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Social representation of health for Umbandists and the transcultural care of Madeleine Leininger

Representação social da saúde para os umbandistas e o cuidado transcultural de Madeleine Leininger

Representación social de la salud para los umbandistas y el cuidado transcultural de Madeleine Leininger

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ABSTRACT

Objective: to analyze the structure of the social representation of health for Umbanda fans with a view to approaching transcultural care. **Method:** qualitative descriptive-exploratory study, based on the structural approach of the Theory of Social Representations and Transcultural Theory by Madeleine Leininger. Participants were captured using the Snowball technique, who responded to an online questionnaire containing sociodemographic characteristics; DUREL scale; and instrument of free evocations. Data were analyzed using descriptive statistics and the evocations using prototypical and similarity analysis. **Results:** 110 individuals participated, predominantly women (70%), between 29 and 39 years old, and with high religiosity. The prototypical analysis highlighted life, well-being and having faith as probably central and hospital and doctor as contrasting elements. The similarity analysis demonstrated, in addition to the previously and probably central elements, care and the body with centrality behavior. **Final considerations:** multidimensional conceptions of well-being and quality of life mark this representation, based on high religiosity and transcultural and comprehensive health care.
Descriptors: Nursing; Transcultural Nursing; Health; Culture; Religion.

RESUMO

Objetivo: analisar a estrutura da representação social da saúde para umbandistas com vistas à abordagem do cuidado transcultural. **Método:** estudo qualitativo descritivo-exploratório, fundamentado na abordagem estrutural da Teoria das Representações Sociais e Teoria Transcultural de Madeleine Leininger. Os participantes foram captados pela técnica *Snowball,* que responderam a um questionário *online*, contendo caracterização sociodemográfica; escala DUREL; e instrumento de evocações livres. Os dados foram analisados por estatística descritiva e as evocações pela análise prototípica e de similitude. **Resultados:** participaram 110 invíduos, predominando mulheres (70%), entre 29 e 39 anos, e com alta religiosidade. A análise prototípica evidenciou *vida*, *bem-estar* e *ter-fé* como provavelmente centrais e *hospital* e *médico* como elementos de contraste. A análise de similitude demonstrou além dos elementos previamente e provavelmente centrais, *cuidado* e *corpo* com comportamento de centralidade. **Considerações finais:** concepções multidimensionais de bem-estar e qualidade de vida marcam esta representação, embasada pela alta religiosidade e o cuidado transcultural e integral em saúde.
Descritores: Enfermagem; Enfermagem Transcultural; Saúde; Cultura; Religião.

RESUMEN

Objetivo: analizar la estructura de la representación social de la salud para umbandistas con miras al enfoque de la atención transcultural. **Método:** estudio descriptivo-exploratorio cualitativo, basado en el enfoque estructural de la Teoría de las Representaciones Sociales y la Teoría Transcultural de Madeleine Leininger. Mediante la técnica de muestreo *Snowball* se capturó a los participantes, quienes respondieron a un cuestionario en línea que contenía caracterización sociodemográfica; escala DUREL; e instrumento de evocaciones libres. Se analizaron los datos mediante estadística descriptiva y las evocaciones por medio de análisis prototípico y de similitud. **Resultados:** Participaron 110 personas, predominantemente mujeres (70%), entre 29 y 39 años y con alta religiosidad. El análisis prototípico destacó 'la vida, el bienestar y el tener fe' como probablemente centrales y 'el hospital y el médico' como elementos contrastantes. El análisis de similitud demostró, además de los elementos anteriores y probablemente centrales, 'el cuidado y el cuerpo' con comportamiento de centralidad. **Consideraciones finales:** concepciones multidimensionales de bienestar y calidad de vida enmarcan esta representación, basada en una alta religiosidad y una atención de salud transcultural e integral.
Descriptores: Enfermería; Enfermería Transcultural; Salud; Cultura; Religión.

INTRODUCTION

Since the 16th century, Umbanda has been a Brazilian religion that has brought together Amerindian, African and European beliefs, sometimes in dialog, but most of the time violently. In some regions, Umbanda has been called macumba, and through syncretism, hybridization and other religious phenomena, it has gradually established itself in the different regions of Brazil[1].

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Today, their places of worship, terreiros, are sought out for advice on various everyday situations arising from biopsychosocial relationships[2].

The possibility of understanding Umbanda religious practices from the perspective of the Theory of Social Representations (TSR) is considered due to their community nature, their psychosocial identity and the theological and common-sense knowledge circulating in their social dynamics, in interface with the scientific and academic knowledge that circulates in these social groups. Because of the approach to health for a specific community and the social, cultural and symbolic nature of its phenomena, it also draws on Madeleine Leininger's Transcultural Theory, since both point to the influence of culture on a group's social thinking, as some studies have shown[3], through theoretical contributions[4-10].

The social representations of health are very relevant because this group has a common identity, Umbanda. In addition, they help in the understanding of health, as they have practical functions applied in everyday social relations. They also help to explain and understand reality, as well as defining the identity and specificities of groups, guiding behavior and practices and justifying decisions and behavior[7]. In the light of the theory of social representations, the identity of the researched group is highlighted, due to its framework of shared consensual knowledge[4-8].

Madeleine Leininger's Transcultural Theory guides the planning and implementation of health care, including cultural factors present in ways of life. Thus, favoring culturally congruent care ratifies the entire care process, as well as the interpersonal relationships between patient-caregiver, based on respect, dignity and reciprocity, present in the countless health needs[10].

The Sunrise model, proposed by Leininger, includes four levels, the first of which is made up of the social panorama and people's worldview; the second brings knowledge and practices related to health care from individual or family perspectives; the third pays attention to both professional and traditional knowledge, as well as its incorporation into the cultural scenario, adding diversity and universality to cultural care; the fourth expresses the decisions inherent to nursing care, including the three stages of professional nursing practice: preservation/maintenance, negotiation/accommodation and restandardization/cultural restructuring of care[10]. Mainly through negotiation and cultural restandardization of care, professional practice is adjusted and religious aspects are observed in order to verify which actions can be met.

Despite the current panorama of religious violence, Umbanda provides a space for welcoming and caring, and is socially relevant, especially for the poorest sectors of the population. Allied to this, the justification for this research is the incipient production on the subject.

The aim was to analyze the structure of the social representation of health for umbandistas with a view to approaching transcultural care. The guiding questions adopted were the following: how is the social representation of health structured for the Umbanda people researched and how can this object be understood through the proposal of transcultural health care according to Madeleine Leininger?

METHODOLOGY

This is a qualitative, descriptive-exploratory study, based on the structural approach of the Theory of Social Representations[7-8] and Madeleine Leininger's Transcultural Theory[9-10], in addition to its construction complying with the Consolidated Criteria for Reporting Qualitative Research (COREQ) protocol checklist.

Participants were selected using the virtual Snowball technique, adapted for social networks in the process of data collection in scientific research[11].

After approval by the Research Ethics Committee, an invitation for voluntary participation was issued via a link on the social networks of the study authors and collaborators, where potential participants were given access to the information and objectives related to the study, contained in the Informed Consent Form (ICF).

Due to the COVID-19 pandemic, data collection was carried out virtually with the support of the Google For® platform, which produces forms used in research and other academic and pedagogical practices[12]. The form was divided into three sections: characterization of the participants (gender, age and municipality of residence), DUKE religiosity scale (DUREL) and collection of three free evocations for the inducing term "Health". Before the first section, the ICF contained all the information pertinent to participation and only after being aware of and agreeing with the terms, the participant progressed to the following sections, answering the questions.

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Participants over the age of 18 and who considered themselves to be Umbanda followers or sympathizers were included. Participants with incomplete instruments were excluded.

Data collection took place from December 2020 to February 2021. After this stage, the form was closed and the information exported as a report produced by Google Forms® to a Microsoft® Office Excel for Windows 2016 spreadsheet. Identities were protected in the database by codes such as P01 for participant 01.

The socio-demographic characterization and each of the three dimensions of the DUREL Scale were analyzed using descriptive statistics. After the calculations, the interpretation of the DUREL is inversely proportional, i.e. the lower the score, the greater the religiosity and vice versa[13].

To analyze the free evocations, Microsoft® Office Word for Windows 2016 was used to create the dictionary of terms and the final corpus, which was then run in EVOC 2005 software. The software was used to count the total number of terms evoked, the simple frequency of occurrence of each word and the weighted average occurrence of each word according to the order of evocation[14].

A cut-off point was established for the minimum and intermediate frequencies, as well as Rang[14]. Subsequently, co-occurrence analysis was carried out, in which the similarity index was calculated in order to identify the link, as well as its strength, between the evoked cognemes[15], giving rise to the Maximum Similarity Tree of evocations of the inducing term "Health".

RESULTS

Between 110 participants who composed the final sample, the highest percentage of participants in the study were women (70.0%), people aged between 29 and 39 (29.1%) and residents of the city of Rio de Janeiro (75.5%). In terms of the DUREL scale, the religiosity index was 2.88 for Organizational Religiosity (RO), 3 for Non-Organizational Religiosity (RNO) and 4.43 for Intrinsic Religiosity (IR).

Regarding the prototypical analysis, the EVOC software version 2005 accounted for 330 words evoked, of which 117 were different. To construct the table, the frequencies were: a minimum of 6, and an intermediate frequency of 10, with the average of the average orders of evocation (A.O.E) or Rang, equal to 2, on a scale of 1 to 3 (Figure 1).

O.M.E.	**< 2,00**			**≥ 2,00**		
Freq. Média	**Evoked term**	**Freq.**	**A.M.E**	**Evoked term**	**Freq.**	**A.M.E**
≥ 10	Life	26	1.846	Care	32	2.000
	Well-being	16	1.375	Nutrition	11	2.455
	Having faith	13	1.923			
< 10	Hospital	9	1.667	Prevention	9	2.000
	Important	7	1.857	Peace	8	2.750
	Primordial	6	1.000	Physician	7	2.143
				Body	6	2.000
				Illness	6	2.000
				Mind	6	2.000
				Need	6	2.667

Note: n = 110; Fr min = 6; Fr intermediate = 10 and Rang = 2.00.

Figura 1: Four-House Chart of Participants' Evocations of the Inductive Term "Health" (n=110). Rio de Janeiro, RJ, Brazil, 2022.

In the upper left quadrant (ULQ), called the central core, the cognemes are identified: life, well-being and having-faith, as they meet the criteria of higher frequency (≥10) and lower average recall order (AME <2). In the upper right quadrant (URQ), there are the elements of the first periphery: care and food, due to their high frequency (≥10) and late recall. The lower right quadrant (LRQ), also called the second periphery, shows peripheral elements with a low frequency

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(<10) and a high AME value, demonstrating that they were evoked less frequently and late, the terms being: prevention, peace, physician, body, illness, mind and need. With regard to the lower left quadrant (LLQ), known as the contrast zone, there are elements with low frequency (<10) and lower AME (<2.00): hospital, important and primordial.

Figure 2 shows the maximum similarity tree, which expresses the connection between the terms from Figure 1, as well as their strength of connection.

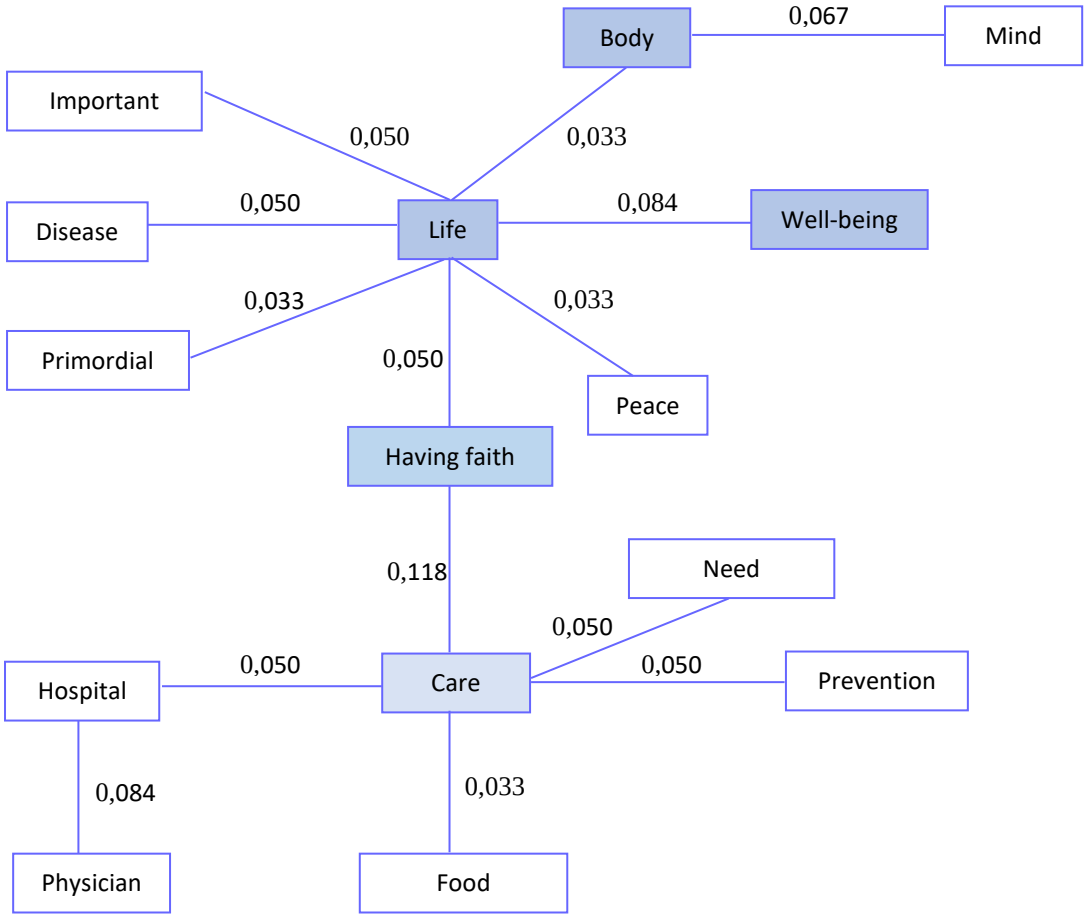

Figura 2: Maximum Similarity Tree of Participants' Evocations of the Inducing Term "Health" (n=59). Rio de Janeiro, RJ, Brazil, 2022.

The lowest index used to compose the maximum similarity tree was 0.033. It is organized into two blocks, one upper and one lower, interconnected by the cogneme having-faith, with life in the upper block and care in the lower block standing out, these being the cognemes with the greatest number of links to other words. Life, which is probably the central nucleus in the figure, has the highest number of connections and organizes the upper block, linking to well-being (0.084), illness (0.050), important (0.050), have-faith (0.050), primordial (0.033), body (0.033) and peace (0.033). The elements with the strongest links between them are: life and well-being (0.084) and body and mind (0.067).

Connecting the two blocks, having faith is linked to care with 0.118. The lower block is structured around this lexicon, probably due to its high frequency, as it is part of the first periphery of the representation. This cogneme establishes a large number of links (five): have-faith (0.118), need (0.050), prevention (0.050), hospital (0.050) and food (0.033). In addition, having faith and care have the highest link strength (0.118) in the Maximum Similarity Tree, followed by hospital and physician (0.084) and life and well-being (0.084).

DISCUSSION

The characteristics observed in the participants corroborate studies[16-18] that affirm the existence, in Umbanda, of symbolic aspects shared by the cariocas, since, as the last precursor, Umbanda had the macumbas of Rio, in addition to highlighting the role of women in these communities, a Bantu heritage, adding belonging expressed in their daily practices, through values, beliefs and identity construction[16,17]. Through DUREL's RO, RNO and IR dimensions[19-20], it can

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be seen that the Umbanda members investigated have high intrinsic religiosity but medium organizational and non-organizational religiosity. However, we recognize the limits of the scale, since weekly attendance, analyzed by the scale, is not a tradition in Umbanda.

With regard to the structural analysis of the representation, the ULQ contains the most stable and important elements in the representation. This is where you can learn about the type of relationship and values that the group establishes with the object[7]. Life, well-being and having-faith are elements that add the conceptual dimension to the inducing term "health", which is evidenced by the upper block of the maximum similarity tree, with the elements life, well-being, peace, important, primordial, illness, body and mind.

The peripheral elements are organized around the central core, giving concreteness to the representation and allowing for modifications due to its more flexible character and adaptability to the evolution of the representation itself, on the other hand, it acts as a defense against sudden transformations[7]. The peripheral system is based on a practical dimension, reinforced by most of the lower block of the similarity tree (care, prevention, food, hospital, physician).

It is known that the concept of health established by the World Health Organization (WHO) in 1988 has been updated to a biopsychosocial perspective in a multidetermined concept, explaining religiosity/spirituality as part of its determinants[21]. In this sense, Umbanda terreiros are not only a physical space, but also a symbolic space for relationships and care. Thus, the consultants are welcomed in their suffering and advised by the spiritual leadership or by a member of the terreiro[2].

Spiritual practices in Umbanda develop through the phenomenon of trance that mediums exhibit, and they start to have the mannerisms, speech, personality and knowledge attributed to certain spirits which, according to the community's belief, legitimizes them and enables them to carry out rituals of care and healing through prayers, blessings, passes and spiritual cleansing baths[22].

In this way, the data from this study showed the relationship between religion and care for the body, since the elements of having-faith, care, need, food and prevention appear, with the first two being the terms with the highest strength of connection (0.118) in the maximum similarity tree. Umbanda, as an organized religion and religious community, promotes a psychosocial and spiritual effect of comfort and, from this experience, may originate the presence of physical elements that will be present in everyday life, such as amulets and patuás, considered sacred symbols. However, going beyond the physical aspect, there is symbolic knowledge coming from religious tradition that needs to be respected in the construction of care possibilities and, at the same time, integrated into the holistic conception of health care.

Thus, religious health practices in Umbanda can be encompassed within the perspective of transcultural care, as they help to re-signify health care[9-10]. Based on the premise of scientific knowledge, hegemonic biomedical practice seeks resolution and objectivity in health, embodying a specialized form of action, most often characterized as fragmented. On the other hand, from the religious and spiritual dimension, in the context of health work, there is a tendency to propose and implement forms of comprehensive care[22], given that the concept of health is established through different psychosocial factors.

The social thinking of this group seems to reinforce the holistic and integral conception of religious practice in health. In the conceptual block, health appears as body, mind, life, primordial and well-being, while in the practical block, care, prevention, food and need can be observed, both interconnected by the element of faith. Nurses based on the transcultural approach are able to propose care actions taking into account patients' beliefs and values, in order to make individual educational and care adaptations in an effective and meaningful way[24]. In the religious context, dealing with health has other nuances that go beyond hegemonic health practices, and there is also the search for health care from the perspective of religious practices[23].

As for the elements in the first periphery, as they have high frequencies, they may be central[25]. A second way of checking the centrality of representation is to understand that elements with high frequencies tend to establish a greater number of links[26]. The more links an element has, the greater its centrality behavior, which reinforces the evidence that life, well-being, care and having-faith are probably central in this representation, as they each make at least three links with other elements, including among themselves, in addition to having a high frequency and almost all the lowest rangs.

The tree of similarities illustrates a peculiarity of the group in relation to this representation, because, at the same time as they highlight defined conceptual and practical elements that have already been pointed out, having faith is at the heart of the tree, giving meaning to the representation through a holistic view of health, especially because of its link to life and care. The specificities of care for each individual emerge from subjectivities and intersubjectivities[27].

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Life and care are re-signified through the affective, attitudinal and transcendental dimension that faith has for this group of religious people, appearing as a point of organization and balance in the internal organization of the elements in the face of the two most obvious dimensions: the conceptual and the practical. In this sense, the connection between well-being, illness and life establishes the understanding of an interconnection between these cognemes. Graphically, life appears between the two other cognemes, which refers to a sense of care, highlighting the stronger connection between life and well-being, and a weaker connection between life and illness.

Figure 3 shows a schematic summary of this representation, taking into account the most important elements with centrality characteristics.

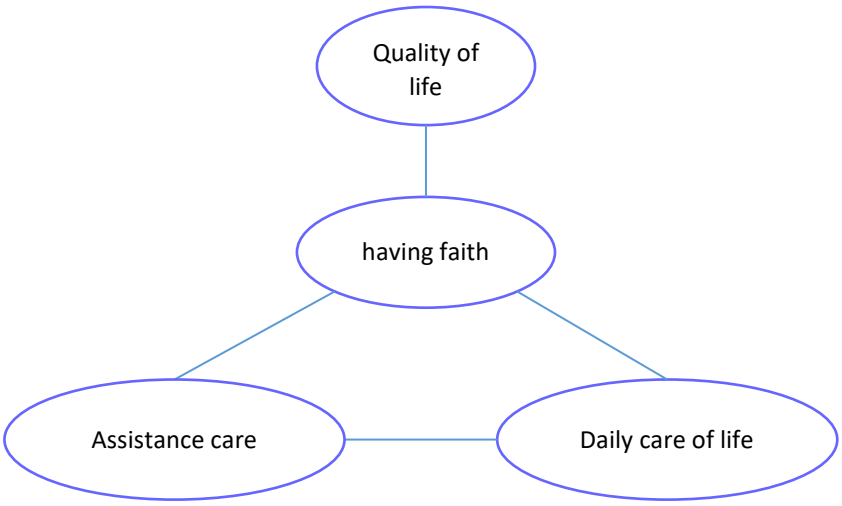

Figure 3: Schematic Synthesis of the Social Representation of Health for Umbandists. Rio de Janeiro, RJ, Brazil, 2022.

Religiosity and spirituality help in times of adversity, in dealing with life's problems on a daily basis, and in resolving and resigning to times of anguish[28]. In this way, it is important for religious people to preserve what is sacred to them, while, for health care, it is necessary to achieve cultural sensitivity in the search for holistic and integral health care. Thus, from Leininger's theoretical perspective, effective communication is necessary, along with the building of positive relationships within a respectful cross-cultural context of care[29-30].

Once the essence of care-centered nursing is recognized, care actions or transcultural care practices must obey three stages: 1 - cultural preservation/maintenance: professional attitudes that observe the support, support and empowerment of the subject, for the preservation of their health; 2 - cultural accommodation/negotiation: aims to support measures of negotiation, adaptation and regulation of the individual's health; 3 - repatterning/restructuring: nursing conduct to help the individual transform standardized ways of life and health into healthier habits, through the resignification of the meanings attributed to them[31]. This form of professional nursing action is outlined by the Sunrise Model, where cultural care actions must converge with people's beliefs, values and philosophies of life, through the linear valorization of the knowledge mobilized in care[9-10, 32].

Therefore, care takes on an orientation role, guiding daily practices to maintain health and restore it. For this reason, nurses must get to know their patients and value their personal, social and cultural characteristics so that transcultural care is favorable[24].

Study limitations

The study's limitations stem from the small number of participants, which does not express the reality of the population sample of umbandistas in the municipality of Rio de Janeiro and makes it impossible to generalize the data. Also noteworthy is the difficulty in collecting data due to the institutional dynamics of the terreiros surveyed during the pandemic period.

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CONCLUSION

The conclusion of this research is that the social representation of health for the Umbanda practitioners who took part in this study is marked by multidimensional conceptions that encompass an expanded concept of well-being and quality of life, through religiosity and comprehensive health care. It is therefore necessary for nurses to understand and respect the beliefs, cultures and values of individuals and their different health and illness care practices.

Although the biomedical dimension is very present, faith also emerges as a structuring and mediating element, giving meaning to the representation by strengthening therapeutic adherence and reinforcing the idea of health as something fundamental to life, also strengthened by the affective, attitudinal and transcendental dimensions it has for this group of religious people.

Therefore, this representation has two main dimensions, physical and spiritual, characterized beyond the absence of disease, considering well-being, spirituality, culture, body and mind, as fundamental elements for defining health and planning transcultural care as proposed by Leininger.

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