https://doi.org/10.1590/1982-0275202239e200230

Chronic diseases and religiosity/spirituality during the early stages of the COVID-19 pandemic

Doença crônica e religiosidade/espiritualidade durante os estágios iniciais da pandemia de COVID-19

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Abstract

Religiosity and spirituality have been studied as resources for coping with crisis and social disruption. This study investigates religiosity/spirituality as a potential protective resource against the emotional impact of the COVID-19 pandemic in individuals diagnosed with malignant and non-malignant chronic diseases. This is a cross-sectional, descriptive-exploratory study, with a quanti-qualitative approach. The convenience sample was composed of 78 individuals, divided into two groups. An online form was used. The data from the close-ended questions were tabulated using descriptive statistics. The content of the open-ended questions was examined qualitatively by thematic analysis. The two groups showed signs of emotional distress at similar levels and expressed increased faith and belief that future gains should come from the current distress. Individuals with life-threatening diseases expressed intensified spirituality. Faith was highlighted by participants as a resource to face the challenges of this dramatic period and should be valued by health care teams.

Keywords: Chronic diseases; Coronavirus infections; COVID-19; Mental health; Pandemics.

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Support: *Conselho Nacional de Desenvolvimento Científico e Tecnológico* (CNPq).

How to cite this article

Oliveira-Cardoso, E. A., Freitas, I. S., Santos, J. H. C., Oliveira, W. A., Garcia, J. T., & Santos, M. A. (2022). Chronic diseases and religiosity/spirituality during the early stages of the COVID-19 pandemic. *Estudos de Psicologia* (Campinas), *39*, e200230. https://doi.org/10.1590/1982-0275202239e200230

Resumo

Religiosidade e espiritualidade têm sido estudadas como recursos de enfrentamento em momentos de crise e disrupção social. Este estudo tem por objetivo investigar a religiosidade/espiritualidade como potencial recurso protetivo frente ao impacto emocional da pandemia de COVID-19 em indivíduos com diagnóstico de doenças crônicas, malignas e não malignas. Trata-se de estudo transversal, descritivo-exploratório, com abordagem quanti-qualitativa. A amostra de conveniência foi composta por 78 indivíduos, divididos em dois grupos. Foi utilizado um formulário on-line. Os dados das questões fechadas foram tabulados com uso de estatística descritiva. Os conteúdos das questões abertas foram examinados qualitativamente por meio de análise temática. Os grupos apresentaram indícios de sofrimento emocional em níveis semelhantes e expressaram aumento da fé e da crença de que ganhos futuros devem advir do sofrimento atual. Intensificação da espiritualidade foi expressa por indivíduos com doenças potencialmente fatais. A fé foi destacada pelos partipantes como recurso para enfrentar os desafios desse período dramático e deve ser valorizada pelas equipes de saúde.

***Palavras-chave**: Doenças crônicas; Infecções por coronavírus; COVID-19; Saúde mental; Pandemias.*

The spread of the new coronavirus (SARS-CoV-2) has triggered a global health crisis, which has generated an unprecedented turnaround in the contemporary world. Coronavirus Disease 2019 (COVID-19) is a new and highly contagious infectious disease whose clinical picture can range from no symptoms or mild symptoms to the most serious form, characterized by severe acute respiratory syndrome, which affects about 20% of the infected individuals (Oliveira, Oliveira-Cardoso, et al., 2020). On March 11, 2020, the World Health Organization [WHO] (2020) scaled up the state of emergency. It declared the novel coronavirus (COVID-19) outbreak a pandemic, configuring a global crisis that has impacted the health of individuals, families, and communities, with catastrophic developments in the economy, education, and social conditions (Braga et al., 2020; Brooks et al., 2020; Esper et al., 2022; Messias et al., 2022; Moura et al., 2022).

In Brazil, reckless management of the health crisis has turned it into the most significant humanitarian tragedy in history, with a high number of lives lost that could have been prevented (Santos et al., 2020). This adverse reality and its threatening potential made the proximity of finitude more tangible, which led individuals and families to confront existential questions related to the life-death line. Consequently, the search for answers in the dimension of religiosity/spirituality has increased. Studies conducted during the pandemic have confirmed the spiritual dimension as a critical element to be integrated into health care (Chirico & Nucera, 2020; Fardin, 2020; Koenig, 2020; Moreira et al., 2012; Roman et al., 2020), especially in the context of lonely death, far from family, aggravated by the need for abbreviation or suppression of funeral rituals (Oliveira-Cardoso et al., 2020).

Religiosity and spirituality are closely related constructs, and that is why the literature has elaborated the concept of Religiosity/Spirituality (R/S). According to Koenig (2012), religiosity is a phenomenon linked to religion, defined as an organized system of beliefs, values, practices, behaviors, ceremonies, and rituals to facilitate closeness with the transcendent or a Higher Power, which varies according to different manifestations in Western or Eastern traditions. Spirituality concerns the individual's attachment to that which is sacred. It concerns both the search for and the discovery of the transcendent that lies outside the self, and yet is also part of the self, as the ultimate and insurmountable truth/reality. Spirituality is closely linked to the supernatural, the mystical realm, and eventually organized religion, although it also extends beyond and begins before it (Benites, Rodin, Oliveira-Cardoso, et al., 2021; Freitas et al., 2017; Pinezi, 2009). Although they are distinct constructs, there is clearly an overlap between spirituality and religiosity (Koenig, 2012).

Some of the dimensions present in the complex articulation between R/S and health are already well documented. For example, the R/S binomial is associated with health outcomes, quality of life, and other related constructs, such as personal well-being. In addition, in the literature, there is evidence that religious beliefs and practices are associated with better health conditions, including benefits in cases of chronic

diseases, such as cancer and infectious ones (Bergerot et al., 2014; Geronasso & Coelho, 2012; Koenig, 2012; Moniz et al., 2022; Pozzada et al., 2022; Santos & Hormanez, 2013; Santos et al., 2013).

A study conducted in Germany with 979 individuals between December 2019 and May 2020 examined changes in subjective well-being, stress, and coping strategies during the early stage of the COVID-19 pandemic. Results showed that life satisfaction was positively related to active coping with the situation, distraction, and religion and negatively related to threat assessment and self-blame. The authors concluded that the pandemic triggered unprecedented health and socioeconomic crisis and a severe psychological crisis, leading to declining subjective well-being (Zacher & Rudolph, 2021). These results are consistent with the centrality assigned to preserving the feeling of satisfaction with life in scenarios of considerable adversity (Fonseca et al., 2014).

One of the most recurrent coping resources in the global health emergency scenario triggered by the pandemic dissemination of the new coronavirus has been the R/S. Studies have pointed out the spiritual dimension as a critical element to be considered and integrated into health care at this critical moment of humanitarian crisis (Chirico & Nucera, 2020; Fardin, 2020; Koenig, 2020).

In the Italian context, a survey assessed the prevalence of peritraumatic distress (an essential predictor of posttraumatic stress disorder) during phase 1 of the pandemic in Italy and its relationship with different variables, including religiosity. A total of 329 people participated in the study. They responded to an instrument that measured symptoms of peritraumatic distress, the emotional impact caused by a particular event, lifestyle data, and history of exposure to COVID-19. The results showed that one-third of the sample had mild to severe symptoms of peritraumatic distress, and 61% of the subjects assessed reported being religious. However, "being religious" did not prove to be a protective factor during the pandemic. The authors pointed out that this phenomenon can be explained by the compulsory closure of religious temples in compliance with social distancing measures. These places offer welcoming spaces where comfort and social support can be found (Costantini & Mazzotti, 2020).

In the United States, a country with the highest number of infected and fatal victims, a research investigated the relationship between social and psychological resources and suicidal ideation/behaviors during the COVID-19 pandemic. The study involved 10,368 individuals who responded to instruments that measured suicidal behaviors, the intensity of social ties, and a sense of mastery over life. In addition, the importance attributed to religion was evaluated using a Likert-type scale, with response options ranging from 1 (not at all important) to 4 (very important). The results showed high use of social and psychological resources, with about two-thirds of the participants reporting that religion is somewhat or very important in their lives. In addition, people with stronger social ties showed higher scores concerning the feeling of having control over life, and those who attributed importance to religion showed lower scores of ideation or behaviors related to suicide (Fitzpatrick et al., 2020).

Also, in the U.S. context, a study evaluated the perceived stress and coping resources related to the experience of social isolation in people diagnosed with chronic diseases. Chronic conditions grouped a heterogeneous set of incurable diseases characterized by their long course and progressive losses. Some, such as chronic hypertension, diabetes mellitus, obesity, and respiratory conditions, are increased risk factors for worsening COVID-19. A total of 269 individuals participated in the study. They completed scales presented in an online form. The results indicated that religion, combined with active coping and availability of emotional support, were associated with well-being in patients with chronic conditions and self-reported disabilities (Umucu & Lee, 2020).

A study conducted before the pandemic highlighted that spirituality gives support for the individual to face changes experienced due to severe illnesses such as cancer. Such changes may involve pain, emotional instability, routine interrupted by treatment, and discomfort caused by its side effects. Moreover, through

faith, many patients reported having resignified the disease, acquiring resources to face the new situation, and better adhering to conventional treatment (Geronasso & Coelho, 2012). Authors draw attention to the fact that, during the pandemic, in addition to the vulnerability to infection by the new coronavirus due to the already existing disease and the consequences arising from the treatment, patients are more likely to experience additional levels of stress, fear, and hopelessness (Corrêa et al., 2020; Oliveira, Oliveira-Cardoso, et al., 2020; Oliveira, Magrin, et al., 2020; Oliveira et al., 2021).

The COVID-19 is an infectious disease for which the efficacy of possible treatments is still debated. The successful development of vaccines against the SARS-CoV-2 virus happened in record time, using different platforms; however, the Brazilian population that could be vaccinated was immunized at a slow pace as of March 2021. Nevertheless, by July 19, 122.7 million Brazilians had received at least one dose of the immunizer; the number of fully immunized individuals, which includes those who took the second dose or the single-shot vaccine, reached 15.98% of the population (Ministério da Saúde, 2021), still far short of what is considered ideal for achieving collective immunity. Therefore, mass vaccination in our country has taken a while to reach a desirable pace for establishing pandemic control.

Although there have already been studies that identified potentiating effects of religiosity/spirituality in coping with fear, helplessness, and hopelessness before the unknown, there are still gaps of knowledge regarding the repercussion of these dimensions in the face of the climate of uncertainty brought about by the new coronavirus in the daily lives of people with chronic diseases in the Brazilian scenario.

In this context, this study aims to investigate religiosity/spirituality as a potential protective resource against the emotional impact of the pandemic of COVID-19 in individuals diagnosed with malignant and non-malignant chronic diseases. More specifically, it is intended to: assess participants' emotional distress during the pandemic, learn about their coping resources, and compare the reports of participants who are religious with those who reported having no religious affiliation.

Method

This is a cross-sectional, descriptive-exploratory study, with a quanti-qualitative approach.

Procedures

The convenience sample was composed of 78 adult individuals of both genders, with self-reported chronic conditions (M_{age} = 44.0; *SD* = 16.11) and who lived in 10 Brazilian states. The time of diagnosis ranged from one to ten years (*M* = 8.2; *SD* = 3.4), and the most commonly reported diseases were diabetes mellitus and hypertension. No participants stated they had a confirmed diagnosis or suspicion of being exposed to COVID-19.

Participants

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Instruments

We used an online form prepared in the Google Forms platform for data collection, composed of items for characterization of the sociodemographic profile (age, gender, marital status, religion, profession, among others) and clinical profile (regarding the disease and treatment). The clinical data were obtained through open-ended questions, such as: *What is your diagnosis? How long have you been suffering from this disease? What treatment do you undergo? How long have you been under treatment for this disease?* How do the diagnosis and treatment impact your life?, and through closed-ended and open-ended questions related to adherence to social distancing measures and the psychological impacts perceived as a result of the confinement experience.

Other questions on the instrument included: *Are you religious? If yes, do you practice your religion? Have you ever had a crying crisis during this pandemic period?* We also investigated questions about the social support network, access to the health system, satisfaction with the care received, positive and negative changes experienced in daily life during the pandemic, and symptoms indicative of psychological distress (changes in sleep and appetite, anxiety, irritability, difficulty concentrating, suicidal ideation, and increased consumption of alcohol and tobacco). Questions such as: *How satisfied are you with the support you received during the pandemic? Compared to the period before the beginning of the COVID-19 pandemic, how much has changed in the following aspects of your psychological health: [Insomnia (difficulty sleeping)], difficulty concentrating, irritability?*

Some questions explored the perception of changes experienced before and during the pandemic, specifically regarding issues of religiosity/spirituality: *With the pandemic, have you felt more sensitive and more fragile to deal with possible difficulties? Did you start to think more about death during the pandemic? Compared to the moment before the pandemic, do you think your way of thinking about the end of life has changed? Did you notice an increase in your faith during this period?*

We chose to use the online questionnaire due to the ease of distribution, filling out, and tabulation of results. In addition, it complies with the health rules of social distancing, ensuring the safety of the participants and the researchers in times of COVID-19.

Procedures

Data collection occurred between May 1 and June 30, 2020. The online questionnaire was disseminated on social networks and distributed to the contact lists of community organizations, patient and family support groups, and health institutions in the five regions of the federation. We requested their collaboration in the dissemination of the survey in order to reach potential participants – adults diagnosed with chronic diseases. It was verified that the average time (self-reported) to fill out the instrument was 45 minutes. (a) 158 forms were collected, six of which were excluded because they were duplicates. Data were organized in alphabetical order considering the respondent's name. In the case of similar names and ages, the answers were compared to verify the presence or not of eventual duplication; (b) From the 152 participants (120 women and 32 men, ranging in age from 18 to 82 years old, most of them without a significant other), we extracted a subsample made up of the total of participants who declared they had no religion (n = 39); and (c) Based on this subgroup, we selected by lot another sub-sample with an equal number of participants who declared they were affiliated to some religion. Then, we sought to match the characteristics of the group without religion, controlling the variables sex, age, marital status, origin, and income (n = 39).

We systematized the answers obtained to close-ended and open-ended questions related to the perceived impacts of the physical and social isolation imposed by the fight against the pandemic to achieve the

objectives proposed in this study. The data from the close-ended questions were tabulated using descriptive statistics. The content of the open-ended questions was examined qualitatively using the inductive thematic analysis procedure (Bauer & Gaskell, 2017).

The answers to the open-ended questions ranged from 12 to 70 words, all with meaning and content pertinent to the investigated topic. After extensive reading of the corpus, the results were systematically coded. Then, they were assembled into potential themes, which were again reviewed, refined, and organized into thematic categories, as Braun and Clarke (2006) proposed. Three categories were established, and frequency counts were used to illustrate pieces of discourse. During the initial analysis stage, the MAXQDA software was used, which enabled the marking of coded parts in the text. Different colors were assigned to facilitate the visualization of the data. Finally, the results were discussed based on the scientific literature.

The ethical guidelines defined by Resolution nº 510/2016 of the National Health Council were respected. The Research Ethics Committee approved the project of the Faculty of Philosophy, Sciences, and Letters of Ribeirão Preto, University of São Paulo (CAAE 32077720.6.0000.5407).

Results

The study sample consisted of 78 participants. Those who expressed having religion were designated as group R (n = 39) and the group with no religion, group S (n = 39). The following religious affiliations were most frequently reported: catholic (50.4%), evangelical (19.8%), and spiritist doctrine (16.5%). The sample characterization data can be seen in Table 1.

Table 1

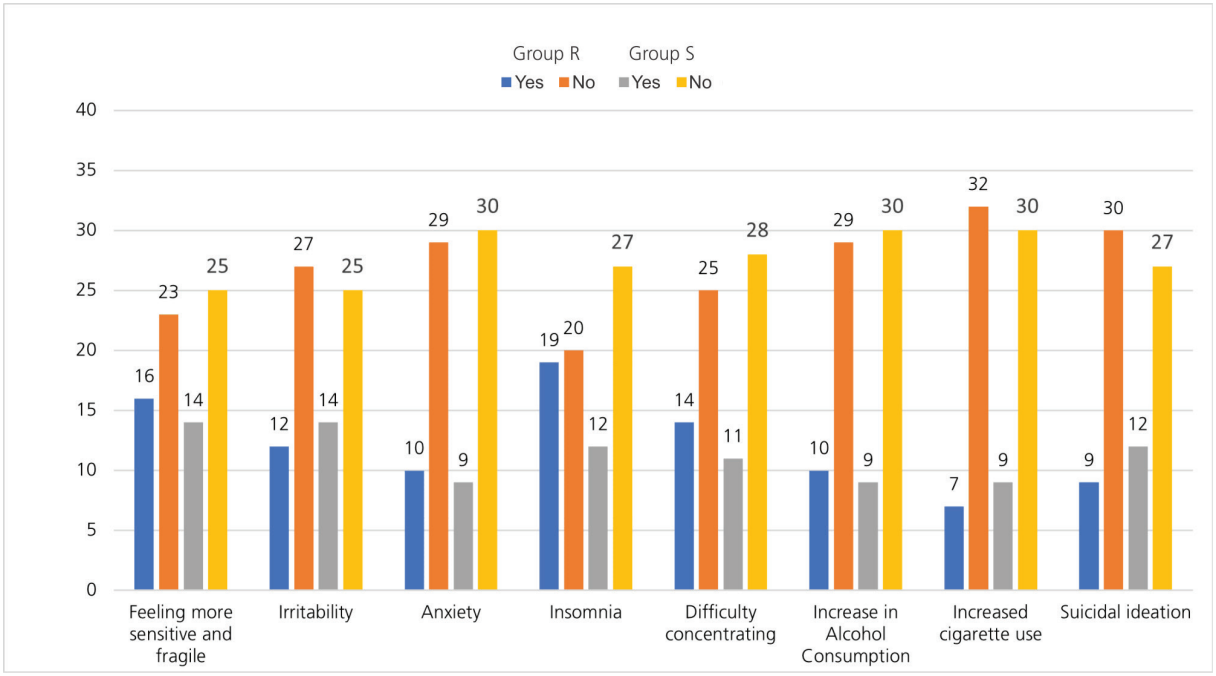
Sociodemographic and clinical characterization of the participants (n = 78)

Variables	*n*	%
Gender		
Female	62	79.5
Male	16	20.5
Total	78	100
Age		
18-40	50	64.1
41-83	28	35.9
Marital Status		
With significant other	28	35.9
Without significant other	50	64.1
Origin		
State of São Paulo	51	65.3
Other states	27	34.7
Income		
1 to 2 minimum wages	31	39.7
> 2 minimum wages	47	60.3
Religion		
Yes	39	50.0
No	39	50.0

The data resulted in three thematic categories: *Strengthening religiosity/spirituality; Emotional and behavioral responses; Perception of the future: the uncertain tomorrow and lessons from trauma.* The results extracted from the closed-ended questions were graphically represented in Figure 1 and are expressed as percentages in the text. In addition, those from the open-ended questions appear as excerpts of speech from some participants.

Figure 1

Absolute frequency of participants in Group R and Group S, according to the emotional and behavioral reactions manifested (n = 78)



Note: Group R: with religion; Group S: without religion. The y-axis (ordinate) represents the number of individuals, and the x-axis (abscissa) the emotional and behavioral reactions manifested.

Strengthening religiosity/spirituality

Individuals affected by progressive and life-threatening conditions, mostly neoplastic diseases, expressed practicing religiosity in a higher proportion (59%, *n* = 23). In contrast, in the group without religion, the majority (71%, *n* = 28) had chronic diseases with decreased risk of unfavorable outcomes in short/medium term.

Chronic degenerative diseases seem to configure a situation that intensely mobilizes the struggle for survival given the increased perception of threat to life (Oliveira et al., 2010). The experience of illness may relativize or have a moderating effect on the potential impact of the perceived risk of infection by COVID-19. Although SARS-CoV-2 infection was a condition initially unknown to medical science, particularly in the early months of the pandemic, infectologists and epidemiologists had already mastered the non-pharmacological protective measures that could prevent exposure to the virus and reduce the chances of infection, despite its high rate of transmissibility and lethality.

> When I had cancer, I learned that religion and strengthening my intimacy with God was helpfull. Today I exercise: practices of faith, breathing, thankfulness for being able to follow daily and very closely the development of my children (41 years old, female, married, catholic, chronic myeloid leukemia).

Slightly more than half of the participants in group R (54%) stated that their faith increased during the pandemic period, and this proportion was even higher in group S (69%).

> What will I keep from this period? The strengthening of my intimacy with God and my family members (41 years old, female, married, Catholic, acute myeloid leukemia).

> In this difficult moment, I think that what marked me the most was that I rediscovered my faith, that I managed to find in it the strength to be myself, starting to perform more genuine and coherent actions (56 years old, female, married, no religion, psoriasis).

This data invites us to think about the specificities of religiosity concerning spirituality, which was made explicit in some answers.

> I have no religion, but I have my beliefs and prayers, I cultivate my spirituality (22 years old, female, single, no religion, medullary aplasia).
>
> My quality of life is good, because I have faith that these difficult moments will pass. I have no religion, but I believe in a God (72 years old, female, married, no religion, hypertension/hypothyroidism).

Emotional and behavioral responses

By the time of the pandemic, most participants, 25 in group S (64%) and 20 in group R (55%), stated that they felt unable to cope with the emotional difficulties triggered. Prior to COVID-19, more than half of the individuals in each group did not feel the need to seek psychological care (56.7% in S; 52.3% in R), and few had sought emotional, psychological, or psychiatric support (18%, n = 14, of participants in each group). However, this perception changed substantially in the pandemic scenario since the majority started to recognize the need for this type of care (53.3% in S; 52.8% in R).

> I feel like there are a lot of things that I wasn't prepared for. I can't handle it, no. I will keep forever the bad memory of the chaos, of the fear felt and lived in the country (21 years old, female, single, no religion, asthmatic bronchitis)
>
> I miss hugging. Some days I can't do anything, some days I make myself crazy wanting to do everything (44 years old, female, single, catholic, thrombophilia).
>
> During the quarantine the image that remains is that we are all adrift on the high seas. In years, the hatred for social injustice and the feeling of helplessness have never been so present and never hurt so cruelly (31 years old, female, single, catholic, asthmatic bronchitis).

When we investigated the most recurrent feelings and behaviors in this period, the two groups showed similar answers, except for the self-assessment about feeling sad; in this aspect, it is observed that the R group presented a higher number of participants who reported not feeling sad (67%), while in the S group, 51% of the participants perceive themselves as sadder during the pandemic in comparison to how they were before. Despite this, all participants report frequent bouts of crying during this period for no known reason, suggesting emotional lability. Crying for no apparent reason appeared related, in some cases, to the perception of the suffering of others. This increased sensitivity results from identifying individuals in vulnerable situations, favoring depressive experiences. On the other hand, it was noted that this sensitivity could also mobilize empathy and openness to otherness, strengthening feelings of solidarity and belonging to the community and the search for the strengthening of family bonds.

> I feel sad for so many deaths, I have cried a lot, even though I didn't know the people who died because of the disease. And I wish that everything passes quickly, because the doctors, nurses, technicians, psychologists and many others are also exhausted in this fight. I pray to God that all of this can pass soon and I hope that we can get out of this situation better (44 years old, female, single, catholic, thrombophilia).
>
> I haven't been able to meet face-to-face with my youngest daughter in four months. I cry when I think about it. This is making me very sad and upset. I saw how much I love her and for sure, I will

> make an effort to see her more often and make up for this time of deprivation (55 years old, female, married, catholic, rheumatoid arthritis).

The high number of participants who reported suffering from insomnia (n = 31) and feeling more sensitive and fragile in general (*n* = 30) is noteworthy, as shown in Figure 1.

> I miss socializing, seeing and hugging loved ones. My husband has a 90+-year-old grandmother who is in a nursing home. She doesn't understand what is happening and suffers a lot. She thinks that her grandchildren and children have abandoned her. This situation is too sad, and it depresses me. I also miss spending time with my nephews, playing and hugging them. I miss their happiness (44 years old, female, married, spiritist, breast cancer).

Suicidal ideation was observed in both groups: R (23.0%, *n* = 9) and S (30.7%, *n* = 12). Despite the number of participants who endorsed the statement in the closed-ended question "During this period, did you ever think about taking your own life?" was proportionally small, this is a worrisome finding due to the potential severity under potentiating circumstances of social helplessness, individual uncontrollability, high mortality, and social isolation, suggesting the need for continued monitoring of these individuals.

> I have no contact with my family, but I stopped visiting friends and my boyfriend because of the isolation, which worsened my anxiety and the feeling of being depressed. I have thought about killing myself a few times, and the government's news doesn't help. The neglect by the authorities makes my feeling of helplessness even greater (26 years old, female, single, no religion, vitiligo).

Several accounts were permeated by pain and suffering. Dysphoric experiences and negative feelings appeared significantly intensified in the younger participants.

> Since the pandemic's beginning, I have experienced many anxiety attacks, and I am short of breath. Sometimes I think I have COVID-19 because of the shortness of breath, but it's just anxiety. Sometimes I go out and have a panic attack. I get worried, wondering what I have. Sometimes I think it would be better to die than to live with this anguish (29 years old, female, single, Catholic, aplastic anemia and paroxysmal nocturnal hemoglobinuria).
>
> After this despair, and seeing the despair of several workers, people and family members that live with an enormous fear of having an important loss, we start to think more about the other (21 years old, male, single, no religion, myocarditis).
>
> The memory of the political polarization in the country increases the fear and anguish... So many lives lost, so many people with financial difficulties. Fear, fear, a lot of fear (24 years old, female, single, no religion, obesity).

Perception of the future: the uncertain tomorrow and the lessons of trauma

The pandemic has gained dramatic contours worldwide, but Brazil has become one of the global epicenters, with the acceleration of the transmission rate and vertiginous progression of the death curve between May and June 2020. Besides, there was the prolonged state of exception caused by the uncontrolled spread of the virus, which required the maintenance of non-pharmacological measures and the indefinite extension of social distance. Consequently, the growing exposure to the threats of loss (employment, income, health) has made catastrophic thoughts and anguish of annihilation recrudescence. Insecurity has become part of families' routine, even those who have not had members diagnosed or developed the most severe forms of the infection. Most of the participants, 25 from group R (64%) and 23 from group S (59%), reported that they started to think more frequently about finitude and terminality since the beginning of the pandemic.

> How not to think about death seeing the images of the open graves in the Manaus cemetery? (26 years old, female, single, no religion, medullary aplasia).

Despite not being the majority, the number of participants who changed their way of thinking about the end of life was expressive: 17 (43.5%) in the R group and 16 (41.0%) in the S group.

> I will never be the same again after the experience of living a historical moment of great suffering, given the rapid and unexpected subtraction of thousands of lives, combined with the anguish that maybe you yourself, or your loved ones, are one of those victims of a virus that you can't see and that can infect you through your own negligence (46 years old, female, married, no religion, obese).

Despite so many experiences that mobilize suffering, the participants were able to keep hope alive in a better future. After the pandemic, the participants expect that better days will come. They believe that they "will be better people" and that they "will live in a better world" with "more justice and solidarity" (group R: 46%; group S: 41%).

> I think we have learned to have time to take breaks. In a way, we are all addicted to doing tasks non-stop, we have become "doers". Now I have had space to contemplate, talk, sunbathe (62 years old, female, married, catholic, hypercholesterolemia).
>
> I would say that this was when I reencountered myself and acquired strength to be myself, starting to perform more simple and coherent actions, especially in the work environment (56 years old, female, married, no religion, psoriasis).

The reports suggest the need to search for meaning to assimilate the moment experienced in an attempt to mitigate the pain of the losses disseminated in the community and elaborate the collective mourning.

> I think this came to teach us lessons. I would like to keep this phase's learnings, such as empathy, patience, and values (31 years old, female, single, no religion, asthmatic bronchitis).
>
> After all this, I think we will realize that this was an opportunity for the human being to become better (44 years old, female, married, spiritist, breast cancer).

A recurring theme in the reports was the perception of the need to develop empathy and the awareness of responsibility regarding one's own existence and the life of others, with the growing understanding that the action of an individual (such as respecting physical and social isolation and wearing a face mask) has consequences that can be decisive for the well-being of the collectivity. Furthermore, in the participants' perception, the attitude of self-care can also lead people to be concerned about the well-being of the other, thus trying to connect more strongly with community members, reinforcing collaborative bonds, and favoring solidarity.

> What I will remember from that period, what will remain for me is that I was part of a story and that I took care of myself to stay positive in someone's story (37 years old, male, single, catholic, scleroderma).

Discussion

This exploratory study evaluated a sample of individuals living with a chronic illness and their emotional/behavioral responses in the face of the early stages of the pandemic. The results suggest that those who had previous diagnoses of life-threatening conditions, such as neoplastic diseases, are more likely to exercise

their R/S than those who lived with other chronic conditions with a prolonged and manageable course. The R/S seems to function as a coping resource that mitigates the anguish and uncertainty raised because they perceive themselves as having an increased risk for developing the most aggressive forms of COVID-19.

The prior diagnosis of a chronic condition brings the patient face to face with the inexorability of the disease and the perceived proximity of finitude (Benites et al., 2017; Benites, Rodin, Leite, et al., 2021; Mazer-Gonçalves et al., 2016). Particularly in those individuals who experience the context of onco-hematologic treatment, the recurrent use of R/S as a coping strategy is observed. Discovering one has a potentially fatal disease can raise reflections and mobilize fantasies about terminality and the meaning of life (Benites et al., 2017; Cardoso & Santos, 2013; Cardoso et al., 2009, 2018; Madeira et al., 2020; Mathias et al., 2011; Silva et al., 2021; Vieira et al., 2021). In the collective imagination, such a diagnosis is still closely associated with suffering and death, for example, cancer.

More than half of the participants of each investigated group experienced an increase in faith with the arrival of COVID-19 in the country. However, this increase was more significant in those who declared they had no religion. The attachment to faith, which in this case is related to spirituality and not to religiosity, appears as a resource that is mobilized to deal with the anxieties triggered by the negative impacts of isolation and domestic confinement (Chirico & Nucera, 2020; Fardin, 2020). Spirituality aids in coping with acute crises by allowing the individual to elaborate a meaning, which offers a purpose or significance to the disruptive experiences (Pinezi, 2009). When one is in a state of suffering, turning to spirituality becomes protective (Porreca, 2016). A hypothesis to be further investigated in future studies is that both religiosity and spirituality can be activated as coping resources with adaptive value at the time of the pandemic, in line with the findings of other research (Costantini & Mazzotti, 2020; Umucu & Lee, 2020).

The literature is consistent when evidencing that a traumatic event can contribute to triggering a movement of search for meaning and significance in the face of painful and anxiogenic experiences, giving contour to the lived reality (Benites et al., 2017; Koenig, 2012). With its rituals and cults, the practice of religion offers the opportunity to experience pain and suffering in a shared way in the sacred space, favoring a collective purging of suffering (Benites, Rodin, Oliveira-Cardoso, et al., 2021). Religious practice can be empowering when it allows people not to withdraw from reality with negationist postures, strengthening the hope that together they will be able to overcome adversity and find possible answers when they are no longer searching for the "why" but rather "what for." However, with the prohibition of crowds of people, the varied religious rituals were temporarily suspended. As a result, churches, temples, and *candomblé terreiros* [candomblé is an afro-Brazilian religion] became empty, which imposed limitations on using these welcoming spaces. This situation has produced obstacles to the freedom of the collective experience of religiosity. Nevertheless, it does not seem to have weakened the strength of faith that nourishes the experience of spirituality.

Symptoms of psychological suffering were identified in a significant portion of the sample. The participants felt more sensitive and fragile due to the pandemic, reported changes in sleep, anxiety and irritability symptoms, difficulty concentrating, suicidal ideation, and increased consumption of alcohol and tobacco. This data strengthens the recommendation that health professionals should prioritize a specific screening for depression and anxiety. Both groups reported dysphoric feelings such as sadness, fear, insecurity, and affective lability. These results are consistent with previous studies' results (Costantini & Mazzotti, 2020; Umucu & Lee, 2020). Finally, both groups had participants who experienced a desire to end their own lives at some point during the pandemic, with a slightly higher frequency in the group with no religious affiliation. It may be related to the fact that people who attach importance to religion tend to have lower scores of suicidal behavior, both in terms of ideation and attempt (Fitzpatrick et al., 2020).

Despite recognizing the difficulties inherent in the pandemic moment, participants believe that both they and the world will come out of this challenging experience transformed and "for the better." Such a

need to find purpose and attach positive meaning to suffering can be understood as an adaptive strategy for coping with an unusual time of loss and collective grief. For some people, it is possible that the experience of the pandemic has contributed to change old dynamics of personal and social relationships, opening new possibilities for the construction of ways of relating to oneself and others in new terms, and may favor a rethinking of life priorities (Porreca, 2020). Nevertheless, this transforming potential is far from being the rule. In fact, in the current stage of a complex phenomenon, like an ongoing pandemic, we see the coexistence between various modes of existence. We do not think that individualism, as a mode of subjectivation, has been "broken" by the challenging situation triggered by the pandemic; maybe it has been tensioned. In any case, one should be cautious of both exaggerated optimism and unfounded pessimism.

In this context, the promotion of solidarity can strengthen social ties and unite the different, contributing to breaking crystallized boundaries and liquefy prejudices that were difficult to transpose until then, such as those that take place in ethnic-racial relations, or between different social strata and religions (Barros, 2020) in a society as profoundly unequal as the Brazilian one, besides tensing the deep-rooted human fear of death (Barbosa et al., 2011).

Like any systemic crisis, the degree of uncertainty is accompanied by a longing for answers. The R/S can contribute to this process of searching for the meaning of life and human relationships in a scenario of mass murder unprecedented in Brazilian history. However, it remains to be seen if humanity will be able to transcend the tragic circumstances of the pandemic scenario, revaluing the human attributes that have been reduced and degraded by exacerbated individualism. This demands a new look, one that allows going beyond the obvious and that can be facilitated by contact with transcendence, integrating knowledge and beliefs around values such as hope, empathy, solidarity, and compassion in the encounter with otherness (Porreca, 2020).

Reflections on R/S need to be on the agenda of health professionals, considering that the process of death and dying has dramatically accelerated in the pandemic situation, incurring the danger of its trivialization. The conditions of high morbidity and mortality experienced in this "war scenario" and the exceptionality of the situation of dying alone in hospitals and long-stay institutions for the elderly, aggravated by *post-mortem* marked by the absence of traditional farewell rituals, complicate the families' grieving process (Oliveira-Cardoso et al., 2020; Silva et al., 2020), creating conditions for the development of complicated grief (Cardoso & Santos, 2013; Madeira et al., 2020). It is observed that the health professional who acts on the frontline of the fight against COVID-19 has often become the sole and ultimate companion of patients at the end of life.

Understanding the meaning of spirituality helps the professional offer sensitive, multidimensional, and integrative care to the patient and family member, even from a distance. It is the recognition that spiritual well-being can offer support in the face of finitude (Silva et al., 2020). Understanding that caring for spirituality is one of the philosophical precepts of palliative care, it becomes necessary to recognize this dimension as a target for therapeutic strategies that aim at well-being in terminality and bereavement (Arruda-Colli et al., 2021; Benites, Rodin, Leite, et al., 2017, 2021; McClain et al., 2003; Moreira et al., 2012; Schmidt et al., 2011).

The uncontrolled spread of the new coronavirus made Brazil the epicenter of the disease in Latin America in the first months of 2020, according to WHO (2020). The unprecedented humanitarian tragedy, the "naked death," and the repeated exposure in the media of worrying figures of new cases of infection made the imminence of death become part of the routine of the population in times of pandemic and social helplessness, mobilizing anguish, commotion, and feeling of community devastation. The sense of uncontrollability in the face of the threat and domestic self-confinement contribute to accentuating symptoms such as loneliness and insomnia. The situation of exception and suspension of daily life also seem to contribute to repositioning the subject in the world. In this moment of universal suffering, reinforcing empathy among

people helps alleviate loneliness, strengthening the sense of self-efficacy and individual responsibility. By showing solidarity, one can leave the paralysis of fear and move towards adopting effective actions to help.

This study has some limitations. It is important to emphasize that the analyses were prepared based on self-reported information taken from forms with online responses, which precludes direct interaction with the participants for clarification. As a suggestion for future studies, we recommend using standardized instruments in combination with observation and individual interviews, which allow further investigation. The cross-sectional design makes it impossible to interpret the causal effect of the pandemic situation on the dimensions of R/S expressed by the participants. Another limitation observed was the small number of participants, which restricted the possibilities of analyzing the material and generalizing the results, bringing challenges to understanding the complexity of the phenomenon studied.

On the other hand, this study is important due to the possibility of contributing to the practice of mental health professionals who work in the context of the pandemic, especially in the management of patients with comorbidities. Thus, the results offer relevant subsidies for planning actions and health policies. Strengthening faith and empathy seem to be valuable resources to get through this dramatic period and, as such, should be valued and encouraged in assistance programs for vulnerable populations. The devastation caused by the spread of the new coronavirus tests the human capacity to resist and overcome day after day. However, it is essential to realize that, beyond the challenges, immense possibilities exist, such as the prospect of thriving new ways of living in a community.

Contributors

E. A. OLIVEIRA-CARDOSO was responsible for the conception and design of the study, data analysis and interpretation, discussion of the results, writing, review and approval of the final version of the manuscript. I. S. FREITAS and J. H. C. SANTOS collaborated with the data collection, analysis and interpretation, discussion of the results, and writing of this paper. W. A. OLIVEIRA contributed to the data analysis and interpretation, discussion and edting of the results. J. T. GARCIA collaborated with the data analysis, interpretation and discussion of the results. M. A. SANTOS contributed to the conceptualization and design of this research, data analysis and interpretation, discussion of the results, writing, review and approval of the final version of the manuscript.

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Received: November 14, 2020
Final version: July 24, 2021
Approved: March 17, 2022