general practice (NORDEP) – I: randomized double-blind study.	Norway
9.	Katon et al. 1996	A multifaceted intervention to improve treatment of depression in primary care.	United States of America

#### **5.4.1. Core concept: Increased community involvement and participation.**

The discussion unfolds first by breaking down the core concept and deliberating on increased community involvement and participation separately. The core concept is then assimilated through a discussion of the conceptual properties. This discussion will be followed by the development and formation of hypothetical models. At the granular level, it is emerging that mental healthcare shows beneficial outcomes when community members find a meaningful voice and actively participate in the care provided to them.

Fundamentally, the findings of this review demonstrate that increased community involvement can be located at the etymological and ontological levels of healthcare. Simply put, the resources of psychosocial health care services pertinent to psychosocial health management should resonate with the indigenous people. A pilot test conducted by Chibanda *et al.* (2011) measured the feasibility and effectiveness of friendship bench" intervention in Zimbabwe. It found the importance of the use of indigenous tools in elevating the meaning and application of the intervention. In addition, the meaning of the symptoms and the diagnosis of common mental health disorders were significantly beneficial to the positive outcome of the intervention. Simultaneously, there was an amassing of the etymological and ontological meanings of the study. For example, the main outcome measure of the intervention was the Shona Symptom Questionnaire (SSQ). The SSQ is demystified in the paper as a screening tool consisting of 14 items of indigenous idioms corroborated with widely accepted taxonomic and diagnostic items (Chibanda *et al.*, 2011:4). Indigenous language was used in most instances. For instance, "the friendship bench" was referred to in the local language as '*Chigaro Chekupana-mazano*' (sic) (Chibanda *et al.*, 2011:2).

Furthermore, community involvement also became evident by insourcing craftsmanship from the people of the same community to craft the bench used for the intervention (Chibanda *et al.*, 2011:4). At the centre, the involvement of lay workers from the community was of paramount importance. This was also established in the work of Bolton *et al.* (2003:3120) where indigenous people of the same sex as the group led the intervention of group interpersonal psychotherapy for depression in rural Uganda.

Confirmative to this, community health workers (CHWs) in the peri-urban and urban areas of Cape Town in South Africa were also involved in a pilot counselling intervention to manage perinatal depression and anxiety (Boisits *et al.*, 2021:4). There is also corroborative evidence in Asia where primary healthcare workers in a rural town of Rawalpindi, Pakistan carried out mental healthcare interventions for the treatment of perinatal depression (Rahman *et al.*, 2008:903). Further confirmation is also in Latin America, where a group of non-medical workers in Chile was involved in the intervention to offer a stepped-care program for the management of depression (Araya *et al.*, 2003:998).

This material evidence of increased community involvement confirms the emerging constructs of Phase One of the research. Hence, by constantly comparing this finding, it is prudent to relate it to the core category referred to as communal roles in Phase One of the research.

It is a common cause for mutual appreciation that communal persons are involved in psychosocial health management as a matter of an innate principle to improve the health of all. Additionally, men also take the lead in mental health issues involving fellow males and contra wise with women. Furthermore, the interventions reviewed herein corroborate the emerging constructs of Phase One of the research that psychosocial care given at the community level is accessible and cost-effective.

This meaningful involvement has undeniably yielded positive results in communal contexts since the beginning of time. However, with this increased community involvement is contradictory evidence of toned-down community participation by the 'so-called experts in the field of mental health. This finding contradicts the emerging constructs of Phase One of the research, in which indigenous communities are respected as custodians of care. Therefore, they are experts in their own rights because they participate meaningfully in science appraised in psychosocial health management. This appreciation necessitates a mutual exchange of knowledge between local science and biomedical science from those involved and negates a hierarchical structure of care that positions the local people as inferior.

The toned-down participation of local persons is due to experts extending from mental health nurses to psychiatrists selecting, training, and supervising the involved non-medical persons in psychosocial health management. They position themselves as knowledge holders with infinite power in science. For instance, local persons involved in a randomized controlled trial in Chile to treat depression were assigned group leaders and supervisors in the form of social workers and nurses (Araya *et al.*, 2003:996). This was also observed by Boisits *et al.* (2021:4) and Chibanda *et al.* (2011:5), where various specialists in the field of mental health selected and supervised CHWs for their study. Furthermore, this supervision of local people by specialists was also noted in a non-inferiority trial conducted in northern Pakistan (Rahman *et al.*, 2019:3-4). However, Boisits *et al.* (2021:12) reported that community health workers needed more time to sharpen their counselling skills, further justifying the need for training and supervision. It is worth noting that a significant working relationship between CHWs and various specialists was a significant finding (Boisits *et al.*, 2021:12).

Admittedly, even with narrowed community participation, the review found that increased community involvement yielded positive results. Hence, Chibanda *et al.* (2011:7) found that involving lay workers created an environment of trust, hope, and less stigma for mental healthcare users, wherein problems were simplified into manageable items at times. However, monitoring the outcome of the intervention and providing feedback was easier because of the accessibility of lay workers to mental health care users (Chibanda *et al.*, 2011:7). Corroborative evidence for these is the findings of Araya *et al.* (2003:998) and Rahman *et al.* (2008:907), who found that with the increased involvement of local people, there were increased rates and retention of participants in the trial. In contrast, Vanden Bossche *et al.* (2021:11) reported no meaningful benefits of the use of CHW in Belgium for psychosocial health challenges due to social distancing due to the COVID-19 pandemic.

Chibanda *et al.* (2011:7) report that it is feasible for lay health workers to conduct problem-solving therapy for the management of depression and common mental disorders in Zimbabwe. Even so, this pilot test can be criticized for its design of only testing the intervention with one group because this feasibility report could be biased. In another

study, in which a randomised trial was performed with two groups, a stepped-care program was used to treat depression in Chile. It was found that the intervention demonstrated significantly positive outcomes compared to the normal care of mental health care users (Araya et al., 2003:998). However, with the reporting of significant differences between the controlled and normal groups, several limitations were noted on admission by the authors. Important to this review is the fact that programs of this nature are only introduced at a certain point in the life of a psychosocial health challenge. Based on the progress of the mental health care user, the intervention was stopped, continued, or replaced where possible.

In contrast, Malt *et al.* (1999:1182) found beneficial evidence of using both pharmacological and psychological interventions for the management of mild to moderate depressive symptoms. This psychological intervention included simple counselling, emotional support, and close follow-up, although the latter study lacked the longitudinal use and response of the two treatments combined. Similarly, a randomized trial with an intervention that focused on the combination of behavioural skills and counselling targeting adherence to medication to manage depression demonstrated positive results (Katon *et al.*, 1996:929).

This evidence compares well with the finding in the first phase of the research that the attainment of harmonious equilibrium can be through connatural equilibrium and/or equilibrium of choice, where a communal person chooses a combination of either of the practices in maintaining the balance of life. Essentially, these developments accentuate the emerging constructs of Phase One of the research in that psychosocial health and its management is first and foremost an interconnected, shared, and purposeful lifelong endeavour and not just a timed intervention.

#### **5.4.2. Inductive-deductive synthesis**

It is apparent in the development of hypothetical relationships between the emerging concepts that the review mostly finds confirmatory grounds in Phase One of the research, thus strengthening the progression of the emerging Middle-range theory. However, the emergence of contradictory findings between existing literature within the body of

knowledge and emerging formal theory is unavoidable. This is evidenced by the limited and guarded participation of local people by experts in the field within the interventions found in the literature. Notwithstanding this, this study argues that meaningful community participation is prudent in a psychosocial health management approach. Simultaneously, increased community involvement and limited participation demonstrated beneficial results. These beneficial outcomes include trustworthiness among local persons, accessibility and cost-effectiveness of care, simplification of health problems, less stigmatization, timely feedback, and progress monitoring.

Another important finding is that interventional programs have no long-term benefits for mental health challenges. Supporting the finding that the psychosocial health management approach should be a never-ending shared process enshrined in lifestyle.

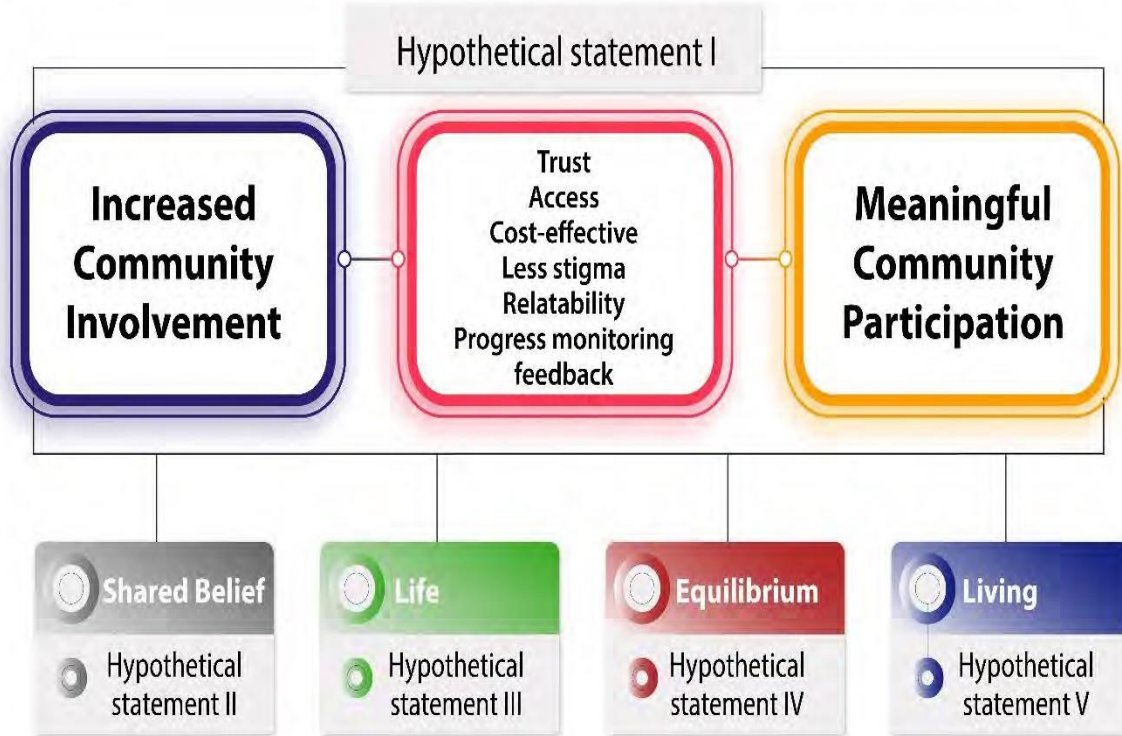
There is further evidence that psychosocial health care should methodically resonate with local people. This founding presupposes that not only at a philosophical level but also, practically that psychosocial health and its management stand to be defined, applied, and appreciated contextually. Therefore, with these inductive-deductive processes, a hypothetical model is formed in the discussion below.

### **5.5. Emerging outcome:** Hypothetical models for psychosocial health management among Southern African indigenous communities

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Fundamentally, the review demonstrates that it is confirmatory and strengthens the emerging construct from Phase One of the research project. The data are handled and appreciated as never-ending, allowing the progression of the Middle-range theory. The formation of these hypothetical models is grounded in the cultural-axiomatic statements that emerged from the formal theory. Therefore, Figures 14 and 15 below demonstrate the hypothetical statements and hypothetical models, respectively.

# Psychosocial Health Management Approach



**Figure 14:** Proposed Hypothetical Statements.

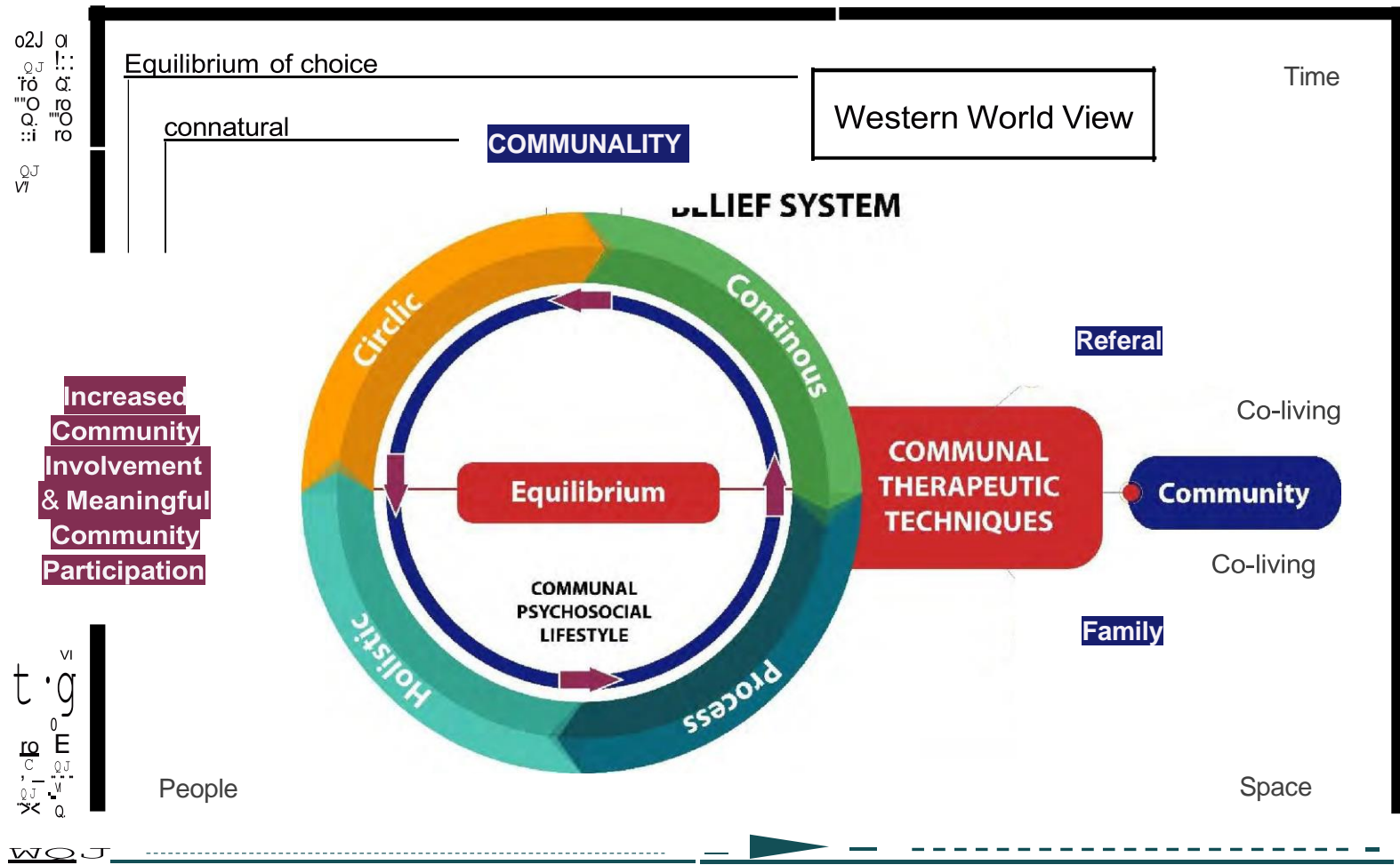


Figure 15: Proposed Hypothetical Models

## HYPOTHETICAL STATEMENT I:

### ***Increased community involvement and meaningful participation demonstrate practical and beneficial outcomes in the management of psychosocial health.***

As shown in Figure 14 this hypothesis is based on the finding that increased community involvement and meaningful participation demonstrate the benefits of trust, access, cost-effectiveness, less stigmatization, relatability, timely feedback, and progress monitoring. Consequently, this implants hope for not only the local people who receive psychosocial health care, but also those providing it. Therefore, it accentuates a sense of belief and fulfilment.

Grounding itself within the shared belief system, this hypothesis cements the etymological and ontological expressions of psychosocial health management, positioning communal persons as custodians of psychosocial health management (see Figure 15). Above all, custodianship seeks to account for the benefits of increased involvement and meaningful participation, as explained above. Essentially, as custodians of care, communal persons locate indigenous sciences in their authentic form in demystifying and applying the meanings of health, illness, healing, psychosocial health, and the design of care. Most importantly, this is achieved using indigenous languages. Hence, the findings of this research indicate that psychosocial health is interconnected with the meanings of health, illness, and healing. This interconnectedness emanates from the belief in holism and continuity of life. Therefore, a psychosocial health challenge is a consequence of an imbalance between life and living. Thus, psychosocial health management within a communal context is appreciated as a lifelong mutual process of harmonious interactions between life and living.

Most importantly, increased community involvement and meaningful participation also self-updates the psychosocial health management approach (Figure 15). For instance, when an individual chooses to align with their understanding of biomedical sciences. His/her involvement and meaningful participation will inform psychosocial health

management provided by the biomedical sciences. This means that the model is culturally sensitive, congruent, and competent.

## HYPOTHETICAL STATEMENT II:

***A belief system is shared and valued by all within a given communal context, because communal persons shoulder equal understanding and appreciation of the knowledge generation and interpretation of the given reality.***

This hypothetical statement is based on evidence pointing to the significance of a psychosocial health management approach that is culturally sensitive, congruent, and competent in a communal context (see Figure 14 & 15). First, this hypothetical model proposes that a psychosocial health management approach is sensitive to the shared belief that psychosocial health results from an imbalance between life and living. Second, cultural sensitivity comes with congruency in managing the psychosocial health challenge by appreciating that it is interconnected to health, illness, and healing, drawing strength from the holistic and continuous nature of life. In addition, there is a lifelong mutual process of harmonious interactions between life and living.

This hypothetical statement elevates the importance of increased community participation and meaningful participation through custodianship. Hence, the psychosocial health management approach is to commence at the family level, to the community level, and escalate to a curative system where needs be. Then, with a culturally congruent approach, competent psychosocial health management emerges, demonstrating the benefits of trust, access, cost-effectiveness, less stigmatization, relatability, progress monitoring, timeous feedback, and progress monitoring.

Equally, this hypothetical model stands culturally awake to the development that some within a given communal context are ascribed to Western ways of life. Hence, the model position is an inclusive approach that respects the indifferences found in each context.

### **HYPOTHETICAL STATEMENT III:**

***Life is a holistic-circlic continuous process that is independent from living, because a belief system is shared by all within a given communal context.***

This hypothesis is labelled life in Figure 14. This hypothetical statement expresses the imperativeness of the shared belief that life is a holistic-circlic continuous process in the management of psychosocial health challenges. Therefore, the evidence that life circles and interconnect with all that is within communal space is everlastingly related to the interconnectedness of health, illness, and healing, overlooking the understanding of psychosocial health. This is located in the emergence of the idea that living within a communal context is a constant desire to align with life. Therefore, this hypothetical model requires a psychosocial health management approach that is instilled within the way of life.

Furthermore, this hypothetical statement grounds itself on the shared belief that the meaning and appreciation of life is the founding principle of the belief system among communal persons. This is because the future (the yet-to-be-born), those living on Earth, those who were here before, and the surroundings are all dependent on the meaning of life. Psychosocial health management endeavours to locate the point of harmonious balance within those areas of life. Hence, an independent phenomenon within a communal context that begs not to be separated from psychosocial health management is significant.

Furthermore, these hypothetical models represent mutual existence with other worldviews (see Figure 14 & 15). When a psychosocial health approach within a given context is confronted with differing shared beliefs, the models become sensitive and respectful.

## HYPOTHETICAL STATEMENT IV:

***The interconnectedness between independent life, and living is fulfilled when a status of equilibrium between life and living has been reached.***

Above all, this hypothetical statement indicates that the goal in the management of psychosocial health is to attain a harmonious balance between life and living (see Figure 14 & 15). Hence, psychosocial health management is valued as a lifelong, mutual process. This is because attaining the point of equilibrium is a lifestyle. Fundamentally, this hypothetical statement illustrates that a psychosocial health management approach is centred around a lifestyle given in a communal context. This is referred to in this as a communal psychosocial lifestyle. This undertaking takes caution of lifestyle choices with psychosocial health management, which can be influenced by Western ways of life or African ways of life, or both. Hence, inclusiveness between the connatural equilibrium and the equilibrium of choice is essential.

## HYPOTHETICAL STATEMENT V:

***If life is independent, the point of equilibrium is the sense of balance between life and living. Therefore, interconnected to life and living.***

Since harmonious balance is attained through a communal psychosocial lifestyle, this hypothetical statement intends to position the lifestyle depicted as living by Figure 14 as an important aspect of a psychosocial health management approach. Hence, communality forms an integral proposition in this hypothetical statement. A psychosocial health management approach is required to appreciate the fact that the principles of communality are at the centre of living. Hence, a psychosocial health challenge is a shared development that is managed through communal therapeutic techniques enshrined in lifestyle. Similarly, if some share an indifferent view, the model requires a psychosocial approach to respect and upload principles of living.

## 5.6. Theoretical Assumptions

Essentially, the emerging meaning from Phase One is that psychosocial health is an interconnected, shared, purposeful, and life-long endeavour. It focuses on maintaining a harmonious balance between life and living to achieve the wellness of a communal context. It is evident that a theoretical assumption is made to achieve the needs aligned with a cost-effective, accessible, and culturally competent psychosocial health management approach. In this setup, increased community involvement and meaningful participation proved to be fundamental. Importantly, this assumption further cements the finding from Phase One that a shared belief system within a communal context is as important as psychosocial health management.

Furthermore, this assumption positions local people as custodians of care provided to them. Therefore, appreciating the mutual responsibility that communal persons carry for the betterment of all within a communal context is significant. This advances the emerging theory to stand for the co-existence of African and Western ways of life in the process of fortifying psychosocial health management as a way of life. Ultimately, there is an endeavour to achieve a harmonious balance of life. Thus, the hypothetical model emerging from this review is a needs-aligned, cost-effective, accessible, and culturally competent psychosocial health-management approach.

Primarily, the hypothetical model for psychosocial health management among indigenous Southern African communities emerging from this research is cost-effective and accessible. Psychosocial health management is a way of life guarded by communal roles. This means that the management of psychosocial health challenges is inherent to the communal lifestyle and is centred within the shared belief system and communal therapeutic techniques that are inseparable from the lifestyle. Therefore, they were readily accessible to the community. Moreover, the hypothetical model needs to be aligned because it embeds the meanings of health, illness, healing, and psychosocial health within the epistemological, ontological, etymological, and practices of indigenous Southern African communities.

## 5.7. Conclusions

Therefore, it can be concluded that the intended purpose of this phase was achieved through the formulation of a hypothetical models by employing a critical, integrative literature review design. This hypothetical model expands the progression of the emerging Middle-range theory, which is to be confirmed and validated in the next phase of the research by making use of an expert validation process. The developed models comprise five hypotheses illustrating a psychosocial approach that prioritizes increased community involvement and meaningful participation. Fundamentally, these hypotheses are grounds for a culturally sensitive, congruent, and competent psychosocial health management approach.

## Chapter six

# *QUANTITATIVE STRAND*

### PHASE III:

### Content Validity Index (CVI),

### Content Validity Ratio (CVR), & Kappa Statistic

*The emerging Middle-Range Theory: From Hypothetical Models to Middle-Range Theory*

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#### 6.1. Introduction

Building from the qualitative strand of the research to the quantitative strand, this chapter progresses the emerging psychosocial health management approach from hypothetical models to a Middle-range theory. The previous chapter attended to the inductive-deductive development and the formation of hypothetical models. Therefore, the formed hypothetical models were confirmed and validated deductively through an expert review. The validity of the emerging theory was established to ensure its recognition and acceptance (Lam, 2018:372). That is why confirmation and validation focused not only on the items but also on the entirety of the emerging theory by evaluating the approach in its total comprehensiveness. Hence, the primary researcher employed the content validity index (CVI), content validity ratio (CVR), and multi-rate Kappa statistic to ensure the overall validity of the hypothetical models.

It is noteworthy that the overall aim of this research was to develop, confirm, and validate a communal holistic therapeutic approach for psychosocial health management among Southern African indigenous communities. This chapter addresses the final aspect of the aim by confirming and validating the emerging theory. This was realized by accomplishing Objective Four of the research, which was to confirm and validate the approach through

expert validation (see Chapter One). This thorough task followed the inductive-deductive theory generation process, as illustrated in Figure 3 (see Chapter Two). Because this chapter is quantitative in nature, developments going forth are to be considered in line with process four of the inductive-deductive theory generation process. All things considered, it has been demonstrated that the emerging theory expressed through the 40 items is comprehensive and depicts acceptable content validity.

## **6.2. Pilot study**

To mitigate the limitations of CVI, the primary researcher conducted a pilot study. The primary researcher worked throughout this process under the guidance of a quantitative expert, as well as the main promoter.

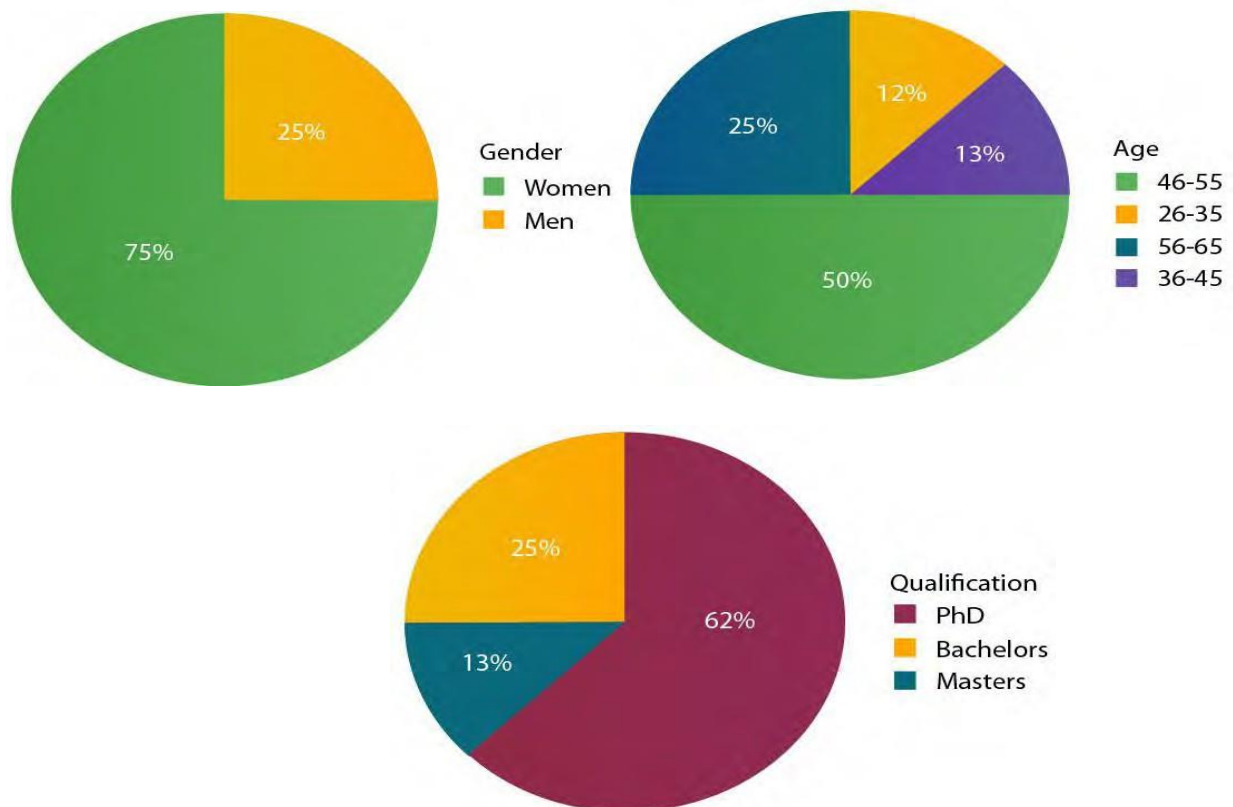
The pilot study served two purposes. First, to determine the extent to which the instructions sent to experts are clear, understandable, and sufficient. Second, for the experts to offer judgement on the emerging theory. Hence, the judgement-quantification stage involved two steps: (1) assertion by a specific number of experts that the items are content valid and (2) assertion that the entire instrument is content valid. Six experts were purposively sampled. Of the six, only four responded positively. The population included one mental health clinician, mental health nurse educator, health science researcher with grounded theory experience, quantitative expert, and clinical nurse.

The pilot employed the CVI and CVR as methods of data collection and analysis. The instructions sent to the experts were clear and understandable. Furthermore, from the 40-item instrument, all items were modified, and some were moved to a different hypothesis based on the experts' comments. Therefore, the number of items of the instrument remained at 40 with no addition or elimination. Finally, according to the experts' comments, the instrument was generally accepted as content valid.

### 6.3. Population and sampling method

**Table 9:** Demographic table

	Frequency	Total
<b>GENDER</b>		
Men	2	8
Women	6	
<b>AGE</b>		
26-35	1	8
36-45	1	
46-55	4	
56-65	2	
<b>HIGHEST QUALIFICATION</b>		
Doctor of Philosophy (PhD)	5	8
Masters	1	
Bachelor's Degree	2	



**Figure 16:** Demographic data

The population of this phase of the research was a panel of eight (8) experts sampled using a purpose-sampling method (see Table 9). Of the eight, six were women and two were man (see Table 9 & Figure 16). The ages of four of the experts sampled were between 46 and 55 years, two of the experts were between 56 and 65, one was between the ages of 36 and 45, and the other was between the ages of 26 and 35 (see Table 9 & Figure 16). Moreover, five experts held a Doctor of Philosophy (PhD) as the highest qualification, one had a master's degree, and the other two held a basic degree (see Table 9 & Figure 16). Their areas of expertise were mental health, indigenous knowledge systems, social and health research, and nursing.

Therefore, there were seven nursing experts and one mental health clinician. Two of the experts hold PhDs in the field of Nursing Sciences (Mental Health Nursing). The other two of the experts hold PhDs in the field of Nursing Sciences (Mental Health Nursing and Indigenous Health). One of the experts holds a PhD in the field of Nursing Sciences and Indigenous Health. Among the experts, only one expert holds a Master's degree in Nursing Science and Indigenous Health, and lastly, the two of the experts hold basic degrees in Mental Health Nursing and Mental Health (Clinician) respectively.

#### **6.4. Methods**

For data collection, the experts received a comprehensive set of documents. This included the CVI and CVR forms, along with open fields for qualitative judgements on questions related to the total comprehensiveness of the emerging theory. In addition, a clear illustration of the models using two diagrams and discussions embedded within hypothetical statements was part of the set of documents. The documents also included a cover letter that clearly explained the significance of the research, instructions to follow, the importance of each expert's response, and the need to respond promptly. The experts were allocated a minimum of two weeks upon receipt of the documents. The experts were encouraged to arrange with the researcher to extend the allocated time. Importantly, only two experts met the time allocated to complete the review. However, all experts indicated that the instructions were clear and understandable, but the time allocated was sufficient. Therefore, it was concluded that the delay was caused by other commitments. This was further confirmed through consultation with experts.

#### **6.4.1. Reliability**

A quantitative expert was appointed to ensure the consistency of the instrument for the reliability of the items contained in the CVI form, and therefore, the entirety of the hypothetical models. The experts also sought to mitigate the limitations of the CVI.

Reliability was achieved through a consensus discussion between the researcher, supervisor, and a quantitative expert. In addition, a pilot study was conducted for experts to offer quantified judgments for each item, determine the clarity and comprehensiveness of the instructions, and further evaluate the approach in its total comprehensiveness. Finally, the Kappa statistic method was used to enhance the CVI outcome. Therefore, the tool used to measure CVI was considered reliable.

#### **6.4.2. Content validity index (CVI)**

This study employed CVI as a method of data collection and analysis by measuring the degree to which an instrument has an appropriate sample of items for the construct being measured (Pilot & Beck, 2007 & Lam, 2018:377). Hence, the primary researcher applied the procedure of expert proportion agreement, in which experts' reviewers evaluated the relevance of an itemized instrument against the domain of content it represents (Wynd *et al.*, 2003:510). The analysis focused on each item of content validity (I-CVI), which expresses the proportion of agreement on the relevance of each item, which is between zero and one (Zamanzadeh *et al.*, 2015:169 & Pilot *et al.*, 2007:460). Accordingly, judgement was made as follows - values range from 0 to 1 where CVI greater than 0.79 (79%), the item was considered relevant, between 0.70 (70%) and 0.79 (79%), then the items needed revision, and if the value is below 0.70 (70%) then the item was eliminated (Zamanzadeh *et al.*, 2015:169; Rodrigues *et al.*, 2017:3; Pilot *et al.*, 2007:460 & Lynn, 1986:384). In addition, the experts were requested to indicate any omitted areas noted from the model. Importantly, the experts were requested to offer a qualitative judgement on whether the model in its total comprehensiveness was content valid for its relevance and acceptance in psychosocial health management among Southern African indigenous communities.

*Formula*

I-CVI = Agreed items/N

Where N is the total number of experts.

*As demonstrated on Table 10, for the application of this formulae the original scorings of the experts were coded as following;*

3 & 4 = 1

1 & 2 = 0

#### **6.4.3. Content validity ratio (CVR)**

The research further employed the CVR to measure the essentiality of an item (Zamanzadeh *et al.*, 2015:168; Rodrigues *et al.*, 2017:3). The experts were requested to determine whether an item was important or necessary against a construct in a set of items. Therefore, experts used the CVR form to score each of the items from 1 to 3 with a three-degree range of - not necessary, useful, but not essential, essential (Zamanzadeh *et al.*, 2015:168). Notably, CVR varies between 1 and -1 (Zamanzadeh *et al.*, 2015:168 & Rodrigues *et al.*, 2017:3), where a higher score indicates further agreement of members of the panel on the necessity of an item in an instrument. According to Zamanzadeh *et al.* (2015:168) and Rodrigues *et al.* (2017:3) the CVR formula is as follows:.

*Formula.*

$$\text{CVR} = (\text{Ne} - \text{N}/2) / (\text{N}/2)$$

where Ne is the number of panellists indicating essential and N is the total number of panellists.

#### **6.4.4. Multi-rate Kappa statistic**

To decrease the inflation of chance agreement because of the CVI rating, this research used Cohen's (1960) Kappa statistic method. The proportion of agreement remaining after determination of chance agreement is represented by the Kappa statistic (Wynd *et al.*, 2003:511 & Cohen, 1960:40). This method was deemed suitable to further mitigate the limitations of CVI. This was achieved by juxtaposing the total proportion agreement ( $P_c$ ) with the maximum possible value, accounting for chance agreements ( $1 - P_c$ ).

Therefore, we determined the I-CVI score for each item. The probability of chance agreement (Pc) and content validity index of each item (I-CVI) were used to calculate the kappa statistics. The formula for the Kappa statistic is as follows:

*Formula.*

First, the probability of chance agreement for each item (Zamanzadeh *et al.*, 2015:169).

$$P_c = \frac{N!}{A! (N-A)!} \cdot 5N.$$

N = number of experts in a panel

A = number of panellists who agree that the item is relevant

After calculating the I-CVI for all items. Finally, the Kappa statistic was calculated by entering the values of the probability of chance agreement (Pc) and the content validity index of each item (I-CVI).

$$k = \frac{(I-CVI - P_c)}{(1 - P_c)}$$

*Evaluation criteria for Kappa*

Kappa was evaluated based on the degree of 'excellent', 'good', and 'fair'. The values above 0.74 are deemed 'excellent', between 0.60 & 0.74 is considered 'good' and the ones between 0.40 and 0.59 are regarded as fair (Zamanzadeh *et al.*, 2015:169-170). Therefore, after controlling for items by calculating adjusted kappa, each item with an I-CVI equal to or higher than 0.78 was considered excellent.

## 6.5. Results

**Table 10:** Summary of the results

Hypothesis	Items	Experts								Experts in Agreement	Calculations			Interpretation	
		1	2	3	4	5	6	7	8		I-CVI	CVR	k		
1	1	1	1	1	1	1	1	1	0	1	7	0.88	0.75	0.875	Excellent
	2	1	1	1	1	1	1	1	1	1	8	1	1	1	Excellent
	3	1	1	1	1	1	1	1	1	1	8	1	1	1	Excellent
	4	1	1	1	1	1	1	1	1	0	7	0.88	0.75	0.875	Excellent
	5	1	1	1	1	1	1	1	1	1	8	1	1	1	Excellent
	6	1	1	0	1	1	1	1	1	1	7	0.88	0.75	0.875	Excellent
	7	1	1	1	1	1	1	1	1	1	8	1	1	1	Excellent
	8	1	1	1	1	1	1	1	1	1	8	1	1	1	Excellent
	9	1	1	1	1	1	1	1	1	1	8	1	1	1	Excellent
	10	1	1	1	1	1	1	1	1	1	8	1	1	1	Excellent
	11	1	1	1	1	1	1	1	1	1	8	1	1	1	Excellent
	12	1	1	1	1	1	1	1	1	1	8	1	1	1	Excellent
	13	1	1	1	1	1	1	1	1	1	8	1	1	1	Excellent
	14	1	1	1	1	1	1	1	0	1	7	0.88	0.75	0.875	Excellent
	15	1	1	1	1	1	1	1	1	1	8	1	1	1	Excellent
	16	1	1	1	0	1	1	1	1	1	7	0.88	0.75	0.875	Excellent
2	17	1	1	1	0	1	1	1	1	7	0.88	0.75	0.875	Excellent	
	18	1	1	1	1	1	1	1	0	7	0.88	0.75	0.875	Excellent	
	19	1	1	1	1	1	1	1	1	8	1	1	1	Excellent	
	20	1	1	1	1	1	1	1	1	8	1	1	1	Excellent	
	21	1	1	1	1	1	1	1	1	1	8	1	1	1	Excellent
3	22	1	1	1	1	1	1	1	1	8	1	1	1	Excellent	
	23	1	1	1	1	1	1	0	1	7	0.88	0.75	0.875	Excellent	
	24	1	1	0	1	1	1	1	1	7	0.88	0.75	0.875	Excellent	
	25	1	1	1	1	1	1	1	1	8	1	1	1	Excellent	
	26	1	1	1	1	1	1	1	1	1	8	1	1	1	Excellent
4	27	1	1	1	1	1	1	1	1	8	1	1	1	Excellent	
	28	1	1	1	1	1	1	1	1	8	1	1	1	Excellent	
	29	1	1	1	1	1	1	1	1	8	1	1	1	Excellent	
	30	1	1	1	1	1	1	1	1	1	8	1	1	1	Excellent
	31	1	1	1	0	1	1	1	1	1	7	0.88	0.75	0.875	Excellent
5	32	1	1	1	1	1	1	1	1	8	1	1	1	Excellent	
	33	1	1	1	1	0	1	1	1	7	0.88	0.75	0.875	Excellent	
	34	1	1	1	0	1	1	1	1	7	0.88	0.75	0.875	Excellent	
	35	1	1	1	1	1	1	1	1	1	8	1	1	1	Excellent
	36	1	1	1	1	1	1	1	1	1	8	1	1	1	Excellent
37	1	1	0	1	1	1	1	1	1	7	0.88	0.75	0.875	Excellent	
38	1	1	1	1	1	1	1	1	1	8	1	1	1	Excellent	
39	1	1	1	1	1	1	1	0	1	7	0.88	0.75	0.875	Excellent	
40	1	1	1	1	1	1	1	0	1	7	0.88	0.75	0.875	Excellent	

**Note\*\*** *k* means Kappa statistic. I-CVI means proportion of agreement. CVR means ratio of agreement.

## 6.6. Discussion of results

Table 10 shows the calculated expert judgement and interpretation from a panel of eight experts. The intention of this non-experimental quantitative design was to validate and confirm the level of validity enjoyed by the items and the totality of the emerging theory. Therefore, the discussion below focuses mainly on demonstrating whether the items of the emerging theory are content valid, and whether the emerging theory in its comprehensiveness is content valid.

Judgement-quantification of expert panel

A. Are the items' content valid?

This was determined by calculating item relevance and clarity agreement rates (I-CVI), the Kappa statistic, and item essentiality (CVR). The CVI form consists of five hypotheses expressed through 40 items (see Annexure M)

All items were found to be relevant and acceptable, with I-CVI values greater than 0.79. For example, under hypothesis one, item one '*The psychosocial health care provided involves the family, community, and the curative institutions*'. The I-CVI was calculated to be 0.88 with a CVR of 0.75 and a kappa value of 0.875, indicating that the item was excellent. This means that the finding that the item was judged to be relevant and with the highest level of essentiality to the emerging theory is not based on inflated agreement, but a true reflection of a proportion of agreement. All things considered, this item is relevant and shows the highest level of essentiality. Therefore, confirming and validating the importance of involving the family, community, and the already existing curative systems when providing psychological health among Sothern African indigenous.

But also, with hypothesis four, item 22 '*The psychosocial health care provided appreciates that harmonious balance is achieved through a holistic-continual process of healing involving basic and advanced communal therapeutic techniques*'. For this item, the I-CVI is 1, with a CVR of 1 and a Kappa value of 1, considering the item as excellent. Similarly, this means that item is relevant and acceptable. Furthermore, the evident proportion of agreement is not based on an inflated agreement but on a true reflection of agreement.

Therefore, it was concluded that the items of this emerging theory expressed in the CVI and CVR forms depict acceptable content validity. The findings demonstrate the acceptance and recognition of this emerging theory. This finding offers an informed supposition on the fundamentality of cultural axioms in the management of psychosocial health found in this study. Meaningful community participation and regard for shared belief systems are central to the management of psychosocial health. Affirming the emerging theory as an approach to psychosocial health management that positions communal persons as custodians of care, with the appreciation that a belief system is central to psychosocial health.

#### B. Is the entire instrument content valid?

This was determined through an in-depth analysis of the qualitative fields provided to the experts requesting them to indicate any omissions, strengths, additions, and suggestions for the improvement of the emerging theory. In the panel, one of the experts offered a judgement by saying, *'the instrument is content valid. The content touches the most important aspects of a communal holistic therapeutic approach for psychosocial health management'*. Another expert indicated that, *'the items generated for the instrument covers all relevant parts of the domain'*. The same expert further contributed by saying, *'the model clearly shows how psychological systems work in communal context'*. This assertion was further corroborated by another expert *'the instrument content is valid and encompasses most of the Southern African Indigenous community'*. Equally, one of the panelists said, *'Very comprehensive instrument as it has touched almost all parts that affects the life of an indigenous person'*. Hence, a deduction is made that the emerging theory is comprehensive and appreciative of all that is important for psychosocial health management within an indigenous community.

Moreover, another expert commends that the emerging theory *'incorporating indigenous knowledge and practices is an essential aspect of the approach, recognizing the significance of local traditions and heritage'*. One panelist said, *'the focus on a shared belief system and interconnectedness of life and living highlights the importance of holistic and context-specific approaches to psychosocial health'*. Important to this was the contribution of another expert, *'the instrument is valid as it encompasses all the aspects*

*of an indigenous life which include culture and belief systems. This indeed will encourage full participation in the care since clients, family members including the community members are well equipped with knowledge and skills in the care provided. Since each member is involved in the care, trust in the provider is well built and the client also gets all the support needed from both provider and community including the family. Issues of stigma are minimized since it is a communal responsibility'. Therefore, the instrument is indeed comprehensive, as it respects and relates to the communal context.*

At the same time, one of the experts is apprehended by the findings made above; *some specific aspects might change over time as beliefs change and people may choose to follow a certain practice, while others may not. Therefore, I think some flexibility is required, perhaps by including respect and understanding of people's belief systems and practices over time, and that community members may find themselves at different stages, for example following some indigenous practices, but not others, or seeking healing and help in the community, but also at Western health care systems'. This was corroborated by another expert, who suggested that it's essential to consider cultural variations within different communal contexts. Some aspects of the approach may need to be tailored to specific cultural beliefs and practices. With no intention of suggesting generalization of the findings of this research, therefore, caution should be exercised in the emerging theory to be a psychosocial health management approach able to co-exist with opposing worldviews within its communal context. This positioning has already been established in this research.*

That is why this research finds contradiction on what is said by another expert, *'the model and the overall ideas are also focused on altering the western way of life. The focus should be on government machinery, which involves creating new health care policies that incorporate indigenous knowledge or altering existing ones because this is a highly delicate issue. The emerging theory is clear on its position in respect to ways of life where no science is superior to the other. Hence, sensitivity and respect are shown to communal persons who choose to attain a balance of life through Western ways of life.*

As importantly, another expert points out an omission, *'there is no discussion of how this strategy might affect the community or society as a whole. The effect that this strategy*

*will have on families, communities, and governmental infrastructure is also absent. I would insist that this method be used to demonstrate the impact on the creation and modification of policies*'. In opposition to that, one expert submits, *'in my opinion, the instrument will produce desirable outcomes as the care provided involves all aspects of an individual's life. It is also culturally acceptable as compared to the western way of providing care. The care allows community participation, respects cultural beliefs which indeed would enhance the healing process*'. This aspect was better advanced by one of the panelists, *'as per the nature of middle-range theory, some concepts are abstract but sufficiently close to empirical data to generate specific interventions for practice. For example, the items generated from the hypothesis show a way to potentially test and refine the model*. Thus far, but also with the appreciation of the overall aim of this research it should be appreciated that the testing or determination of the impact and effectiveness of the emerging theory is an aspect implicated in the future research. At the same time, the emerging theory is presently adamant in its influence on policies related to psychosocial health management and the revitalization of indigenous healthcare practices.

On the other hand, panelists offered their expert opinions on the following to be added to improve the emerging theory. One expert contributed by saying, *'naming of a child is believed to be therapeutic to families and communities that name children in a chronological order such as first born (C) from first born son(B) is named after grandfather (A) who is the father of (B), Second born (D) from (B) is named after grandfather from maternal site. If this name is followed, health will prevail throughout the child's life.*'. Essentially, this confirms the founding in this research of the spiritual practice of transferring a name from those who were here before to the one who is physically on earth. This compares to the emerging meaning of the circlike nature of life and, therefore, the delegation of roles among communal persons in the theory.

Meanwhile, one of the experts added *'how would the researcher feel about including human rights as part of equilibrium? Human rights is something very relevant to all cultures and forms part of cultural identity and the world view of cultures*'. First, the emerging theory finds human rights to be subjective, limited, and compartmental. Holism

and the interconnectedness of life form a foundational finding of the emerging theory. This is neither to say that human rights are a contradiction to the emerging theory, nor is it to say that the emerging theory does not believe in human rights. Rather, the findings of this research lean towards (Dembour, 2010:3) who acknowledges the subjectivity of human rights. Dembour (2010) derives human rights from four points of contention. The deliberative scholars, who conceptualize human rights through the expression of political values and community participation. The protest school of thought, where an argument is made that justice is a fundamental pillar in the meaning of human rights. Discourse contenders argue that human rights exist only as conversational phenomena. Finally, the naturalistic doctrine contends that human beings are born with their rights (Dembour, 2010:3-4). Thus, the emerging theory is compared to the latter school of thought.

Be that as it may, Fagan (2012:10) demonstrates that to appreciate the essence of human rights one has to purposely understand the nature of being. This foundational question is answered by the emerging theory that a human being within a communal context is a communal person. The person who lives with a sense of belonging is embodied by a shared belief system. Communal persons share the belief that all that is within a communal context is equal. This is because the right of 'being' within a communal context is beyond 'human.' Therefore, the right should be extended to all within the communal context, including animals, plants, and cosmology. Hence, the principle of Ubuntu that says '*I am because you are*' shares equal meaning with '*I am because my environment is*'.

Equilibrium is a holistic entity that involves the interconnectedness and circlic nature of life. All things considered in answering the question of including human rights as part of equilibrium. The emerging theory finds that human rights are innate to the communal person and, therefore, are integral to the balance of life (equilibrium).

Another addition from experts was '*the concept of cultural accommodation and the importance thereof. This is severely lacking in health care providers and Western Based Knowledge systems and care yet is of essence to the health care user. Cultural accommodation allows for special diagnosis being made such as in amafufunyana*'. This compares with the findings of this research, as the emerging theory advances for cultural

acceptance and sensitivity in the management of psychosocial health. Equally, the emerging theory seeks to influence policy formations, and mental health practitioners regard psychopathology as understood by indigenous sciences.

Furthermore, one of the experts added *'would it add to include the rites of passage of both genders as therapeutic in nature? This will make the questionnaire appropriate for both contexts.* This research found that the male rite of passage suffers suppression as an indigenous practice by government laws in communal contexts. This is because indigenous practices, such as animal hunting and forming foundational teachings for male rites of passage, are now heavily regulated by governments. Limiting the teachings involved in the male rites of passage. Therefore, the male rite of passage is practiced less often. However, because this practice is comparable with the emerging theory equally appreciates Inxhabasas as a therapeutic intervention.

Finally, another expert added *'What about community members and family members not following conducive practices such as respect and displaying harmful practices? A family may also cause harm, for example, child abuse and domestic violence. These practices are opposed to psychosocial health and should be acknowledged by the community as harmful to support family members that need to distance themselves from family members causing harm and not facilitating psychosocial health. A person may also experience conflicting feelings: Must I stay loyal to cultural practices or follow my own belief system? So, acceptance of different perspectives should form part of the approach – being tolerant and accepting and respecting different value systems. Harmful practices towards self and others should be rejected by community members who should take a stance against these members and encourage them to respect others'.*

It is noteworthy that, as much as Communal Psychosocial Lifestyle (CPL) is purposed to preserve the life of the community, it is not a wholly concept absolute and insulated from the chaos of the realities of life. This is why the emerging theory, in part, demystifies psychosocial health as a never-ending pursuit of the balance of life (equilibrium). This is with the understanding that the attainment of a harmonious balance in life is not free from the chaos of life. Hence, emerging theory equally appreciate life as a mixture of good and bad. This is comparable to the finding made by Pienaar (2004:112) that “life is a dirty

mixture of pleasure and deadly bad things.” The locus of this emergence is that even in the goodness of a communal person, there are those who inflict harm to the psychosocial health of the community. Thus, to obtain good health, one will have to endure a state of chaos at times.

CPL has emerged to involve a shared cultural belief system, co-living systems, and communal therapeutic techniques. Therefore, there is a shared appreciation that those who cause harm to the life of the community are managed with patience and boundary setting with forthright interventional conversations. This is better explained by one of the participants who shared “*If you don’t want to listen to the laws of the elders, go out there so you can experience the bitterness of life.*” This simply shows that the emerging theory appreciates the coexistence of other systems and laws informed by other worldviews. Hence, anyone choosing not to follow the shared ways of life and carry mutual responsibility for the goodness of the community by committing harm and acts of violence will be dealt with by the justice and criminal laws of the state.

## **6.7. Conclusion**

Evidently, a non-experimental quantitative design involving CVI, CVR and Kappa statistics has shown that the hypothetical models emerging from Phase Two of the research demonstrate acceptable content validity and comprehensiveness. Therefore, with the strengths noted and suggestions offered by the experts, it is evident that the emerging theory demonstrates comprehensiveness and attends to important elements of psychosocial health management among Southern African indigenous communities. Therefore, it is concluded that the instrument in its totality is content valid.

## Chapter seven

### OVERALL SUMMARY:

# OUTCOME OF THE RESEARCH, UNIQUE CONTRIBUTION, RECOMMENDATIONS, LIMITATIONS, AND STRENGTHS.

*The emerging Middle-range theory*

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### 7.1. Introduction

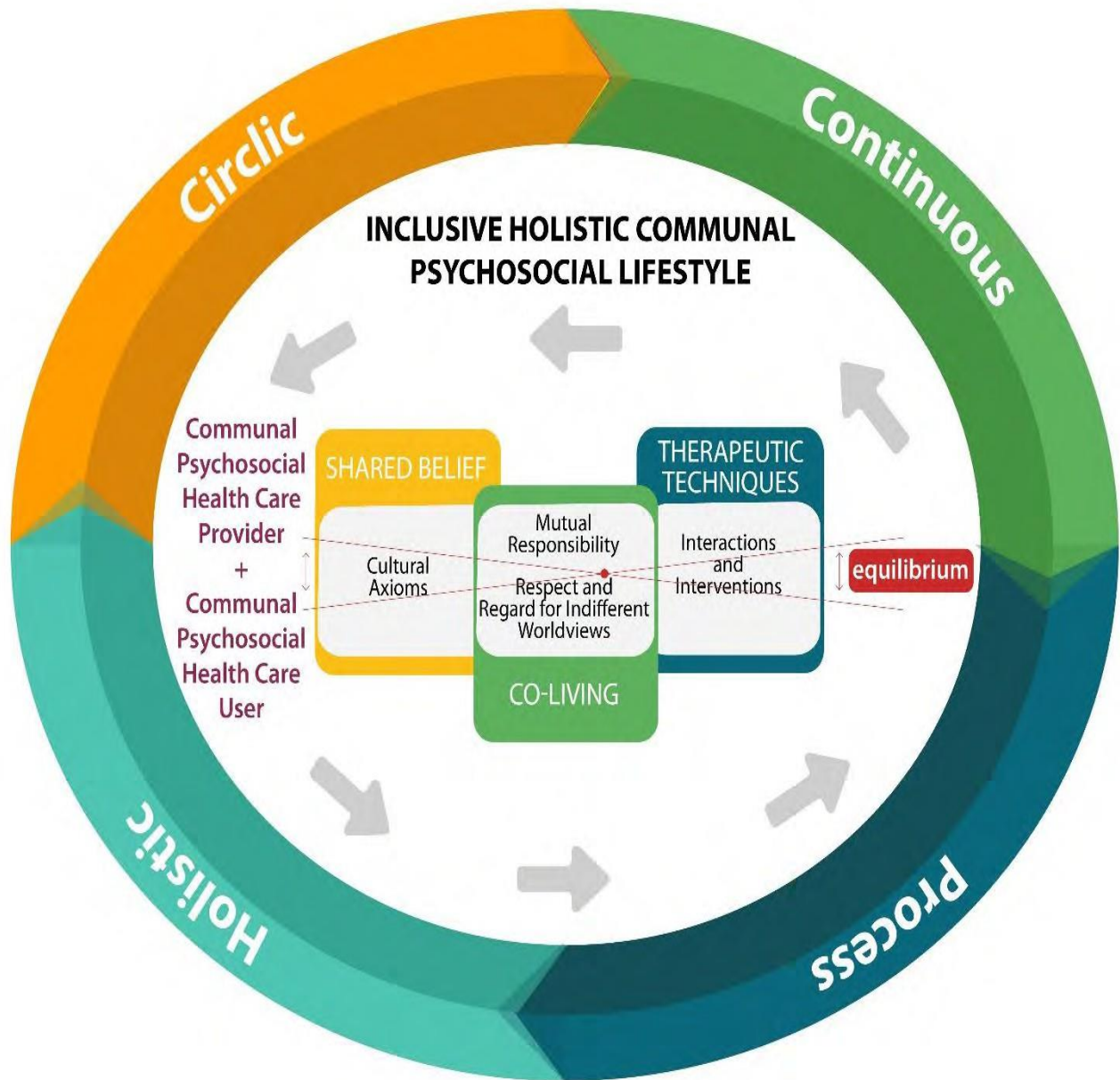
The previous chapter advanced the emerging psychosocial health management approach from a hypothetical models to a Middle-range theory level by employing CVR, CVI and Kappa statistic. This chapter critically appraises the overall aim and objectives of the research against the findings emerging from it. This chapter further presents the outcomes and unique contributions to the body of knowledge, as well as the overall summary of the research. Concomitantly, this chapter describes the appraisal of the research processes and methods used to achieve each phase of the research. This was done through a discussion involving the evaluation of syllogism, limitations, and strengths of the research, followed by conclusive remarks.

### 7.2. Emerging outcome of the research

**Middle-range theory: Inclusive Holistic Communal Psychosocial Health Management Approach.**

Overall, the findings of this research present an emerging Middle-range theory. It has come out that the emerging Middle-range theory is inclusive, holistic, and communal in its approach to psychosocial health management among Southern African indigenous communities. Thus, the discussion below is intended to express and contextualize what,

who, how, and when of the Inclusive Holistic Communal Psychosocial Health Management Approach (see Figure 17).



**Figure 17:** Inclusive Holistic Communal Psychosocial Health Management Approach

*What?*

To locate and appreciate the context of the emerging Middle-range theory, it is important to discern the meaning of Inclusive Holistic Communal Psychosocial Health Management Approach. This approach is informed by a **shared cultural belief system**. For instance, the belief of Ubuntu is that *I am because you are (inclusive of all within the communal context)*. Necessitating the appreciation of life as a holistic-continuous process. Therefore, everyone in a communal context is mutually responsible and devoted to good health. Justifying the **holistic** nature of the approach.

Moreover, this approach is embedded in **co-living** systems. Within a communal context this Middle-range theory recognizes the indifference of all. This allows psychosocial health management to be culturally sensitive and congruent with opposing worldviews. Thus, the emerging Middle-range theory is regarded as an **inclusive** approach. At the same time, the emerging Middle-range theory recognizes the dominance of African ways of living amid the imminence of postcolonial hegemony. Hence, the approach is further informed by communal therapeutic techniques used for the management of psychosocial health at the family and community levels. Even so, those who choose to make use of curative systems (clinics, hospitals) as the first line of care are respected and appreciated.

On these grounds, the emerging Middle-range theory appraises psychosocial health as an entity interwoven with the belief in holism and continuity of life. Furthering the **holistic** meaning of the approach. Hence, it is related to its interconnectedness with health, illness, and healing. Hence, psychosocial health is appreciated as a lifelong interaction with the chaos of life in pursuit of a harmonious balance of life. A mutual interaction striving for the equilibrium of life within the interconnectedness of life (the physical body, mind, emotions, spirit, surroundings (cosmos, those physically living on earth, and those who passed on) and economic circumstances). Therefore, CPL is understood as 'living' wheeling in the opposite direction to life (anticlockwise). In contrast, life is recognised as wheeling clockwise as a holistic-circlic continuous process. Thus, the balance between life (harmony) and living (chaos and catastrophe) is referred to in this **Inclusive Holistic Communal Psychosocial Health Management Approach** as the **equilibrium of life** (or good health).

### *Who?*

The emerging Middle-range theory recognizes communal persons as those involved in the pursuit of equilibrium through the chaos and calamity of life. Thus, those who assume the shared responsibility of providing care are referred to as **communal psychosocial health care providers** whereas those receiving care are referred to as **communal psychosocial health care users**. However, the emerging Middle-range theory acknowledges, respects, and regards other ways of life informed by indifferent sciences in the management of psychosocial health, such as in clinics and hospitals. Therefore, attending to the **communal** aspect of the emerging Middle-range theory. Hence, at the family level, elderly people are generally involved and will take the lead in the cultural process. People assume the responsibility of providing care on the nature of the problem (uncles, aunts, and traditional healers), typically those with experience in life. At the community level, there are local chiefs, traditional leaders, traditional healers, and faith-based healers. Therefore, if the psychosocial health challenge remains unsolved, the matter is referred to as a curative system, such as clinics or hospitals, if accessible (**Western ways of life**). At the same time, the emerging middle-range theory acknowledges that those who will opt for curative systems as the first line of care will be respected and appreciated.

### *How?*

**Communal therapeutic techniques** are considered within the communal context as the way in which balance of life is achieved (**African ways of life**). This is because of the belief that health, illness, and healing are intertwined with the equilibrium of life. Therefore, these techniques include basic therapeutic interactions such as humility, sharing positive feelings, and providing support. Moreover, it includes advanced therapeutic interactions such as storytelling and metaphors, boundary setting, and self-resilience disclosure. Communal therapeutic techniques also involve basic and advanced interventions, such as graveyard visits, '*Mpho ya badimo*' and plant medicine use. At the same time, biomedical sciences found in curative systems are also regarded as a means to achieve equilibrium of life (**Western ways of life**).

### *When?*

Psychosocial health is believed to be a lifelong process. The management of psychosocial health is an interaction that is engaged by communal persons from birth to the assumption and through the next life. This is because life is understood to be a holistic-circlie continuous process and, therefore, never-ending.

*Why? (Shared Cultural Belief System)*

The fundamentality of the emerging Middle-range theory is based on the axiomatic statements expressed through five hypotheses in which evidence was shown by way of CVI, CVR, and Kappa statistics that they are comprehensive and content valid. First, the understanding that *increased community involvement and meaningful participation results practical and beneficial outcomes in the management of psychosocial health*. This includes the benefits of trust, access, cost-effectiveness, less stigmatization, relatability, timely feedback, and progress monitoring. Psychosocial health challenges are a consequence of the imbalance between life and living (chaos and harmony). This hypothesis posits that communal persons are custodians of their own indigenous sciences in the management of psychosocial health.

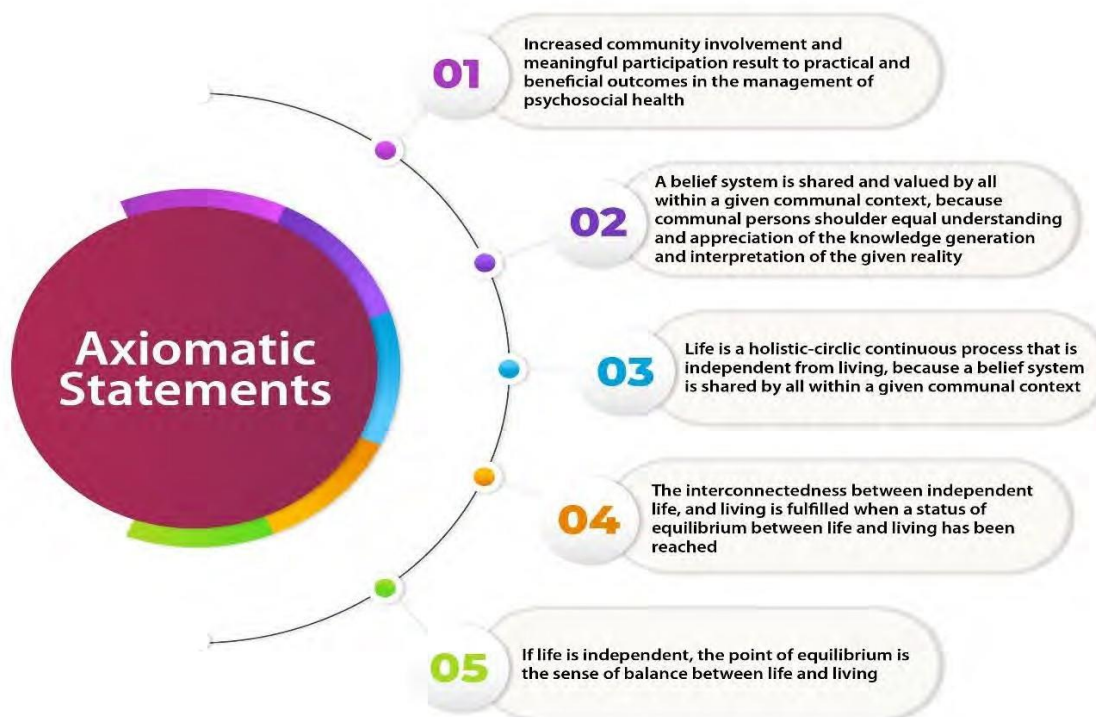
Second, the appreciation that *a belief system is shared and valued by all within a given communal context, because communal persons shoulder equal understanding and appreciation of the knowledge generation and interpretation of the given reality*. Hence, psychosocial health management starts at the family level and continues to the community level and refers to curative systems if needed. Third, the belief that *life is a holistic-circlie continuous process that is independent from living, because a belief system is shared by all within a given communal context*. Therefore, shared beliefs are integral to psychosocial health management. Fourth, *the interconnectedness between independent life, and living is fulfilled when a status of equilibrium between life and living has been reached*. This is why psychosocial health management derives from the mutual interaction between the interconnectedness of life in pursuit of a balance of life, even in catastrophic moments of suffering.

Finally, *if life is independent, the point of equilibrium is the sense of balance between life and living*. Therefore, they are interconnected with life and life. The emerging middle-range theory further suggests that psychosocial health management is a lifelong process

managed by the use of communal therapeutic techniques founded in the lifestyle of a communal person. At the same time, the emerging Middle-range theory appreciates and respects that there are those we indifferent ways of life that will choose to inform their ways of life with other worldviews (i.e., **Western ways of life**).

Evidently, the emerging outcome of this research is an emerging Middle-range theory bounded by inclusiveness, holism, and communality in the management of psychosocial health among Southern African indigenous communities.

### 7.3. Unique contribution of the research to the body of knowledge



**Figure 18:** Axiomatic statements

Admittedly, it is not unique for indigenous people to practice indigenous health science as the first line of care in psychosocial health management (See Figure 17 & 18). It is also

not unique for indigenous communities to combine indigenous sciences with biomedical sciences.

However, this research uniquely contributes an emerging Middle-range theory for psychosocial health management among indigenous Southern African communities. This emerging Middle-range theory proposes an Inclusive Holistic Communal Psychosocial Health Management Approach (Figure 17). This proposition is cemented by five cultural axioms (figure 18) fundamental to the management of psychosocial health, particularly in the communal contexts found in Southern Africa.

Distinctively, this emerging Middle-range theory illustrates that the said axioms embed themselves in the belief that life is a holistic-circlic continuous process independent of living, wherein the point of equilibrium (good health) is the sense of balance between life and living. Therefore, this interconnectedness articulates the meaning and management of psychosocial health. This is why these five cultural axioms are found to be of evidential value in the management of psychosocial health management in communal contexts. If regarded and applied in this context, there is a preliminary assumption that psychosocial health challenges can be diagnosed and managed effectively. This finding provides the needed science for managing psychosocial health within indigenous communities using a clear, evidence-based, and holistic therapeutic approach.

Moreover, this research uniquely contributes to the holistic meaning of psychosocial health as a lifelong cultural process inseparable from health, illness, and healing; therefore, it is informed by the interconnectedness of life. It has a continual desire to attain a harmonious balance of life against the chaos of living. Hence, to achieve a harmonious balance, a holistic therapeutic approach applies a succinct management process involving family, community, and biomedical systems.

#### **7.4. Overall summary**

The overall summary is engorged by the appraisal of the key research findings against the overall aim and objectives of the research as well as the research process and methods followed to achieve the intended outcome.

classical Grounded Theory contends with the need for a pre-study literature review. Therefore, this research began with a non-committal literature review delineating the research problem, demonstrating the need for and rationale for the research. With this understanding, the overall aim of the research was to develop, confirm, and validate a communal holistic therapeutic approach for psychosocial health management among Southern African indigenous communities, made up of two facets: developmental and validation. This was achieved by exploring four research objectives. These four research objectives were interlinked to the three phases of the research, guided by an inductive-deductive theory generation process (see Chapter Two, Figure 3). Consequently, this negated the need to follow an explorative sequential mixed method design, as described in Chapter Three. These explorative sequential mixed methods enhanced the rigor of the research and strengthened its contributions. Therefore, the following research phases contributed to the overall outcome.

### **Phase I: Grounded Theory.**

#### Research objective(s)

**(1)** Develop a formal theory from the preliminary conceptual framework by utilizing a grounded theory. & **(3)** Develop a preliminary communal holistic therapeutic approach for psychosocial health management in African indigenous communities.

The purpose of this phase was to develop a formal theory using Classical Grounded Theory. Thus, in this phase, objective One and Three of the research were achieved, addressing the development aspect of the overall aim. The outcome of this phase was a formal theory {four-dimensional inclusive holistic communal psychosocial health management for Southern African indigenous communities (4IC-PHM-SAIC) theory}.

### **Phase II: Critical, Integrative Literature Review.**

#### Research objective(s)

**(2)** Conduct a critical, integrative literature review to compare, and contrast the constructs emerged from the formal theory against alternative models from existing

literature. & **(3)** Develop a preliminary communal holistic therapeutic approach for psychosocial health management in African indigenous communities.

This phase was set out to develop hypothetical models using the constructs emerging from Phase One of the research. This was achieved through the utilization of a critical integrative literature review. The outcome of this phase is hypothetical models grounded in the axiomatic statements that emerged from phase one. Essentially, this hypothetical models demonstrates the benefits of involving local people in the psychosocial health management provided and acknowledging their meaningful participation. The critical, integrative literature review allowed the researcher to synthesize and constantly compare the existing literature with the findings of Phase One of the research. This provided trust and truth values to the research findings.

**Phase III:** Content validity index (CVI), content validity ratio (CVR), and Multi-rate Kappa statistics.

Research objective(s)

**(4)** Confirm and validate the approach through expert validation (CVI, CVR, and kappa statistic).

Fundamentally, the intended purpose of this phase was to confirm and validate the emerging hypothetical models advancing the emerging theory into a Middle-range theory. Objective Four of the research was achieved in this phase, addressing the validation and confirmation aspects. Primarily, the items of the emerging theory, expressed in the CVI and CVR forms, depict acceptable content validity. Furthermore, evidence has demonstrated that the emerging theory attends to important elements of psychosocial health management among Southern African indigenous communities. This confirmation and validation of the emerging theory by experts strengthened the trustworthiness of the research and corroborated the emerging findings.

At the heart of the findings, the emerging theory thus far expresses the significance of meaningful community involvement and participation, shifting the paradigm of

custodianship of care to local people in the management of psychosocial health. Elucidating an Inclusive Holistic Communal therapeutic approach that is culturally aligned with indigenous South African communities. This inclusive holistic therapeutic approach upholds cultural regard and acceptance of indigenous science and communal practices. Hence, an approach that appreciates psychosocial health management as a lifelong cultural process embedded within the ways of life is manifested by mutual interaction between the interconnectedness of life in striving for a sense of harmonious balance.

A harmonious balance (equilibrium) between the chaos of living and independent harmony of life. At the same time, the emerging theory attests to a communal therapeutic approach that is respectful and shows the acceptance of other ways of life informed by indifferent worldviews.

## **7.5. Recommendations of the research**

*The recommendations made herein will be ensured through continued collaboration with the communities concerned, pursuant consultation and lobbying of political, academic and health services leadership. Enabling the advancement and operationalizing of the empirical evidence found in this research manifesting in the future practice, health science curriculum, policy, and future research.*

### **7.5.1. Future practice (Mental health care nurses, Community health nurses, Health promotion officers)**

The emerging findings of this research indicate the fundamentality of communality in psychosocial health management. Therefore, Community involvement and meaningful participation is imperative. This research demonstrates that meaningfully making use of readily available resources, such as but not limited to culture and people within communal contexts, is beneficial to the psychosocial health care provided. Therefore, psychosocial health management approaches should recognize, appreciate, and maximize the strengths and weaknesses of the communal context.

Moreover, the search recommends for practice a psychosocial health management approach that is inclusive of indifferent worldviews found within a communal context. This means, regard and acceptance should be afforded to the African and Western ways of life in the management of psychosocial health. Therefore, a practice demonstrating cultural congruence.

This recommendation is of central importance in quelling away the existing perception of nursing care remaining a 'technical' profession with less involvement in psychosocial health. Since it is generally known that nursing is the backbone of health care systems, this recommendation is important to the future practice of psychosocial health nursing care. Because in them providing a comprehensive and holistic quality nursing care, and with their competency of advocacy, nurses are called by the findings of the current research to ensure that the care provided to the mental health care user is relatable, particularly in indigenous communities.

### **7.5.2. Teaching and Learning (Curriculum development)**

This research recommends teaching and learning related to psychosocial health to involve the emerging Inclusive Holistic Communal Psychosocial Health Management Approach in curriculum development of health science disciplines. This will inform the psychosocial health care provided in communal contexts to be needs aligned, cost-effective and culturally congruent.

### **7.5.3. Government legislators and policymakers (Local, provincial, and national)**

Psychosocial health management approaches, programs, and policies (including the Mental Health Act) should start demonstrating appreciation for the coexistence of the African and Western worldviews.

### **7.5.4. Future research (Health science researchers, Mental health nursing researchers, Community nursing science researchers)**

The empirical findings of this research demonstrate preliminary evidence on the fundamentality of cultural axioms in psychosocial health management among Southern African communities, particularly in communal contexts. Therefore, further research is

needed to test this development through Randomized Controlled Trials and other methodologies.

These cultural axioms need to be further explored qualitatively and further tested through quantitative methods on their construct validity to stand scientific grounds as theorems of psychosocial health management.

## **7.6. Limitations of the research**

- First, the research was conducted during a worrisome time of the COVID-19 pandemic. Hence, all data collection for Phase One of the research was conducted virtually (online). This is because the logistical arrangements for data collection were affected by the lockdown restrictions imposed by governments across countries.
- African indigenous contexts carry a sense of sacredness due to knowledge prostitution and many other reasons. Therefore, indigenous communities might be careful in disclosing sacred information.
- Lastly, in phase three of the research, time management was a challenge during the pilot study. This is because most of the experts sampled for the pilot study could not honor the time allocated for their expert reviews. This delayed the analysis and eventually, the completion of the research.

## **7.7. Strengths of the research**

- The longstanding trust-relation between the researcher and Participant-group One played an important role in the true value of the information provided by the local people. This rapport allowed the participants to feel appreciated and respected. The researcher maintained prolonged engagement with Participant-group Two. Consequently, this allowed participants to value the research and provide truthful information as far as possible.
- Because the research involved two participant groups. This allowed the research to compare and contrast the data from the two groups, thereby strengthening the

value of the oral history and information provided. Fundamentally, this was achieved through data theory and method triangulation by converging the data of the two participant groups. This was further achieved through member checking. Moreover, an independent reviewer was appointed for a critical, integrative literature review in phase three, ensuring the quality of the review. Therefore, strengthening the findings of the research. In phase three, experts across a multitude of disciplines of clinical practice and research, were appointed to confirm and validate the emerging Middle-range theory. Furthermore, a quantitative expert was appointed for phase three of the research to ensure consistency of the items, to perform statistical tests, and to co-analyse the data. All things considered this limited the researcher bias.

- For Phase One of the research, the researcher ensured that sufficient (thick description) and quality (rich description) data were collected to achieve saturation.
- The explorative sequential mixed method design allowed the research to explore the emerging Middle-range theory qualitatively and further validate the theory quantitatively. This strengthened the research findings by increasing the accuracy and validity of the emerging theory.
- Classical Grounded Theory allowed the research to inductively handle the data in phase one with emphasis on theoretical sensitivity, theoretical sampling, and data dependence. Hence, the emerging Middle-range theory is grounded in data that limits researcher and confirmation bias.
- During the data collection for Phase One from the Participant-group One each question was translated into Afrikaans, and the participants were allowed to deliberate in their language of choice. Data were transcribed and translated into English. This minimized language barriers.
- During the sampling of the literature in phase two of the research for the critical, integrative review, a pilot was conducted to test the accuracy and consistency of the search terms. Therefore, the results of this pilot prudently informed the design and execution of the review of a controllable sample.
- Throughout the study, the researcher, with the guidance of the promoters, updated the plan and timelines pertaining to the study. This allowed the researcher to

identify and define the challenges to maintain the focus of the research and at the same time achieve set goals.

- Because of the broadness of the niche of the research, this allowed the emergence of the Middle-range theory to be grounded within the large amounts of raw data. Moreover, this broadness offers a culturally congruent starting point for psychosocial health management approaches among indigenous communities. However, this broadness creates opportunities for future research to explore and test the theory within a specific context and niche.
- It is further evident that the researcher followed all the necessary scientific processes, as required for the methodologies employed, ensuring that confirmatory bias is limited as much as possible.
- Finally, to minimize the bias of confirmation with expert validation by experts, a pilot study was conducted to determine whether the instructions sent to the experts were clear and comprehensive. Furthermore, experts were asked to suggest any omissions, strengths, or contributions that may help enhance the validity of the instrument.

## 7.8. Conclusion

This innovative approach in psychosocial health management is solidifying the role of nursing care in the field of mental health, particularly psychosocial health. Hence, psychosocial health is an area in nursing that this research positions as a matter of importance to comprehensive and holistic nursing care. Fundamentally, a communal holistic therapeutic approach for psychosocial health management among Southern African indigenous communities is realized in this research as an Inclusive Holistic Communal approach embedded in the five axiomatic statements. An approach appreciated and understood within a context where psychosocial health management is enshrined in the lifestyle. Necessitating the appreciation of life as a holistic-circlic continuous process independent of living where an imbalance between the two is regarded as a psychosocial health challenge. Thus, the point of equilibrium between life and living determines the meaning of good health.

That is why psychosocial health management is a shared responsibility where the life-long process of attaining the said equilibrium brings the holistic, interconnected, and inclusive meaning of psychosocial health. Belief system, mutual responsibility, respect, and regard for other worldviews found within a communal context engulf psychosocial health management. Hence, the participation and meaningful involvement of the family and community at large is of importance. Essentially, an approach by the community and for the community answers the call for a needs-aligned community-based mental health services made by WHO.

Therefore, with this unique contribution, psychosocial health management will be utilized to transform the mental health practice, education and research. Thus, a psychosocial health management approach that is accessible, cost-effective and culturally congruent.

Consequently, the contribution of this research becomes the arteries for the success of SDGs three and 17. By ensuring the psychosocial well-being of those in marginalized communities and strengthening the sciences informed by indifferent paradigms for ‘a shared prosperity in a sustainable world.’

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# ANNEXURE A: Faculty Research Committee Approval



University of Venda

SCHOOL OF HEALTH SCIENCES

## RESEARCH PROPOSAL EVALUATION FEEDBACK

**Name of Student:** Khauhelo Succes Mahlatsi (20025422)

**Proposed Degree:** Doctor of Philosophy in Nursing Sciences

**Topic:** A COMMUNAL HOLISTIC THERAPEUTIC APPROACH FOR PSYCHOSOCIAL HEALTH MANAGEMENT AMONG SOUTHERN AFRICAN INDIGENOUS COMMUNITIES

**Supervisors:** Prof A.J Pienaar

: Prof M Mulaudzi

: Dr T Malwela

**Date** : 17/02/2021

### COMMENTS

#### Proposal layout

- The proposal layout is in accordance with the guidelines.

#### Topic

- The topic is appropriate and researchable and meets the expectations of a PhD study.

#### Introduction and background

- The candidate succinctly introduces the study with relevant recent literature.

### Conceptual/theoretical framework

- A well expressed and illustrated theoretical framework which is relevant to the Aims and objectives of the study

### Conceptualisation of the problem

- The candidate explicitly and clearly shows why the psychosocial paradigm in the treatment and realisation of mental health is suited to the indigenous African environment..

### Study approach/design

- The chosen study approach and design is suitable, and the candidate demonstrates a clear understanding of the approach and design he has chosen through lucid exposition backed by relevant literature.

### Population and sampling

- The chosen populations and the sampling methods preferred are likely to produce rich data.

### Instruments

- These are clearly explained with a strong support from literature.

### Data management

- The candidate takes the reader through a well-reasoned and logically presented procedure all the time supported by relevant literature.

### Ethical protocol

- The candidate shows a clear understanding of the ethical route which he will follow from the institution to the gatekeepers and participants in the field.

### Referencing style

- In text citing and the listing of the reference list are consistently applied and written.

### Presentation

- N/A

General comments:

- The candidate demonstrates knowledge, skill and ability expected of a PhD candidate

DECISION:

1.  Approved with no corrections [ x ]
2.  Approved with minor corrections to be checked by supervisor/promoter [ ]
3.  Approved with major corrections to be checked by supervisor/promoter [ ]
4.  Approved with major corrections to be resubmitted for checking by panel [ ]
5.  Approved with major corrections, student to present again to panel [ ]
6.  Rejected, reconceptualization required [ ]

Chueng M.J (Research Assistant)

Date: 17/02/2021

Prof RT Lebeso (Research Professor)

Date: 17/02/2021

# ANNEXURE B: Executive School Higher Degree Committee Approval



University of Venda

School of Health Sciences

Research Office

Executive School Higher Degree Committee

To : Mr Khauhelo Success Mahlatsi

Department of Advance Nursing Sciences (D.Cur Candidate)

From: Prof RT Lebese

Research Professor, School of Health Sciences

Date: 05 May 2021

**The decision of the Executive School Higher Degree Committee on 05 May 2021**

Application for approval of a thesis proposal report in Advance Nursing Sciences:  
Khauhelo Success Mahlatsi (2002542)

Title: A communal holistic therapeutic approach for psychosocial health management  
among Southern African indigenous communities

Promoter : Prof AJ Pienaar

Co-promoter : Prof MT Mulaudzi

\_\_\_\_\_ Dr T Malwela

ESHDC recommended for approval by the UHDC



\_\_\_\_\_  
Prof RT Lebese  
Research professor (Chairperson of ESHDC)  
School of Health Sciences

# ANNEXURE C: Research Ethics Committee Approval

ETHICS APPROVAL CERTIFICATE

RESEARCH AND INNOVATION  
OFFICE OF THE DIRECTOR

NAME OF RESEARCHER/INVESTIGATOR:  
**Mr KS Mahlatsi**

STUDENT NO:  
20025422

PROJECT TITLE: **A communal holistic therapeutic approach for psychosocial health management among Southern African indigenous communities.**

PROJECT NO: SHS/21/PDC/09/0907

SUPERVISORS/ CO-RESEARCHERS/ CO-INVESTIGATORS

NAME	INSTITUTION & DEPARTMENT	ROLE
Prof AJ Pienaar	Shifa Tameere-Millat University/UNIVEN	Promoter
Prof MT Mulaudzi	University of Venda	Co - Promoter
Dr T Malwela	University of Venda	Co - Promoter
Mr KS Mahlatsi	University of Venda	Investigator - Student

Type: Doctoral Research

Risk: Minimal risk to humans, animals or environment (Category 2)

Approval Period: July 2021 – July 2024

The Human and Clinical Trials Research Ethics Committee (HCTREC) hereby approves your project as indicated above.

**General Conditions**

While this ethics approval is subject to all declarations, undertakings and agreements incorporated and signed in the application form, please note the following:

- The project leader (principal investigator) must report in the prescribed format to the REC:
  - Annually (or as otherwise requested) on the progress of the project, and upon completion of the project
  - Within 48hrs in case of any adverse event (or any matter that interrupts sound ethical principles) during the course of the project.
  - Annually a number of projects may be randomly selected for an external audit.
- The approval applies strictly to the protocol as stipulated in the application form. Would any changes to the protocol be deemed necessary during the course of the project, the project leader must apply for approval of these changes at the REC. Would there be deviated from the project protocol without the necessary approval of such changes, the ethics approval is immediately and automatically forfeited.
- The date of approval indicates the first date that the project may be started. Would the project have to continue after the expiry date; a new application must be made to the REC and new approval received before or on the expiry date.
- In the interest of ethical responsibility, the REC retains the right to:
  - Request access to any information or data at any time during the course or after completion of the project,
  - To ask further questions; Seek additional information; Require further modification or monitor the conduct of your research or the informed consent process.
  - withdraw or postpone approval if:
    - Any unethical principles or practices of the project are revealed or suspected.
    - It becomes apparent that any relevant information was withheld from the REC or that information has been false or misrepresented.
    - The required annual report and reporting of adverse events was not done timely and accurately.
  - New institutional rules, national legislation or international conventions deem it necessary

ISSUED BY:

UNIVERSITY OF VENDA, RESEARCH ETHICS COMMITTEE

Date Considered: June 2021

Name of the HCTREC Chairperson of the Committee: Dr NS Mashau

Signature:



<p>UNIVERSITY OF VENDA OFFICE OF THE DIRECTOR RESEARCH AND INNOVATION</p> <p>2021-07-21</p> <p>Private Bag X5050 Thohoyandou 0950</p>
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UNIVERSITY OF VENDA  
PRIVATE BAG X5050, THOHOYANDOU, 0950, LIMPOPO PROVINCE, SOUTH AFRICA  
TELEPHONE: (015) 962 8042/8113 FAX: (015) 962 8040  
"A quality driven, financially sustainable, rural-based Comprehensive University"

## ANNEXURE D: Memorandum of understanding

### THE GRIQUA ROYAL HOUSE DIE GRIEKWA KONINGLIKE-HUIS



Administration Office: 10th & Boardman Str. Faith Mission Centre, Lennoxville, Edburg, P.O. Box 7480, P.O. Box 316, Ekurhuleni 7480  
Tel: 021 952 9901 Fax: 021 951 5400 Email: [artandobu@gnote.co.za](mailto:artandobu@gnote.co.za)

#### MEMORANDUM OF UNDERSTANDING

This memorandum serves as an agreement reached between the Seboka Team under the leadership of Prof. Abel J. Pienaar and the Griqua Royal House. An appointed Seboka member will be expected to abide and respect the values and norms of the community while conducting research.

The following are the terms and conditions of agreement.

- The Seboka team is given the permission to conduct the research within the Griqua community, on a mutual capacity principle;
- The conducted research will be based on the Indigenous Knowledge Systems, of which the community will lead and guide the proceedings;
- The team (Seboka) will conduct the research using multiple research methodologies but the primary approach will be conducting "makgotla" with the assistance of a nominated member of the Griqua Royal House;
- The Seboka team will always respect the community and make sure that all the information is treated confidential;
- The research will be conducted by the appointed Seboka researcher, who will in turn sign the consent;
- Both parties also agree that the shared information remains the property of the Griqua Royal House unless otherwise stated;

This memorandum will be used as a global consent for conducting the research in the community. The participants' rights will also be taken into consideration and be respected while conducting the research. These rights are but not limited to the following:

AKO

K-S

- Autonomy and self-identification
- Pnvacy
- Confidentiality
- Justice
- Non m leficence
- Voluntary part1cip lion
- Freedom of speech and movement as it will be an open forum

These conditions were discussed and agreed upon by the two parties (Community leader and Seboka Team leader). The terms and conditions discussed above are legal and bonding to the **partie**

Signed at CAMPBEE on 17<sup>th</sup> of July 201

Seboka team leader : [Signature]

Griqua Royal House : [Signature]

Researcher : [Signature]

Copies to- Griqua Royal House, Sebeka office and r se rcher



# ANNEXURE E: Consent Form

Research and Innovation  
Office of the Director

## RESEARCH ETHICS COMMITTEE

### UNIVEN Informed Consent

#### LETTER OF INFORMATION

**Title of the Research Study** : A communal holistic therapeutic approach for psychosocial health management among Southern African indigenous communities.

**Principal Investigator/s/ researcher** : Mr Khauhelo Succes Mahlatsi (MNSc; BNSc)

**Co-Investigator/s/supervisor/s** : Prof Abel, J. Pienaar (PhD; MA (Psych.Com. Nursing; M.Ed; B.Cur; Advance University Diploma in Health Science Education and Health Service Management.)

: Prof M.T. Mulaudzi (PhD)

: Dr T Malwela (PhD)

**Brief Introduction and Purpose of the Study:** Commuality and Ubuntu are important principles of the systems of life among indigenous communities in Africa. This circumstance continues to be amid a contradiction of mental health practitioners educated in western health system, despite these practitioners have to practice in these indigenous communities. Notably, psychosocial care provided in these indigenous communities proves to be a mismatch, evident by compartmentalized western health model, over-reliance on pharmacological interventions, shortage of mental health nurses and the dubiousness of therapeutic interaction.

Thereupon, the purpose of this research is to develop, confirm, and validate a communal holistic therapeutic approach for psychosocial health management in Southern African indigenous communities, a process for the community, by the community (South Africa, Zimbabwe and Malawi).

**Outline of the Procedures** : Information will be collected by means of Makhotla, this process will be recorded with an audio recorder. The engagement will begin with community leaders/chief who will then relay the information to the members of the indigenous community as per their protocol.

Importantly, as a participant you need to understand the explanation, read and comprehend the following explanations of the study before accepting or refusing to participate in this research. The following describes benefits, risk, right to refusal/withdrawal, confidentiality, and costs or payment related to participation in the study.

This information will also be thoroughly explained by the researcher in a manner easier to understand with the support of the community leaders

There will be Tow sessions of makhotla followed by individual sessions as per the emergence of the theory (theoretical sampling). The first session of makhotla will involve an unstructured data collection schedule. Wherein, the second session will be confirmatory in nature.

UNIVEN Informed Consent

Page 1 of 4

**Risks or Discomforts to the Participant:** There are no risks associated with participating in this research. This is a community mobilization research. *This project is building on the master's project that was done in the same community.*

**Benefits** : Participation in this research will be beneficial to the community by contributing to the knowledge base of management of psychosocial health challenges within the Southern African diverse context. Thus, it will benefit unique contexts of the African space by developing a general approach in the use of dialogues in relation to healing. Herein, it is anticipated that three publications will result from the project.

**Reason/s why the Participant May Be Withdrawn from the Study:** Participation is voluntary and refusal to participate in this study will involve no penalty. Each participant is free to withdraw consent and discontinue participation at any given moment in time.

**Remuneration** : Participants will not receive any remuneration.

**Costs of the Study** : There will be no costs involved for taking part in this research, except for their time

**Confidentiality** : The information collected during this collaborative research will at all times remain confidential. Names of the participants will not be shared during the research or publication of the results. Data obtained from the community will be used for the research purpose only. Feedback of the results of the research will be given to the community.

**Research-related Injury** : No research-related injury is anticipated.

Persons to Contact in the Event of Arty Problems or Queries:

**Supervisor:** Prof Abel. J Pienaar [abel.pienaar@gmail.com](mailto:abel.pienaar@gmail.com)

Please contact the researcher (+2778 912 1038.), my supervisor (tel no +27826807642.) or the University Research Ethics Committee Secretariat on 015 962 9058. Complaints can be reported to the Director: Research and Innovation, Prof GE Ekosse on 015 962 8313 or Georges Ivo.Ekosse@univen.ac.za

General:

Potential participants must be assured that participation is voluntary and the approximate number of participants to be included should be disclosed. A copy of the information letter should be issued to participants. The information letter and consent form must be translated and provided in the primary spoken language of the research population

**CONSENT**

Statement of Agreement to Participate in the Research Study:

- I hereby confirm that I have been informed by the researcher, *(Khauhelo Succes Mahlats,)*, about the nature, conduct, benefits and risks of this study- Research Ethics Clearance Number: **SHSI21/POC/09/0907**,
- I have also received, read and understood the above written information (*Participant Letter of Information*) regarding the study.
- I am aware that the results of the study, including personal details regarding my sex, age, date of birth, initials and diagnosis will be anonymously processed into a study report.
- In view of the requirements of research, I agree that the data collected during this study can be processed in a computerized system by the researcher.
- I may, at any stage, without prejudice, withdraw my consent and participation in the study.
- I have had sufficient opportunity to ask questions and (of my own free will) declare myself prepared to participate in the study.
- I understand that significant new findings developed during the course of this research which may relate to my participation will be made available to me.

Full Name of Participant                      Date                      Time                      Signature

I, .....

*(Name of researcher)* herewith confirm that the above participant has been fully informed about the nature, conduct and risks of the above study.

Full Name of Researcher

Date.....                      Signature.....

Full Name of Witness (If applicable)

Date .....                      Signature.....

Full Name of Legal Guardian (If applicable)

Date.....                      Signature.....

***Please note the following:***

Research details must be provided in a clear, simple and culturally appropriate manner and prospective participants should be helped to arrive at an informed decision by use of appropriate language (grade 10 level- use Flesch Reading Ease Scores on Microsoft Word), selecting of a non-threatening environment for interaction and the availability of peer counseling (Department of Health, 2004)

If the potential participant is unable to read/illiterate, then a right thumb print is required and an impartial witness, who is literate and knows the participant e.g. parent, sibling, friend, pastor, etc. should verify in writing, duly signed that informed verbal consent was obtained (Department of Health, 2004).

If anyone makes a mistake completing this document e.g. a wrong date or spelling mistake, a new document has to be completed. The incomplete original document has to be kept in the participant's file and not thrown away, and copies thereof must be issued to the participant.

---

References:

Department of Health: 2004. *Ethics in Health Research: Principles, Structures and Processes*

<http://www.doh.gov.za/docs/factsheets/guidelines/ethnics/>

Department of Health. 2006. *South African Good Clinical Practice Guidelines*. 2nd Ed. Available at .

[http://www.nhrec.org.za/?page\\_id=14](http://www.nhrec.org.za/?page_id=14)

# ANNEXURE F: Data Collection Schedule (PHASE I)

*Data collection schedule*

**Title of the research:** A communal holistic therapeutic approach for psychosocial health management among Southern African indigenous communities

*A. Introduction and welcome*

1. Introduce the purpose of the gathering.
2. Inform the participants about the use of audiotape/google-meet recorders and that no names would be used in the transcribed text and ask for permission for this.
3. Clarify the role of the researcher.
4. Presentation by the researcher (+/- 20 min)

*B. Start of the session*

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**CONFIRMATORY AND COMPARATIVE QUESTIONS**

---

*Who, what, why, how, when and whom*

1. What is the meaning of good health vs illness? (what)
2. What is the meaning of healing? (what)
3. What is the meaning of psychosocial health (what)
4. What is the meaning of a person within your community? (who)

*Data collection schedule*

5. How do you manage psychosocial health challenges at a communal level (who is involved, of 'who is saying/doing what to whom; when and why and how they are saying/doing it')
6. What is the role of the persons in the community in managing psychosocial health challenges (what)

**Possible probing questions**

- *Why*
- *When* is the healing process started and when is the end of the healing process
- *Whom* is involved
- *How* would you explain the process/procedure?
- *Who* is involved in this process?
- *Where* is (environment) the engagement held?
- *What* are the psychosocial challenges with in the community?
- Is it a life-long process or periodic or as per the need?
- ***What is the end goal of psychosocial management process?***

---

## CENTRAL QUESTIONS

---

1. *What* is life ?

- **FROM Beginning**
- **TO End (does it end?)**

2. Is life linear or circle process (*what*)?

- *Why?*
- *What* makes it linear or circle
  - A. **(structural components)** / are there any layers to life? How are they connected to one another?
  - B. **spiritual component** – cultural practices, dance, music.
  - C. **mechanical component** – Static or clock work?
  - D. **relation to cosmology** – is it connected to the surroundings?

3. *What* is the source of life? – (**the meaning of axial, WHAT GIVES ENERGY/POWER TO LIFE**)

*Data collection schedule*

**4. Is your way of life interwoven to the management of psychosocial health challenges?**

- *Why?*
- who is involved, of 'who is saying/doing what to whom; when and why and how they are saying/doing it'

**5. what is the end goal to psychosocial health management?**

- continual
- referral
- closure

**Closing remarks**

---

Question: Would you like to add anything new or on what has already been said?

**C. Closure**

Word of gratitude and thanks.

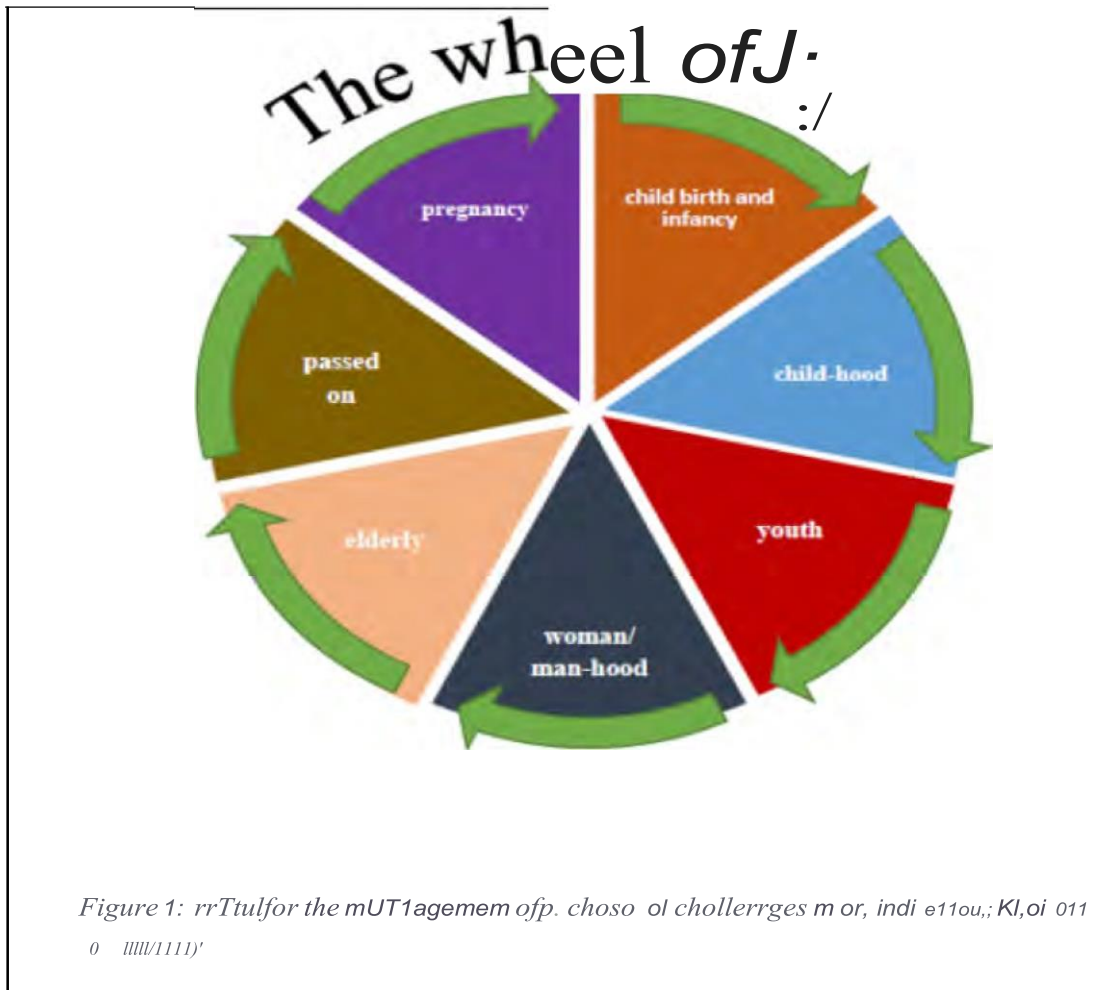
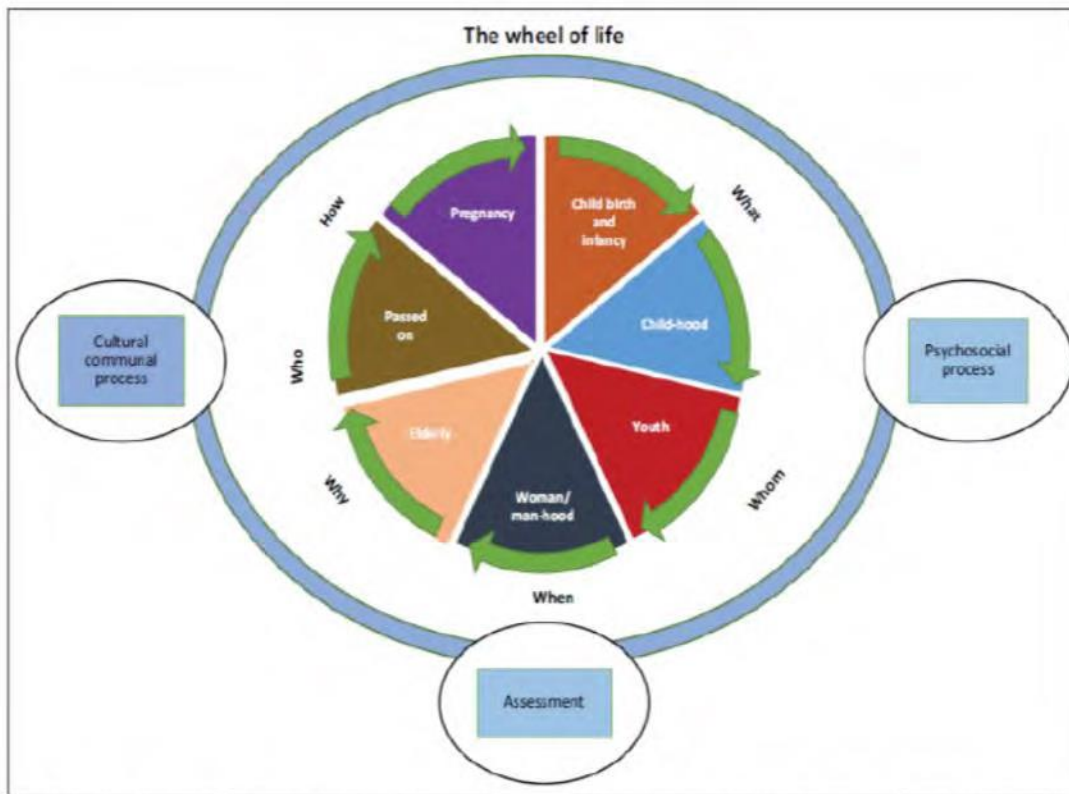


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Data collection schedule



Source: Adapted from Mahlatsi, K.S., 2018, Dialogues of healing in the management of psychosocial health challenges in an indigenous Khoisan community, Masters thesis, School of Nursing Sciences, North-West University

FIGURE 1: The wheel for the management of psychosocial health challenges in an indigenous Khoisan community.

# ANNEXURE G: ANNEXURE G: Language editing certificate



# ANNEXURE H: Request for Independent Reviewer (PHASE II)

[Khauhelo.mahlatsi@gmail.com](mailto:Khauhelo.mahlatsi@gmail.com)

*PhD Candidate*

*University of Venda, South Africa*

**Subject:** Request for your expertise as an independent reviewer.

Dear Mr Aurangzeb

I am writing to express my interest in you accepting my humble request for your participation in our research project. You are invited to participate as an independent reviewer for the critical, integrative literature review chapter. We believe your expertise will add valuable input to the project.

The following is what is expected of an independent reviewer.

**Expectations:**

First round

1. Preliminary review of the design.

Second round

1. Final review of the improved design after pilot test.

Your participation will be highly appreciated.

Looking forward to your response.

*Kindly*

*Khauhelo S. Mahlatsi*



15 February 2023

## ANNEXURE I: Letter from the Independent Reviewer

To whom it may concern

I have conducted an independent review of the critical, integrative review literature chapter for Mr KS Mahlatsi in his Doctoral project (a communal holistic therapeutic approach for psychosocial health management among Southern African indigenous communities).

This involved two rounds of review.

Sincerely

Aurang Zeb

Principal & Associate Professor

Rehman College of Nursing

Hayatabad Peshawar, Pakistan

October 2023

# ANNEXURE J: Request for Expert Reviewer, Pilot Study (PHASE III)

*KHAUHELO S. MAHALTSI*  
[Khauhelo.mahlatsi@gmail.com](mailto:Khauhelo.mahlatsi@gmail.com)  
*PhD Candidate*  
*University of Venda, South Africa*

**SUBJECT:** Request for your valuable participation as an expert reviewer

Dear Expert Reviewer

I am Khauhelo S. Mahlatsi, a PhD student from University of Venda, South Africa. Promoted by Prof. Dr. A.J. Pienaar. My co-promoters are Prof. M Mulaudzi and Dr. T Malwela.

The purpose of this letter is to humbly invite your expert contribution to a pilot of PhD-research project titled:

*A communal holistic therapeutic approach for psychosocial health management among Southern African indigenous communities.*

This research aims to develop, confirm, and validate a communal holistic therapeutic approach for psychosocial health management in Southern African indigenous communities (South Africa and Malawi), **(the abstract is attached)**.

Your valuable participation will be to test the extent to which the instructions and all the attachments sent to you as an expert reviewer are clear and understandable. Furthermore, to add any information you deem valuable to the pilot. This will further inform the rolling out of the project.

We believe that your expertise will add value to the project.

Upon accepting this request, you will receive the necessary documents.

Your availability for this task will be sought for the month of May 2023 for a maximum of one week.

We are looking forward to your favourable response in this regard.

*Yours in kindness,*



Personal details:

**Khauhelo Succes Mahlatsi**

**PhD candidate, University of Venda**

**+27 78 912 7038**

**[khauhelo.mahlatsi@gmail.com](mailto:khauhelo.mahlatsi@gmail.com)**



# ANNEXURE K: Request for Expert Reviewer (PHASE III)

*KHAUHELO S. MAHALTSI*  
[Khauhelo.mahlatsi@gmail.com](mailto:Khauhelo.mahlatsi@gmail.com)  
*PhD Candidate*  
*University of Venda, South Africa*

**SUBJECT:** Request for your valuable participation as an expert reviewer

Dear Expert Reviewer

I am Khauhelo S. Mahlatsi, a PhD student from University of Venda, South Africa. Promoted by Prof. Dr. A.J. Pienaar. My co-promoters are Prof. M Mulaudzi and Dr. T Malwela.

The purpose of this letter is to humbly invite your expert contribution to a PhD-research project titled:

*A communal holistic therapeutic approach for psychosocial health management among Southern African indigenous communities.*

This research aims to develop, confirm, and validate a communal holistic therapeutic approach for psychosocial health management in Southern African indigenous communities (South Africa and Malawi), (the abstract is attached).

Your valuable participation will be to confirm and validate the contents of the emerging tool (CVI & CVR). Upon accepting this request, you will receive the necessary documents.

Your availability for this task will be sought for the month of May 2023 for a maximum of three weeks.

We are looking forward to your favourable response in this regard.

*Yours in kindness,*



Personal details:

**Khauhelo Succes Mahlatsi**

**PhD candidate**

+27 78 912 7038

[khauhelo.mahlatsi@gmail.com](mailto:khauhelo.mahlatsi@gmail.com)

## ABSTRACT

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ervi e rul d policymaker .

## ANNEXURE L: Request for a Quantitative Expert (PHASE III)

*KHAUHELO S. MAHALTSI*

*[Khauhelo.mahlatsi@gmail.com](mailto:Khauhelo.mahlatsi@gmail.com)*

*PhD Candidate*

*University of Venda, South Africa*

**Subject:** Request for your quantitative expertise in co-analysis

---

Dear Prof. Cheryl Nikodem

I am writing to invite your expertise as a quantitative researcher in our research project. You are invited as a consultant to participate in phase three of the research concerning a quantitative, non-experimental design involving CVI, CVR and Kappa statistic. We believe your expertise will add value to the project.

Upon accepting the invitation, the following are what is expected of you.

### Expectations

You are expected in collaboration with the researcher to;

1. Formulate statistical forms for CVI & CVR.
2. Conduct and interpret all the quantitative tests and calculations.
3. Develop and formulate summary tables.
3. Offer expert advice on the overall contents of the chapter.

Thank you in advance for your unwavering support.

*Yours in kindness,*

*Yours in kindness,*



Personal details:

**Khauhelo Succes Mahlatsi**

**PhD candidate, University of Venda**

+27 78 912 7038

[khauhelo.mahlatsi@gmail.com](mailto:khauhelo.mahlatsi@gmail.com)

[20025422@mvula.univen.ac.za](mailto:20025422@mvula.univen.ac.za)

# ANNEXURE M: Letter from the Quantitative Expert

Quantitative Expert

October 2023

---

To whom it may concern

I can confirm that I assisted Mr Khauhelo S. Mahlatsi in his research titled '*A communal holistic therapeutic approach for psychosocial health management among Southern African indigenous communities*'.

I assisted with the validity and reliability of the quantitative phase involving Content Validity Index (CVI), Content Validity Ratio (CVR) and Kappa Statistic.

Sincerely

# ANNEXURE N: Information sent to the Expert Reviewers (PHASE III)

## Cover letter, Section A to H

### COVER LETTER

*Thank you once more for your valuable participation in our research project.*

This cover letter serves to orient you on the contents herein. Firstly, this undertaking is expected to be completed in a minimum of two weeks from receipt of the documents.

The contents herein are divided in eight sections (A to H).

Section A includes the instructions.

Section B entails demographic information.

Section C to F involves the judgement quantification and some quality judgement expected.

Section G envelopes the necessary documents needed to appraise yourself regarding the hypothetical model and the emerging conceptual meanings important for the deliberations of section C to F.

Section H contains checklists to be completed at the end of the review.

#### **Summary statement**

We greatly value your contribution to our project. The amount of work is not taken for granted by us. Equally, timeous completion of this task is as important. However, considering the possibility that you have other commitments, arrangements can be made with the researcher for a maximum one-week extension. As importantly, you must also inquire with the researcher to dispel any misunderstandings. Furthermore, in line with the instructions contained in section A, it is important

that you study the annexures in section G to obtain a greater understanding of what content is being confirmed and validated.

## TABLE OF CONTENTS

<b>CONTENTS</b>
1. Abstract
2. Section A: Comprehensive Instructions
3. Section B: Demographic Information
4. Section C: Content Validity Index (CVI) rating form
5. Section D: Qualitative judgement
6. Section E: Content Validity Ratio (CVR) rating form
7. Section F: Qualitative judgement
8. Section G: Annexure I – Emerging outcome  Annexure II – Emerging conceptual meaning
9. Section H: Check list

## SECTION A: Comprehensive Instructions

### Pre-liminary concepts

1. *Psychosocial health management approach* means the emerging *Middle-range theory*.

### Significance of the research

Fundamentally, the outcome of this research envisions a *holistic therapeutic approach for the management of psychosocial health among indigenous communities particularly in the Southern African region*, culturally competent to the needs of the community. Hence, this emerging Middle-range theory seeks to align the psychosocial health needs, resources, and available systems to effectively manage psychosocial health challenges. As importantly, the research pursues to inform practice as well as teaching and learning in mental health to appreciate the cultural diversity existing in Southern Africa. The research further aspires to open the lens of mental health research to a broad spectrum by realizing the significance of being sensitive to indifferent cultures when contributing to the body of knowledge. Additionally, this approach is envisioned as a lifestyle to the indigenous communities to revitalize indigenous communal use in psychosocial health management. Lastly, this research anticipates rise to new research innovations to inform the policy makers in the Southern African context.

### To guide the evaluator a few instructions are given below:

*Please study section G to have a deeper meaning of the content being confirmed and validated to carry out the instructions.*

1. In line with the CVI rating form you are required to offer an expert judgement quantification for each item based on its feasibility. This achieved by making use of the CVI rating form provided. The rating ranges from 1 to 4 indicating the content validity of each item (**see section C**)
2. In line with the CVR form you are required to offer expert judgement on whether each item is important, necessary, or not necessary (**see section E**)
3. You are required to offer an expert judgement on the entirety of the approach by determining whether the whole approach is content user-friendly and valid (**see section C**).

4. You are required to offer expert judgement on any area(s) you observed to have been omitted (see section D).
5. Evaluate the approach in its total comprehensiveness and offer a judgement on whether it satisfy its expected functions (see section F).
6. You are further required to offer input and suggestions for improvements to enhance the content validity of the psychosocial health management approach (see section C).

### **The importance of your response**

Establishing the content validity of this hypothetical model is essential because an invalid psychosocial health management approach damages the relevance and representation of the emerged constructs for its intended function. Thus, the clinical inferences made in this research should not assume insolent significance. Therefore, your expert, comprehensive responses are needed to avoid misrepresentation, overrepresentation, omissions, and underrepresentation of the elements of the approach. But also, avoid inclusion of measurements not needed (Haynes et al., 1995:240).

### **Privacy and confidentiality**

The information acquired will only be used for its intended purpose. Equally, your identity will not be revealed for public knowledge.

### **Time frames**

You are expected to complete your expert confirmation and validation in two weeks.

### **Summary**

The intention is for these instructions to be understandable, clear, and concise. However, we also trust that the significance of responding to each instruction is made abundantly clear. As a result, it is essential that you fully comprehend these instructions prior to beginning the expert judgment. But also, each aspect of the task carries the same weight of significance. Hence, you are required to attend and treat each area as such. If there are any misconceptions, you can either get in touch with the researcher using the information below or include such information in your qualitative evaluation.

***Thank you,***

**Contact details:**

Khauhelo S. Mahlatsi

[Khauhelo.mahlatsi@gmail.com](mailto:Khauhelo.mahlatsi@gmail.com)

+27 78 912 1038 (WhatsApp or call)

**References**

Haynes, S.N., Richard, D. and Kubany, E.S., 1995. Content validity in psychological assessment: A functional approach to concepts and methods. *Psychological assessment*, 7(3), p.238.

**SECTION B: Demographic information**

Demographic information is necessary to this research for determining whether the expert panel is a representative sample of the target population for generalization purposes. Demographic information also provides information about research participants.

**Instructions**

You are required to indicate the correct option by marking X on the form below.

## Demographic information sheet

	Gender	Mark		Area of expertise (if applicable, mark a maximum of two)	Mark
1.	Man		1.	Working in the Community (Lay community member)	
2.	Woman		2.	Mental Health	
3.	Transgender		3.	Indigenous Knowledge Systems (IKS)	
4.	Non-binary/no-conforming		4.	Clinical Psychologist	
5.	Other Specify:		5.	Social Worker	
6.	Prefer not to respond.		6.	Nursing	
			7.	Researcher	
			8.	Other Specify:	
	Age in years	Mark		Highest qualifications completed	Mark
1.	≤25		1.	Primary school	
2.	26 - 35		2.	High school	
3.	36 - 45		2.	Diploma	
4.	46 - 55		3.	Degree	
5.	56≥		4.	Honors degree	
			5.	Masters	
			6.	PhD	

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## SECTION C: Content Validity Index (CVI)

### Instructions

1. In line with the CVI rating form you are required to offer an expert judgement quantification for each item based on its feasibility. This achieved by making use of the CVI rating form provided. The rating ranges from 1 to 4, indicating the content validity of each item.
2. In line with the CVI rating form you are further required to offer input and suggestions for improvements to enhance the content validity of the psychosocial health management approach.

### CVI rating form

**A communal holistic therapeutic approach for psychosocial health management among Southern African indigenous communities.**

#### Degree of relevance

- 1- the item is not relevant to the measured hypothesis.
- 2- the item is somewhat relevant to the measured hypothesis.
- 3- the item is moderately relevant to the measured hypothesis.
- 4- the item is highly relevant to the measured hypothesis.

#	Hypotheses	Domain	Items	Please X the appropriate response			
				1	2	3	4
1	Increased community involvement and meaningful participation demonstrate practical and beneficial outcomes in the management of psychosocial health (See section G).	1.1. Communal Practice.	1.1.1. The psychosocial health care provided involves the family, community, and the curative institutions.				
			1.1.2. The psychosocial health care provided appreciates the cultural practices found in a communal context.				
				1	2	3	4

		1.1.3. The psychosocial health care provided build on the trust relations already existing within the indigenous communities.				
		1.1.4. At the family and community level of care, the psychosocial health care that is provided is accessible to communal persons without requiring any traveling distance.				
		1.1.5. The psychosocial health care provided is cost-effective to the communal persons.				
		1.1.6. The resources used for the psychosocial health care provided are readily available and familiar to the communal persons.				
		1.1.7. The psychosocial health care provided is needs aligned.				
		1.1.8. The psychosocial health care provided enables timely feedback.				
		1.1.9. The psychosocial health care provided enables the progress of health within the community.				
		1.1.10. The psychosocial health care provided enables progress monitoring.	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>

		1.11. The psychosocial health care provided attempts to decrease stigmatization.				
2	A belief system is shared and valued by all within a given communal context, because communal persons shoulder equal understanding and appreciation of the knowledge generation and interpretation of the given reality. (See section G).	2.1. Shared belief system	2.1.1. The psychosocial health care provided recognizes the principles of communality as central to the management of psychosocial health.			
			2.1.2. The psychosocial health care provided appreciates the sacredness of indigenous knowledge and heritage found within a communal community.			
			2.1.3. The psychosocial health care provided appreciates shared belief that life is understood by communal persons as a holistic-circlic continuous process.			
			2.1.4. The psychosocial health care provided is culturally sensitive towards the shared belief system found within a communal community.			
				<b>1</b>	<b>2</b>	<b>3</b>
	2.1.5. The psychosocial health care provided is culturally congruent with the shared belief system found within a communal community to achieve the					

		balance of life in the management of psychosocial health.				
		2.1.6. The psychosocial health care provided is culturally competent with the shared belief system found within a communal community to achieve the balance of life in the management of psychosocial health.				
3	Life is a holistic-circlie continuous process that is independent from living, because a belief system is shared by all within a given communal context. (See section G).  (Independent circle of life)	3.1. Life	3.1.1. Life is not defined from singularity, but in its essence of continuity, communality, and holism. Therefore, Life is a holistic-circlie continuous process valuing the intersects of those physically alive on earth, those who were here before us, the yet-to-be-born and the cosmos.			
				1	2	3

		3.1.2. Life herein denotes the essence of time, space, and people. Therefore, the psychosocial health care provided appreciates life as interconnected to health, illness and healing illuminating the understandings of psychosocial health.				
		3.1.3. The psychosocial health care provided appreciates health as a phenomenon encompassing one's physical body, mental, emotions, spirit, environment (cosmos, those physically living on earth and those who passed on) and livelihood.				
4	The interconnectedness between independent life, and living is fulfilled when a status of equilibrium between life and living has been reached. (See section G).	4.1. Harmonious equilibrium	4.1.1. The psychosocial health care provided appreciates illness as the disharmony between one's physical body, mental, emotions, spirit, environment (cosmos, those physically living on earth and those who passed on) and livelihood.			
			4.1.2. The psychosocial health care provided appreciates that harmonious balance is achieved through a holistic-continual process of healing involving basic and advanced communal therapeutic techniques.			
			4.1.3. The psychosocial health care provided appreciates healing is a lifelong shared cultural process with its sole intention of locating harmonious equilibrium between one's physical body, mental,	<b>1</b>	<b>2</b>	<b>3</b>

		emotions, spirit, environment (cosmos, the living and those who were here before) and livelihood.				
		4.1.4. The psychosocial health care provided appreciates psychosocial health as a life-long inclusive process striving for harmonious balance within the interconnectedness of life.				
	4.2. Basic and advanced therapeutic interactions	4.2.1. The psychosocial health care provided realize humility as a basic therapeutic interactive skill expected from each communal person.				
		4.2.2. The psychosocial health care provided includes sharing encouraging feelings and providing emotional and other support.				
		4.3.1. The psychosocial health care provided realizes storytelling and metaphors as advanced therapeutic interactions to demonstrate resilience.				
		4.3.2. The psychosocial health care provided appreciates meaningful silence (meaningful presence) as having therapeutic benefits.	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>
		4.3.3. The psychosocial health care provided recognizes self-resilience disclosure as having				

		therapeutic benefits by providing the opportunity for openness, empathy, and rapport.				
		4.3.4. The psychosocial health care provided includes patience and respectful waiting for the attainment of the harmonious balance of life.				
	4.4. Basic and advanced therapeutic interventions	4.4.1. The psychosocial health care provided appreciates graveyard visit as having therapeutic benefits.				
		4.5.1. The psychosocial health care provided recognizes Mpho ya badimo, a thanksgiving to those who were here before us as having therapeutic benefits.				
		4.5.2. The psychosocial health care provided recognizes !nxhabasas, a rite-of-passage for young girls as having therapeutic benefits.				
		4.5.3. The psychosocial health care provided appreciates Spiritual dance (Trance-dance/ spiritual revitalization) as having therapeutic benefits.	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>
		4.5.4. The psychosocial health care provided recognizes medicinal plants as having therapeutic benefits.				

<b>5</b>	If life is independent, the point of equilibrium is the sense of balance between life and living. Therefore, interconnected to life and living. (See <b>section G</b> ).	5.1. Communal psychosocial lifestyle	5.1.1. The psychosocial health care provided appreciates that communal persons carry a mutual duty for the betterment of all. Hence, achieving the balance of life begins at a family level as it is an inborn responsibility for communal persons.				
		5.2. Inclusive psychosocial health management system	5.2.1. Through time contexts evolve, therefore, people adapt accordingly. That is why the psychosocial health care provided appreciates the influence of both African and Western ways of life in a communal context.				
			5.2.2 The psychosocial health care provided respects the epistemological meanings of a communal context.  (The philosophy of knowledge)	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>
				5.2.3 The psychosocial health care provided respects the ontological expressions of a communal context.  (Nature of knowledge)			
5.2.4. The psychosocial health care provided respects the etymological expressions found in a communal context.							

		(Expression of words and language)				
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**Qualitative judgement:** Is the instrument content valid? (Please provide any additional strength observed, inputs and suggestions for improvements).

## SECTION D: Qualitative judgement

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**Offer your expert opinion on any area you observed was omitted?**

## SECTION E: Content Validity Ratio (CVR)

### Instructions

In line with the CVR form you are required to offer expert judgement on whether each item is important, necessary, or not necessary.

<b>CVR scoring form.</b>			
<b>A communal holistic therapeutic approach for psychosocial health management among Southern African indigenous communities.</b>			
Degree range <b>1 – not necessary, 2 -useful but not essential, 3 – essential</b>			
<b>ITEMS</b>	<b>Please X the appropriate response</b>		
	<b>1</b>	<b>2</b>	<b>3</b>
1. The psychosocial health care provided involves the family, community, and the curative institutions.			
2. The psychosocial health care provided appreciates the practices found in a communal context.			
3. The psychosocial health care provided build on the trust relations already existing within the indigenous communities.			
4. At the family and community level of care, the psychosocial health care that is provided is accessible to communal persons without requiring any traveling distance.			
5. The psychosocial health care provided is cost-effective.			
6. The resources used for the psychosocial health care provided are readily available.			
7. The psychosocial health care provided is needs aligned.			
8. The psychosocial health care provided enables timely feedback.			
9. The psychosocial health care provided enables the progress of health within the community.			
10. The psychosocial health care provided enables progress monitoring.			
11. The psychosocial health care provided attempts to decreases stigmatization.			
12. The psychosocial health care provided recognizes the principles of communality as central to the management of psychosocial health.			
13. The psychosocial health care provided appreciates the sacredness of indigenous knowledge and heritage found within a communal community.			
14. The psychosocial health care provided appreciates shared belief that life is understood by communal persons as a holistic-circlie continuous process.	<b>1</b>	<b>2</b>	<b>3</b>
15. The psychosocial health care provided is culturally sensitive towards the shared belief system found within a communal community.			

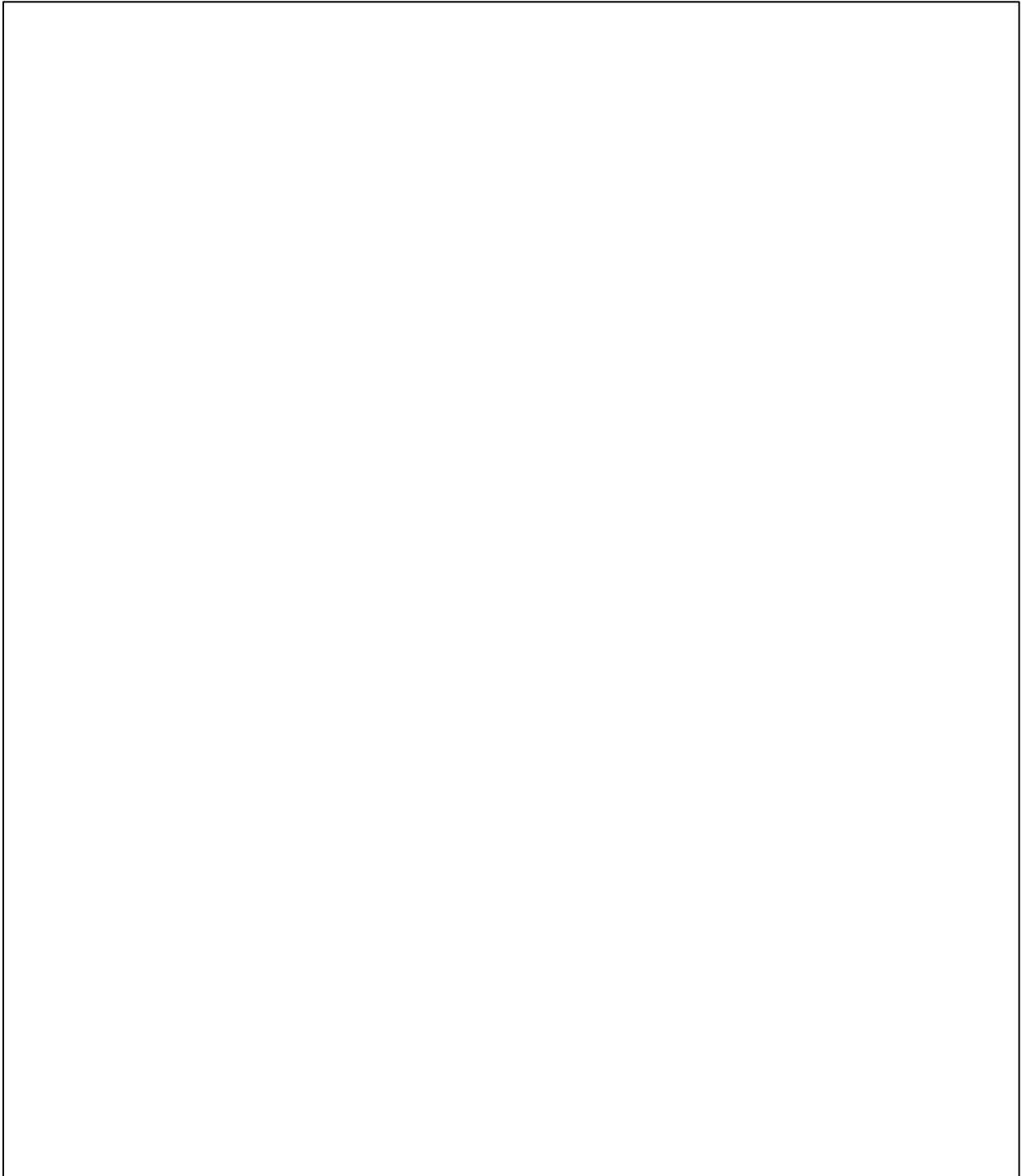
16. The psychosocial health care provided is culturally congruent with the shared belief system found within a communal community to achieve the balance of life in the management of psychosocial health.			
17. The psychosocial health care provided is culturally competent.			
18. Life is not defined from singularity, but in its essence of continuity, communality, and holism. Therefore, Life is a holistic-circlie continuous process valuing the intersects of those physically alive on earth, those who were here before us, the yet-to-be-born and the cosmos.			
19. Life herein denotes the essence of time, space, and people. Therefore, the psychosocial health care provided appreciates life as interconnected to health, illness and healing illuminating the understandings of psychosocial health.			
20. The psychosocial health care provided appreciates health as a phenomenon encompassing one's physical body, mental, emotions, spirit, environment (cosmos, those physically living on earth and those who passed on) and livelihood.			
21. The psychosocial health care provided appreciates illness as the disharmony between one's physical body, mental, emotions, spirit, environment (cosmos, those physically living on earth and those who passed on) and livelihood.			
22. The psychosocial health care provided appreciates that harmonious balance is achieved through a holistic-continual process of healing involving basic and advanced communal therapeutic techniques.			
23. The psychosocial health care provided appreciates healing is a lifelong shared cultural process with its sole intention of locating harmonious equilibrium between one's physical body, mental, emotions, spirit, environment (cosmos, the living and those who were here before) and livelihood.			
24. The psychosocial health care provided appreciates psychosocial health as a life-long inclusive process striving for harmonious balance within the interconnectedness of life.			
25. The psychosocial health care provided realize humility as a basic therapeutic interactive skill expected from each communal person.			
26. The psychosocial health care provided includes sharing encouraging feelings and providing emotional and other support.			
27. The psychosocial health care provided realizes storytelling and metaphors as advanced therapeutic interactions to demonstrate resilience.			
28. The psychosocial health care provided appreciates meaningful silence (meaningful presence) as having therapeutic benefits.			
29. The psychosocial health care provided recognizes self-resilience disclosure as having therapeutic benefits by providing the opportunity for openness, empathy, and rapport.			
30. The psychosocial health care provided includes patience and respectful waiting for the attainment of the harmonious balance of life.			
31. The psychosocial health care provided appreciates graveyard visit as having therapeutic benefits.	<b>1</b>	<b>2</b>	<b>3</b>
32. The psychosocial health care provided recognizes Mpho ya badimo, a thanksgiving to those who were here before us as having therapeutic benefits.			
33. The psychosocial health care provided recognizes !nxhabasas, a rite-of-passage for young girls as having therapeutic benefits.			
34. The psychosocial health care provided appreciates Spiritual dance (Trance-dance/ spiritual revitalization) as having therapeutic benefits.			

35. The psychosocial health care provided recognizes medicinal plants as having therapeutic benefits.			
36. The psychosocial health care provided appreciates that communal persons carries a mutual duty for the betterment of all. Hence, achieving the balance of life begins at a family level as it is an inborn responsibility for communal persons.			
37. Through time contexts evolve, therefore, people adapt accordingly. That is why the psychosocial health care provided appreciates the influence of both African and Western ways of life in a communal context.			
38. psychosocial health care provided respects the epistemological meanings of a communal context.  (The philosophy of knowledge)			
39. The psychosocial health care provided respects the ontological expressions of a communal context.  (Nature of knowledge)			
40. The psychosocial health care provided respects the etymological expressions found in a communal context.  (Expression of words and language)			

## SECTION F: Qualitative judgement

---

**Evaluate the whole instrument in its total comprehensiveness and offer your expert opinion on whether it satisfy its expected functions?**



## **SECTION G**

### **Annexure I: Emerging outcome:**

Hypothetical model for psychosocial health management among Southern African indigenous communities

The two figures below demonstrate the hypothetical statements and hypothetical model respectively.

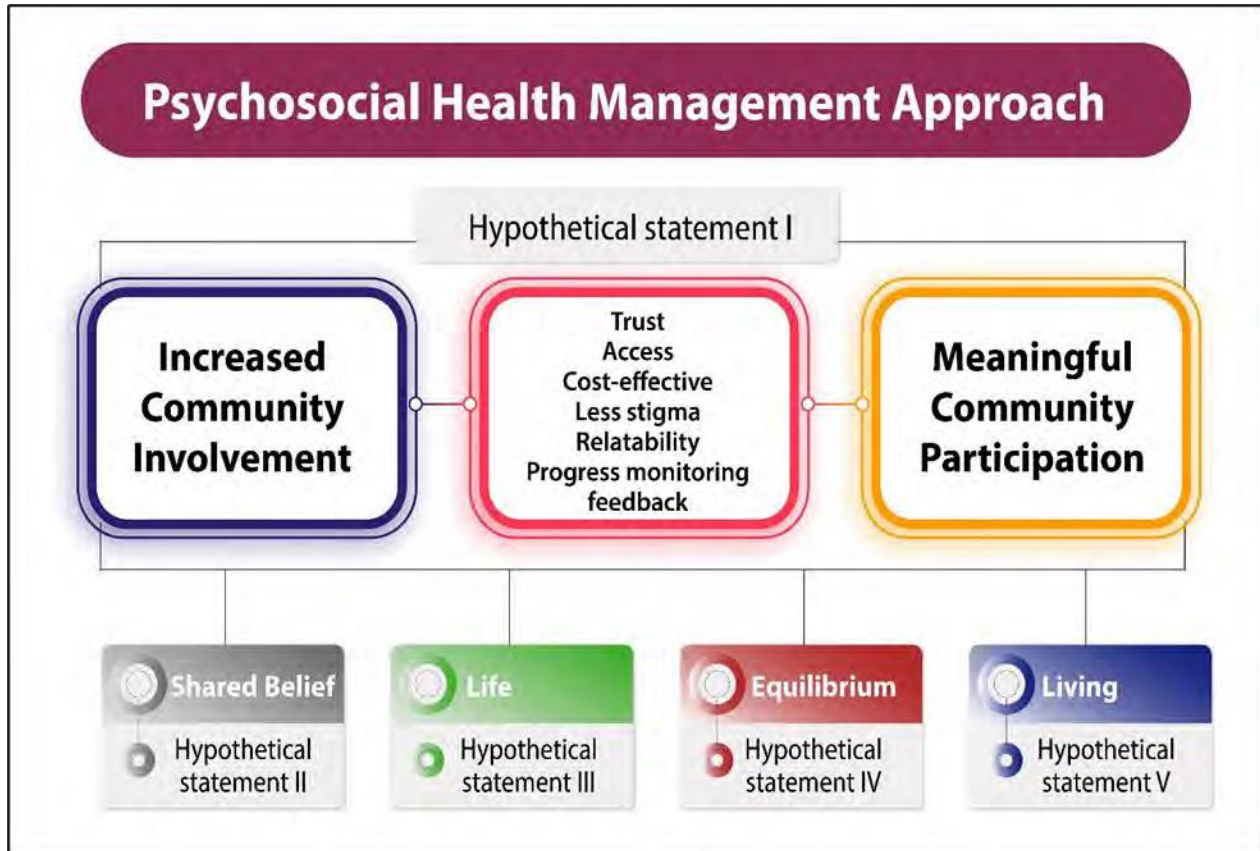


Figure 1: Proposed hypothetical Statements.

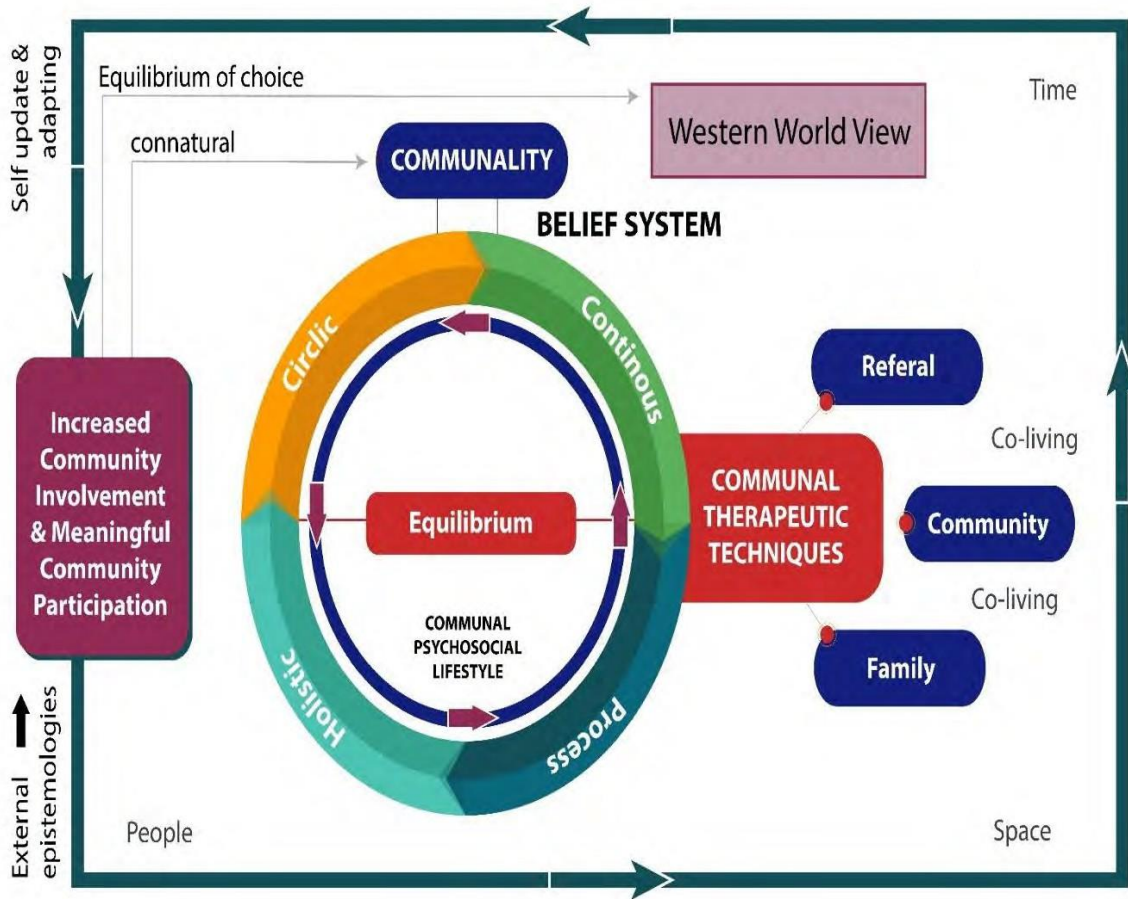


Figure 2: Proposed Hypothetical Models

## SECTION H: Check lists

---

Please complete these checklists to ensure you are satisfied with firstly, what is expected of you and secondly, to ensure you received all the documents.

### Cover letter

**Please indicate with an X on the appropriate answer**

- |   |                              |                             |
|---|------------------------------|-----------------------------|
| 1. Are the instructions comprehensive and understandable?.....          | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. Are you satisfied with the documents provided?.....                  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. Is the time allocated for the reviewers (two weeks) sufficient?..... | <input type="checkbox"/> Yes | <input type="checkbox"/> No |


**Please indicate with X if you received the document.**

CONTENTS	MARK (X)
1. Abstract	
2. Section A: Comprehensive Instructions	
3. Section B: Demographic Information	
4. Section C: Content Validity Index (CVI) rating form	
5. Section D: Qualitative judgement	
6. Section E: Content Validity Ratio (CVR) rating form	
7. Section F: Qualitative judgement	
8. Section G:	
9. Section H: Check list	


# ANNEXURE O: Published Manuscript





**Health SA Gesondheid**  
ISSN: (Online) 2071-9736, (Print) 1025-9848

Page 1 of 10 ■ Original Research



## A conceptual framework for psychosocial health management grounded in the therapeutic merits of indigenous KhoiSan health dialogues



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**Dates:**  
Received: 09 Feb. 2021  
Accepted: 15 June 2021  
Published: 16 Aug. 2021

**Research Project Registration:**  
Project Number:  
IKS170530795284/2017

**Read online:**



Scan this QR code with your smart phone or mobile device to read online.

**Background:** The researchers established that an indigenous KhoiSan community functions healthily without western mental health services. This community relies on indigenous healthcare with positive health outcomes over centuries. Despite this positive evidence, the community's therapeutic achievements have not been explored previously.

**Aim:** To explore the therapeutic merits embedded in dialogues of healing to formulate a generic approach to managing psychosocial challenges.

**Setting:** The study was conducted in an indigenous KhoiSan community, Northern Cape province, South Africa.

**Methods:** A qualitative approach, by using an indigenous African research design, was followed. An African Indigenous Health Research Framework (AIHRF) was employed, particularly applying a classical African indigenous method of data-collection, namely orature. Theoretical sampling was used for the purpose that the emerging data guide the researcher to the next participants. The four-step analysis of the mentioned framework was deployed for data analysis.

**Results:** It was deduced that the therapeutic merits of dialogues go beyond the word of mouth, leading to the emergence of themes related to the successful management of psychosocial health challenges in the KhoiSan community.

**Conclusion:** These findings were used to generate a baseline conceptual framework for the management of psychosocial challenges in the KhoiSan community.

**Contribution:** Revitalisation of communal indigenous practices for the management of psychosocial health challenges within the KhoiSan community. The latter will sensitise research, teaching and learning to foster culturally informed counseling approaches. Moreover, these will inform policy formations to possess a culturally competent approach towards indigenous communities such as the KhoiSan community in the Northern Cape, South Africa.

**Keywords:** communal counsellor; communal counsellor; communal individual; dialogues of healing; healing; psychosocial health; *!nxabasas*; *mpho ya badimo*; the wheel of life

**Introduction and background**

'Unabatedly Indigenous Health Systems in Africa stood the test of time'. This statement conveys the resilience of African indigenous healthcare, despite the evolution and operationalisation of western medical systems in Africa.

Consistent with the above understanding, Moshabela, Zuma and Gaede (2016) assert that indigenous health practices in South Africa remain functional in indigenous communities, although unrecognised. Following this lack of recognition and support by means of policies, Africans have had to adopt western healthcare systems. However, Salamonsen and Ahlzen (2018), Malokoane et al. (2020) and Rispel (2016) argue that a wide range of states across the world have adopted and implemented western health systems with ineffective outcomes and increasing levels of patient distrust. These authors further contend that many western health systems in Africa are under-funded, under-researched and under-resourced, leading these mechanisms into

How to cite this article: Mahlatsi, K.S., Pienaar, A.J., Nare, N.E. & Mulaudzi, T.M., 2021. 'A conceptual framework for psychosocial health management grounded in the therapeutic merits of indigenous KhoiSan health dialogues', *Health SA Gesondheid* 26(0), a1626. <https://doi.org/10.4102/hsag.v26i0.1626>


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<https://www.hsag.co.za> ■ Open Access

Health SA Gesondheid | Vol 26 | a1626 | DOI: <https://doi.org/10.4102/hsag.v26i0.1626> | © 2021 Khauhelo S. Mahlatsi, Abel J. Pienaar, Neo E. Nare, Tshilidzi M. Mulaudzi | This work is licensed under [CC Attribution 4.0](#)  
Submitted: 09 February 2021 | Published: 16 August 2021

# ANNEXURE P: Conference Presentations


## 16<sup>TH</sup> Early Career Scientist Convention SAMRC Research Capacity Development




**A COMMUNAL HOLISTIC THERAPEUTIC APPROACH FOR PSYCHOSOCIAL HEALTH MANAGEMENT AMONG SOUTHERN AFRICAN INDIGENOUS COMMUNITIES**

**Khauhelo S. Mahlatsi**  
PhD-candidate

Promoter: Prof. A.J. Pienaar  
Co-promoter(s): Prof. M.T. Maseko, Dr. T. Malasa



**PREMISE**





"It takes a village to grow a child; A rude child's light die in the darkness" – African proverb

"Nobody wins when the family feuds" – Shawn Jay-Z Corey Carter




**OUTLINE**

- Introduction
- Problem
- Aim and objectives
- Research Methodology
- Preliminary results



**INTRODUCTION**

- Scourge of mental health
- Costs and Access
- South Africa as a context
- Malawi as a context




**PROBLEM**

- Disproportionate funding
- Life-Esedimeri tragedy
- Policy formations
- Western characterized health model
- Cost effectiveness and access

### AIM

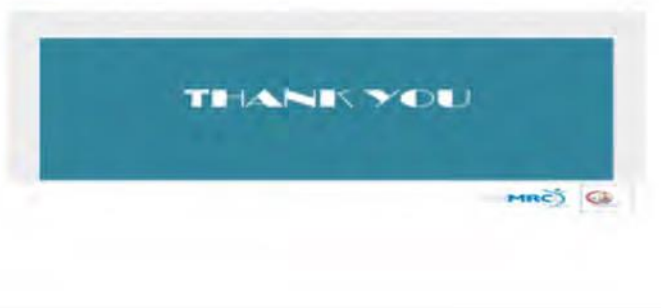
To develop, confirm and validate a communal holistic therapeutic approach for psychosocial health management among Southern African indigenous communities.

### RESEARCH METHODOLOGY

The flowchart illustrates the research methodology. It starts with 'RESEARCH OBJECTIVES' leading to 'Empirical - research design'. This leads to three parallel paths: 'Qualitative research', 'Quantitative methods', and 'Mixed methods'. These paths converge into 'Data analysis', which leads to 'Interpretation of findings'. This process is supported by 'Ethical approval' and 'Sampling'. The final outcome is 'Middle range theory'.

### PRELIMINARY RESULTS

The diagram shows 'COMMUNAL LIFE-STYLE' at the base. Above it are three interconnected elements: 'SHARED BELIEF SYSTEM', 'COMMUNAL SYSTEMS' (which includes 'COLONIAL HEGEMONY', 'WESTERNIZATION', and 'RELIGIO-NIZATION'), and 'COMMUNAL THERAPEUTIC TECHNIQUES'.



# Afro-Asia Seboka International Conference



Afro<sup>SA</sup> – Asia<sup>PK</sup> SEBOKA International Colloquium



REVITALISING COMMUNAL INDIGENOUS (PRIMAL) HEALTH CARE

## Dialogues of healing in the management of psychosocial health challenges in an indigenous KhoiSan community

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Qualifications: PhD; MNC; BNC



### OVERVIEW

- PRACTICE
- TEACHING AND LEARNING
- RESEARCH
- POLICY

### PROBLEM

- African indigenous healthcare withstood the test of time.
- Despite the oppression by colonialism as well as the apartheid system in South Africa, this health care system remained resilient, especially amongst indigenous communities, like the KhoiSan community of the Northern Cape.
- In the researcher's experiential learning in this KhoiSan community, as a registered mental health nurse, he noted that this community survives without a psychosocial therapist, psychologist, social worker or mental health nurse.
- It became evident that the community coped with their own psychosocial health practices and has built resilience over centuries. Although this resilience of African indigenous healing is evident, the exploration of the therapeutic merits of aspects of the indigenous healing system, like dialogues of healing has not been explored. Therefore, the researcher endeavoured to explore the therapeutic merits linked to dialogues of healing that this community utilizes to manage psychosocial challenges.

### AIM AND OBJECTIVES

Exploration of the therapeutic merits embedded in dialogues of healing used in order to formulate a generic approach to manage psychosocial challenges in a KhoiSan community in the Northern Cape.

Objectives were to:

- Explore dialogues of healing in a rural KhoiSan community;
- Elucidate the benefits of these dialogues in relation to healing; and
- Revitalize the healing practice in 'dialogues of healing' for the management psychosocial challenges in the KhoiSan and other African indigenous communities.

### METHODOLOGY

Approach	Qualitative
Research design and framework	Classical African Indigenous African indigenous health research framework (Pienaar, 2017:85)
Sampling	Theoretical sampling
Data collection	<u>Orature</u> Story telling Metaphors Conversations
Data Analysis	Four step analysis • Basic concepts from the spoken word • Joining or grouping of these concept to form themes /clusters • Intuitive deduction / convergence or discovery of new concepts, themes or clusters (insights/ discoveries). • Building a storylinea pattern to form process
Ethical consideration	This research adhered to and applied the five general principles provided by the APA (2010:3-4) • Seboka ethical guidelines • NWU ethics committee

### FINDINGS

1. Indigenous communication systems	2. Communal lifestyle
<p>1. Spoken word</p> <p><u>Categories</u></p> <p>a. Silence b. Metaphors (reprimand / educational) c. Stories</p>	<p>1. Day-to-day practices</p> <p><u>Categories</u></p> <p>a. Behavioural conduct b. Eating habits</p>
<p>1. Active communication</p> <p><u>Categories</u></p> <p>a. Self-endorsement disclosure b. Directive and instructive language</p>	<p>1. Special practices</p> <p><u>Categories</u></p> <p>a. Rite of passage-tribulations b. Gene-visit visit c. Commemoration d. Mpho ya badimo</p>
<p>1. Principles and attitudes of communication</p> <p><u>Categories</u></p> <p>Humility; softness; Don't be clever or strong. Silent communication; Gender speech; Gender-based societal challenges (conversations for men and conversation for women); Process of readiness and non-readiness (reprimand); Patience/respectful waiting; Boundary setting; Direct and instructive language; Self-disclosure (reprimand)</p>	

## OUTCOME: EMERGING THEORY



## RECOMMENDATIONS

- PRACTICE
- TEACHING AND LEARNING
- RESEARCH
- POLICY

## So what?

- PhD- Further research
- Emerging theory- Classic Grounded Theory
- Develop a communal holistic therapeutic approach for psychosocial health management in African indigenous communities- Midrange Theory

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## ANNEXURE Q: Research Processes

### MIXED METHODS: EXPLORATIVE SEQUENTIAL DESIGN

	Phase One Objective One & Three	Phase Two Objective Two & Three	Phase Three Objective Four
<b>Purpose</b>	Development of a Formal Theory	Development of Hypothetical Models	Confirm and Validate the Hypothetical Models
<b>Outcome</b>	Formal Theory	Hypothetical Models	Middle-range Theory
<b>Research Approach</b>	Qualitative	Qualitative	Quantitative
<b>Research Design</b>	Classical Grounded Theory	Critical, Integrative Review	Non-experimental
<b>Study Area</b>	Two Southern African Countries (South Africa, Malawi)	Digital Space and Brick-layered Library	The Broader African Continent
<b>Population of the Research</b>	African Indigenous Communities	Existing Literature	Experts
<b>Sampling Method</b>	Theoretical Sampling	Purposive	Purposive
<b>Data Collection Methods</b>	<i>Makgotla</i>	Critical Review	Expert Confirmation and Validation
<b>Data Analysis</b>	Constant Comparative Analysis	Critical Synthesis Constant Comparative Analysis	Content Validity Index Content Validity Ratio Kappa Static
<b>Coding</b>	Substantive and Theoretical Coding		
<b>Rigour</b>	Trustworthiness Credibility Dependability Confirmability Transferability Sufficiency of data	Pilot study A guideline for assessment of quality	Reliability and Validity Kappa Statistic

# ANNEXURE R: Guideline assessing the quality of literature.

The researcher assessed the quality of data by following the guideline below.

Equally important, depth and rigor are fundamental in quality literature reviews (Palmatier *et al.*, 2018 & Torracco 2005). To illustrate, a review needs to show a befitting selection strategy for articles and capture data and meaning that proposes new meaning for current and future research. In addition, a quality literature review needs to be replicable; that is, the method must be described so that another researcher can similarly conduct and reach similar results. The guideline below was adjusted from Snyder (2016:338) and used for the assessment of the quality of literature.

## Part one: Design

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- (a) In relation to the overall research field, is this literature review needed, and does it make a substantial, practical, or theoretical contribution?
- (b) Are motivation, purpose, and research question(s) clearly stated and motivating?
- (c) Does the review account for the previous literature evaluation and other relevant literature?
- (d) Is the approach/methodology for the literature review clearly stated?
- (e) Is this the most appropriate approach to address the research problem?
- (f) Are the methodology and search strategy clearly and transparently described and motivated (including the search terms, databases used, and explicit inclusion and exclusion criteria)?

## Part two: Conducting the review.

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- (g) Is the search process appropriate for this type of review?
- (h) Is the practical search process accurately described and accounted for?
- (i) Is the process of the inclusion and exclusion of articles transparent?
- (j) Have proper measures been taken to ensure research quality?

- (k) Can the final sample be trusted to be appropriate and in concordance with the overall purpose of the review?

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**Part three: Data abstraction and analysis.**

- (l) Is the data abstracted from the article appropriate for the overall purpose of the review?
- (m) Is the process for abstracting data accurately described?
- (n) Have proper measures been taken to ensure quality data abstraction?
- (o) Is the chosen data analysis technique appropriate in relation to the overall research question and the abstracted data?
- (p) Is the analysis process properly described and transparent?

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**Part four: Structure and description of the review.**

- (q) Is the review article organized coherently in relation to the overall approach and research questions?
- (r) Is the overall method of conducting the literature review sufficiently described? Can this study be replicated?
- (s) Is the result of the review reported in an appropriate and clear way?
- (t) Does the article synthesize the findings of the literature review into a clear and valuable contribution to the topic?
- (u) Are questions or directions for further research included? Are the results of the review useful?