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A RELIGIOSIDADE/ESPIRITUALIDADE COMO RECURSO NO ENFRENTAMENTO DA COVID-19

RELIGIOSITY/SPIRITUALITY AS A RESOURCE TO FACE COVID-19

RELIGIOSIDAD/ESPIRITUALIDAD COMO RECURSO PARA HACER FRENTE A COVID-19

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RESUMO
Objetivo: problematizar de que modo a Religiosidade/Espiritualidade (R/E) pode ser empregada como um recurso no enfrentamento da pandemia da COVID-19. **Método:** Reflexão teórica baseada na literatura científica da área. **Resultados:** Entre as principais aplicações dessa dimensão no contexto de atenção em saúde destaca-se a R/E como recurso para a compreensão dos efeitos da pandemia na vida cotidiana; como recurso de enfrentamento e fonte de apoio para pessoas adoecidas, cuidadores e familiares; como suporte nas situações de isolamento social e quarentena; como recurso para profissionais de saúde diretamente envolvidos no combate à pandemia; como recurso na compreensão de situações de luto. **Conclusão:** Recomenda-se que a R/E possa ser empregada como um recurso não apenas na explicação das repercussões emocionais da doença, mas como estratégia que possa, de fato, promover um cuidado mais humano e integrado diante de um cenário pandêmico impermanente.
Palavras-chave: Pandemias; Religião; Espiritualidade; Infecções por Coronavirus.

ABSTRACT
Objective: Considering that religiosity/spirituality (R/S) has been an important vertex of health care, the objective of this study is to discuss how R/S can be used as a resource to face the COVID-19 pandemic. **Method:** Theoretical reflection based on the scientific literature of the area. **Results:** Among the main applications of this dimension in the context of health care, we highlight: R/S as a resource for understanding the effects of the pandemic on daily life; as a coping resource and source of support for sick people, caregivers, and family members; as support in situations of social isolation and quarantine; as a resource for front-line health professionals during the pandemic; as a resource for understanding grieving situations. **Conclusion:** It is recommended that R/S can be used as a resource not only in explaining the emotional repercussions of the disease but as a strategy that can promote more humane and integrated care in the face of an impermanent pandemic scenario.
Keywords: Pandemics; Religion; Spirituality; Coronavirus Infections.

RESUMEN
Objetivo: teniendo en cuenta que la religiosidad/espiritualidad (R/E) ha sido un aspecto importante de la atención en salud, el objetivo de este estudio es analizar como R/E puede utilizarse como un recurso para hacer frente a la pandemia de COVID-19. **Método:** reflexión teórica basada en la literatura científica del área. **Resultados:** entre las principales aplicaciones de esta dimensión en el contexto de la atención en salud, destacamos: R/E como un recurso para comprender los efectos de la pandemia en la vida diaria; como recurso de enfrentamiento y punto de apoyo para personas enfermas, cuidadores y familiares; 3) R/E como apoyo en situaciones de aislamiento social y cuarentena; como recurso para profesionales de la salud directamente involucrados en la lucha contra la pandemia; como recurso para comprender situaciones de luto. **Conclusión:** se recomienda que R/E se pueda usar como un recurso no solo para explicar las repercusiones emocionales de la enfermedad, sino como una estrategia que, de hecho, puede promover una atención más humana e integrada frente a un escenario de pandemia no permanente.
Palabras Clave: Pandemias; Religión; Espiritualidad; Infecciones por Coronavirus.

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INTRODUCTION

Religiosity/spirituality (R/S) has been acknowledged in the scientific literature as one of the cornerstones of health care since its inclusion in the multidimensional concept of health by the World Health Organization (WHO) in 1998[1]. Although it is evoked as a dimension of care and has been the subject of several studies in different areas, such as Psychology, Medicine and Nursing, how can we incorporate R/S into health care has been the subject of wide-ranging debate. Such reflections almost always are caught out on variables such as ethical dilemmas, lack of training of professionals qualified for this care on undergraduate and postgraduate health care courses, as well as on practical difficulties ranging from justifications such as lack of time to the lack of guidelines and protocols guiding how this aspect of health care can be put into practice. Although such difficulties are frequently reported in the literature, the challenge remains of constructing knowledge that can advance health care practices affecting this dimension [2-5].

In this study, we used the combined terminology, R/S, to include the definitions of religion, religiosity and spirituality from the same analytical perspective, as has been growing in the field of health care[3-4]. Although we consider the terminological differences and the epistemological traditions surrounding these definitions, for their use in the field of health care, we emphasize that the combined term seems to summarize several aspects that could be disregarded if we chose just one or the other particular term. In recent research on R/S in health care, this concept can be defined as the way in which human beings relate to a dimension external to them, which may or may not refer to religious institutions and practices, covering a series of phenomena that place the human being in contact with the transcendent. According to this broad definition, we can include here references to religions, practices, rituals, religious literature, and even appraisals that do not involve any religious symbols, but rather a perspective of transcendental[3-4].

For a long time, science and R/S were seen as completely different and opposing. In the scientific field still exist rationalist and mechanistic conceptions prevail that tend to devalue what cannot be fully measured, predicted or controlled by technology and reason[6]. What is found is that these positions are based on the premise that no evidence can be measured about R/S exercise control over physical health conditions. At the same time, fails to consider their effect on our subjective and psychological aspects. Consequently, the interrelationships between physical, psychological, subjective, social, religious and spiritual conditions of individuals are not considered, giving a fragmented view of the human being that should have been outgrown by now [3].

Although the literature has not failed to recognize and consider R/S as an aspect of care[1] with each new health-disease process triggered, it is necessary to revisit the knowledge produced about this dimension[1-6] and how it can contribute to providing an answer to this pandemic scenario. The emergence of the novel coronavirus and the COVID-19 pandemic has changed the most wide-ranging aspects of care, mobilizing researchers and professionals in terms of possible treatments, exploring contagion and containment of the pandemic, as well as the emotional aspects triggered due to this significant global health scenario. As this is a recent context, references on R/S in the context of the pandemic are still being produced showing the importance of this reflection in directing these proposals. With this goal, we will present how the pandemic appeared and the main evidence about mental health so far, and promote associations that allow a dialogue with the field of R/S.

COVID-19 began to spread very quickly, reaching most countries in the world in a matter of months, profoundly impacting all aspects of people's daily lives. On December 31, 2019, the WHO was alerted to several cases of pneumonia in the province of Hubei in China[7]. The first cases that appeared were related to a seafood market in the city of Wuhan, capital of the central province of Hubei, which was closed in January 2020 as a measure to contain the spread of the disease[8].

After the appearance of cases in China, the COVID-19 virus spread to other regions of the planet, placing a significant portion of the world population under preventive social isolation, waiting for a solution to the disease to be found. Although many details of the emergence of this virus - such as its origin and its ability to spread between humans - remained unknown at this time, an increasing number of cases appeared to be the result of human-to-human transmission[9].

The disease, popularly known as a coronavirus (COVID-19), is characterized by severe acute respiratory syndrome caused by coronavirus 2 (SARS-CoV-2). This is an ongoing global health

emergency, and as of February 24, 2020, more than 80,000 cases of the disease had been confirmed, including more than 2,700 deaths worldwide, affecting at least 37 countries[10]. Due to the proportions, on January 30, 2020, the WHO declared the outbreak a Public Health Emergency of International Importance - the highest level of alert in the Organization, as provided for in the International Health Regulations and, on March 11, 2020, declared it a pandemic[7].

The data presented in scientific publications referring to cases of COVID-19, in February 2020 were just the tip of the iceberg, showing what the disease was doing, what it would become, and what it could still imply for the global population if it continued to spread. WHO data updated on March 31, 2020, showed that, worldwide, there were 750,890 cases of COVID-19 (57,610 new cases since the previous day) and 36,405 deaths (3,301 since the previous day) to that date[7], and every day, cases multiplied vertiginously. By the afternoon of March 31, 2020, Brazil had confirmed 5,717 cases and 201 deaths. On May 25, less than two months after collecting these data, the situation was more than 360 thousand cases and 22 thousand deaths. Currently, on October 16, 2020, Brazil accounts for more than 5 million infected people and 150 thousand deaths. Worldwide, these figures reach almost 39 million infected and more than one million deaths.

Most people infected with COVID-19 will experience mild to moderate respiratory illness and will recover without the need for special treatment. The elderly and those with underlying medical problems, such as cardiovascular disease, diabetes, chronic respiratory disease, or cancer, are more likely to develop complications from the disease[11] and die. The main symptoms presented by those with the disease include fever, cough, and headache, among others.

Research conducted in Beijing[12] with 262 patients infected with COVID-19, showed that the most common symptoms at the onset of the disease were fever (82.1%), cough (45.8%) and fatigue (26,3%), dyspnea (6.9%) and headache (6.5%), severe cases with dyspnea (32.6%, 15 of 46). Other data also show that the average time between contact and onset of the disease, known as the incubation period, was 6.7 days, from the onset of the disease to hospitalization was 4.5 days, and from hospitalization to confirmed case was 2.1 days[12].

Numbers increased significantly each day and, consequently, social concern about the disease grew too, and more drastic preventive measures were adopted by countries in an effort to contain the disease, quarantine being one of them. Consequently, given global apprehension about the pandemic, added to the social distancing and isolation resulting from COVID-19 transmission prevention measures, among other problems, the impact on the population's mental health is inevitable and is an important factor that must be considered as it will affect people's quality of life during and after this period[14-16].

Some preventive measures can contribute to minimizing contamination and the spread of the virus, differing from each other[13]. According to the authors, the purpose of social distancing is to reduce people's interactions in the wider community, before the infection is confirmed and, especially, in cases in which exposure to the disease has not happened or is uncertain. It is applied through interventions such as closing schools or offices, suspending public markets and canceling meetings with several people[13]. In quarantine, circulation is restricted for those who have presumably been exposed, but who are not sick, either because they are not infected or because they are in the incubation period of the virus. During this period, all individuals must be monitored, in the event of any symptoms occurring. Finally, isolation is the measure of removing the infected individual from contact with uninfected persons to protect them. Despite being an important measure, it is usually effective in interrupting transmission if detection is early. Otherwise, isolation is often insufficiently effective in stopping transmission and controlling a pandemic.

Although no data is correlating these events, a study indicates that patients with confirmed or suspected COVID-19 may be afraid of the consequences of infection with a novel, potentially fatal virus, and those in the quarantine may experience boredom, loneliness and anger. Moreover, the study shows that infection symptoms, such as fever, hypoxia and cough, in addition to adverse treatment effects such as insomnia caused by corticosteroids, can lead to worsening anxiety and mental suffering[14].

The general population also suffers the impacts of the disease when they have to deal with feelings of uncertainty, anguish generated by the high mortality rates of the disease, lack of access to basic resources for prevention and to adequate health care services, the economic impact caused by a range of factors, social

distancing, among other aspects. A study carried out with 1210 respondents, aiming to analyze the impact of COVID-19 on people's mental health, showed that, of the total interviewees, 296 (24.5%) reported minimal psychological impact, 263 (21.7%) classified mild psychological impact and 651 (53.8%) reported moderate or severe psychological impact[15]. The interviewees' levels of depression, anxiety, and stress (assessed through DASS 21) revealed that for the depression subscale, 843 (69.7%) were considered to have a normal score, 167 (13.8%) mild depression, 148 (12.2%) moderate depression and 52 (4.3%) severe or extremely severe depression[15]. Regarding anxiety, the authors describe that 770 (63.6%) were considered to have a normal score, 91 (7.5%) were assessed as having mild anxiety, 247 (20.4%) were considered to have moderate anxiety and 102 (8, 4%) had severe or extremely severe anxiety[15]. As for stress, the study found that 821 (67.9%) were considered to have a normal score, 292 (24.1%) were considered to have mild stress, 66 (5.5%) were considered to be moderately stressed and 31 (2.6 %) had severe or extremely severe stress (score: 27-42)[15].

As with the general population, health care professionals are also emotionally impacted by aspects of COVID-19, as they are at the forefront of combating this disease. One study found that health care professionals, especially those working in hospitals caring for patients with confirmed or suspected pneumonia from COVID-19, are vulnerable. They are at high risk of infection and of mental health problems. This study also showed that health care professionals may be afraid of contagion and of spreading the virus to their families, friends or colleagues [14].

Thus, it can be seen that the serious situation experienced during the COVID-19 pandemic can be an aggravating factor for mental health conditions in health care professionals who are struggling with the disease. A study points out that the situation of working with the disease has led to the appearance of mental health problems such as stress, anxiety, depressive symptoms, insomnia, denial, anger and fear. According to its authors, these problems become complex, as they affect workers' attention, understanding and decision-making ability, which can make combatting COVID-19 more difficult, in addition to having a lasting effect on overall well-being[16].

Considering that R/S can function as a coping strategy in the face of stressful events, those that arouse strong emotion[2-6], as can be seen from the first surveys of mental health during the COVID-19 pandemic[14-15], it is suggested that this is a resource that can be used in this context, providing important guidance for patients, family members and also health care professionals. Also considering the emergence of the topic of death in this context, it is conjectured that R/S can provide support in drawing up care protocols that do consider this dimension of health care, referring to WHO recommendations[1].

COVID-19 is a pandemic with significant repercussions on all sectors of human activity, awakening interest, and the need to produce evidence that can offer a response to this phenomenon and its associations with other variables. Regarding resources already developed and under discussion in this situation, as well as contributing to knowledge production and reflections about this event of global proportions, this study will focus on the dimension of R/S.

The R/S topic was chosen not only because of its associations with positive health outcomes[2,6], but also the need to discuss this topic in the context of the pandemic. The pandemic context is still considered new by researchers both in the area of mental health[14-15] and in R/S. In an ever-changing situation, with several studies in progress, no empirical studies have yet been found that provide evidence about R/S in this context, nor in terms of assessing R/S in sick people, family members, and health care professionals, nor yet in terms of using R/S as a coping strategy, in this situation which arouses strong emotions. It is suggested that the situation encompasses the need for discussion about death and dying, which different professionals have often presented as an element capable of evoking attention to R/S[3-4]. Based on this panorama and the gap in knowledge production identified in a context that is still recent, this theoretical reflection aimed to discuss how R/S can be used as a resource to face the COVID-19 pandemic.

METHOD

This is a theoretical reflection supported by the scientific literature on R/S[1-6] articulating how this dimension can help to cope in situations of illness. Theoretical reflection studies cannot be considered review studies, since the collation of evidence is replaced by a dense analytical process based on a range of elements in the literature, incorporating different levels of evidence and different indications for discussion. In an as yet incipient context concerning the production of

knowledge able to provide robust evidence for health care practice, as in relation to the COVID-19 pandemic, such theoretical reflection is timely. It enables approximations that do not produce evidence, but rather indications which can contribute to future designing empirical studies and other analytical paths which is as yet exploratory. Thus, what legitimizes this type of study is precisely the reflexive vigor that can invite knowledge, especially in the field of health care sciences [17].

For the proposed discussion, available studies on the COVID-19 pandemic[14-15] will also be used to outline recommendations on how to use R/S as a health care resource. As shown in the introduction, as the empirical studies about R/S are still incipient in the context of the pandemic, the consolidated production on R/S and its use in health care settings will be used[1-6]. This knowledge can support the discussions here and guided by the challenges of care in the midst of a pandemic of a disease about which little is yet known [14-16].

To organize this theoretical reflection, five categories were produced revealing possibilities of understanding the phenomenon in question — applying R/S in the context of the COVID-19 pandemic. Based on the studies brought together here and current research in the context of R/S, it representing a response to the challenges presented in the study's justification and which permeates the drawing up of such recommendations. As there are still no elements with which to construct a systematic review, such categories were produced based on the consolidated literature on R/S and its use in the context of health care[2-3,5-6,18-23], representing reflexive aspects such as the religious-spiritual concept of coping[18], for example, which can guide the approximation of the R/S dimension with the context of this pandemic, given the first evidence becoming available[13-16]. Thus, these categories were proposed as a way of articulating R/S health care literature with the possible meeting points based on the knowledge available about the COVID-19 pandemic, enabling comprehension over an exploratory context.

RESULTS AND DISCUSSION

R/S as a resource for understanding the effects of the pandemic on daily life

In this reflection, we suggest that R/S can be used as a resource on an individual and collective level to understand or face adverse effects resulting from the pandemic that has affected daily life on a global scale. Of the effects that can be noted — already described or yet to emerge — we highlight: (a) emotional repercussions due to social restrictions, both as a public health measure to delay community spread and isolation or quarantine, in the case of those infected or who have had some level of exposure to the virus; (b) social, cultural and family changes due to death or illness of those close to us, triggering the need to restructure positions, roles and developmental functions, for example in the family nucleus; (c) building a collective feeling of belonging and responsibility with humanity, meaning there is a pressing need for empathy to emerge as a way of bringing together people who have been through similar situations and evoking the consolidation of social support networks going beyond structures of family or close friends, in contextual and environmental terms; (d) the need to adapt in the most diverse situations of life, such as schools, universities, health care facilities.

It should be noted that this production is at the epicenter of a health crisis, which can trigger short, medium, and long-term changes[8-13] with these effects described and discussed here. With regard specifically to R/S as an element linked to the transcendent[5], it is clear that such effects, and several others that will emerge in the future, can be understood as guided by the way we are linked to that which is not necessarily present in our materiality[2-3].

Our connection with the transcendent and/or the divine can function as a mechanism capable of maintaining a critical capacity of support in the reality and decision making of everyday life that would otherwise be suspended [4-6]. R/S offers to people a possibility to connect and describe ourselves going beyond material criteria. It can be a resource for maintaining health for building other strategies that make sense in the middle of painful experiences resulting from any pandemic. This transcendent and/or divine can be exemplified through contact with saints, entities, spirits, sacred books, taking part in religious rituals and in corporal experiences that promote this connection, perseverance in religious principles dear to us, contact with nature, openness to sensory experiences, among others[4,6].

Thus, R/S is raised to a condition allowing us to have an experience that is less dissociated from our context and, therefore, expanding possibilities

for responding to necessary adaptations[1-3]. At this point, it is worth mentioning that the negative effects of R/S on everyday life are also understood. There are situations in which it can be a mechanism for mobilizing spiritual anguish and avoiding responsibility when faced with situations that require forceful responses[18] or even when it mobilizes people to fanatical and radical attitudes that can be harmful[19]. It is also worth mentioning that it is understood that there are controversies and ethical conflicts involving issues related to religious/spiritual beliefs and health care as expressed in scientific publications[20]. Thus, the focus does not disregard negative aspects of R/S, however, it starts from the principle that R/S should be considered a human dimension valued by society and, in health care contexts[1]. From this perspective, we can analyze and understand R/S in a more mature perception of reality, which can promote the adoption of more propositional strategies and actions.

R/S as a coping resource and source of support for the sick, caregivers and family members

R/S is known to be a dimension that has permeated human life since the beginning of civilization; an important socio-cultural element affecting people's ways of life, health conditions and subjective aspects[1-2]. Even today, there is still resistance to the dialogue between R/S and health care, mainly because on many occasions conventional treatment has been replaced by religious/spiritual treatment, which is not recommended, as it may further compromise the health conditions of the sick person[5]. Furthermore, the attitude of certain religious and spiritual leaders on many occasions leads to people refraining from appropriate healthy behavior, being criticized for what they are going through and ending up following inappropriate guidance and being guided based on the religious/spiritual leader's interpretations and conceptions, without any concrete basis.

R/S is a dimension that acts on our subjective aspects providing comfort and protection in the face of difficult situations, creating conditions for coping with moments of crisis, and helping in aspects that are complicated to understand and solve concretely[4-5]. Thus, it must be viewed as an element directly linked to our psychological/subjective aspects. Using it as a tool to direct positions and behavior harmful to our health or that of others is at the very least questionable and should be discussed.

Recent studies point to R/S as among the most significant aspects of human subjectivity, observing that it is related to constructing meaning and ordering individuals' lives, positively affecting their health[21]. In situations of adversity, the R/S used prudently, leaving aside aspects related to religious and spiritual fanaticism, can be an important ally in the process of religious-spiritual coping[18]. It is common for people to turn to R/S in times of adversity as a way of understanding what they are going through and seeking conditions and answers to react to the situations to which they are exposed [4].

R/S refers to the relationship with the transcendent in the search for the meaning of life[22]. It becomes a way of expressing the identity and existential purpose of each of us through our history, experiences and aspirations, and we are supported by God or whatever we consider sacred due to the need for religious/spiritual assistance to better face fear, loneliness and the unexpected[23].

In situations of illness, with diseases that do not yet respond to treatment or which have a social meaning associated with danger and death[22-23] people may turn to R/S in an attempt to find support to deal with the negative aspects linked to these contexts. This search for support in spirituality or religion is known as religious/spiritual coping (RSC)[18].

RSC can be used positively when it makes use of religious/spiritual beliefs and behavior to solve problems or prevent or alleviate the negative consequences of stressful situations experienced at the time[18]. In this sense, the authors exemplify that positive RSC includes strategies with a beneficial effect on the subject, such as, for example, searching for the love/protection of God or greater connection with transcendental forces. In contrast, there is also negative RSC, which is the use of religious/spiritual beliefs and behavior that generate harmful consequences, such as, for example, leaving it to God to solve the problem, without taking any action ourselves[18]. Given the pandemic, there is an urgent need to produce evidence about RSC enabling elements and practices to be developed which allowed the positive value of this resource for both patients, family members and health care professionals.

It is always important not to lose sight of the fact that faith in God, in the divine and sacred is a feeling rooted in culture and as necessary as other ways of coping[1], since the spiritual dimension

occupies a prominent place in people's lives. It is essential to discover users' R/S when planning care [23]. R/S is part of the construction of the personality of each human being, an expression of identity and purpose, that in the face of history, experience and aspirations, it can relieve suffering, as it can change the subjective perspective through which the patient and the community perceives the context of the disease[23].

R/S as support in situations of quarantine, social distancing and isolation

As there are still no protocols indicating effective drugs and research for vaccine production is ongoing, measures related to quarantine and social isolation and distancing have been adopted and recommended by different governments as a way of flattening the curve and, consequently, reducing the overload of health care facilities[13].

In all of these cases, we are restricted to a greater or lesser degree a new situation resulting in significant changes in our routines, as well as limitations to activities causing different losses. The situations presented can be compared to what is known as learned helplessness. Learned helplessness is our response to a reduction in responsiveness to the environment, experiencing a lack of control, associated with depression[24]. Despite being an experimental model, it can be transposed to a clinical interpretation, leading to the belief that the social restrictions imposed place psychological aspects at risk which, if not properly cared for, can generate other types of afflictions that will also overload the healthcare system in terms of mental health[14-16].

Another concern regarding the impact social restriction/isolation can have is to increase the feeling of loneliness. On this point, studies indicate that social isolation and loneliness have different impacts on health and, in addition to a greater chance of depression, there is greater cardiovascular impairment and increased mortality from all causes[24]. In the elderly, these repercussions existed even before the pandemic and are particularly problematic, since they are a segment of the population whose economic and social resources are reduced by the interruption in professional activity, functional limitations, the death of relatives and spouses, and changes in family structures and mobility[24]. To avoid aggravating these situations, it is important to encourage redoubled strategies to prevent and minimize these disorders.

By restricting attendance of religious/spiritual services, avoiding congregations, we are limited to practicing the organizational R/S, which is focused on behavior linked to the context of the religious/spiritual institution, as well as performing activities and positions we may occupy in the congregation. In this regard, evidence indicates that such attendance has a positive impact in reducing the level of deaths, lowering levels of depression and better levels of health, but that among the elderly this attendance is naturally reduced by other health limitations, suggesting that they emphasize and engage more in intrinsic and non-organizational R/S[24]. It is believed that given the social restriction measures that have been applied in response to the pandemic, everyone (elderly or otherwise) can make more emphatic use of non-organizational and intrinsic religious/spiritual experiences. Or that organizational R/S itself can be experienced based on new ways of being and be present, through technology, for example.

In R/S experienced outside the setting of a religion/institution, the search for belief and religious/spiritual behavior with no specific place or time, without any pre-established form, can be evoked in moments of doubt or hopelessness to overcome the difficulty. Strategies such as prayers, talking with God, or with what is divine, reading religious/spiritual writings, private rituals, meditation, religious/spiritual media can be experienced in this moment of social restriction. On the other hand, intrinsic R/S makes up the subjective dimension of the extent to which and how we perceive R/S in life, where we seek to internalize and fully experience R/S[3,5,18]. As parameters of this intrinsic relationship, we have the feeling of the presence of God or connected with the divine and/or sacred (in contrast to the feeling of loneliness), conduct and behavior in line with and according to personal beliefs that guide the way of living[3].

Based on other studies not directly linked to COVID-19, the presence and experience provided by the three possible relationships with R/S suggest that there is a positive relationship between R/S and lifestyle, quality of life, happiness and health[3,6], being an available, accessible resource that can be invested in and encouraged at this critical worldwide moment.

R/S as a resource for health care professionals directly involved in combatting the pandemic

The pandemic has provided increasingly direct contact between the population and health care facilities. Even in situations of poor access to health care, the affected population has been received in health care facilities to treat COVID-19. Thus, although there may be different health care systems, such as informal and cultural (folk) systems, the formal system has been signaled as the most appropriate in this scenario in which scientifically based treatments and conduct can offer more effective responses.

In this closer relationship between patients and health care professionals, due to the increasing influx of infected people to hospitals and reference centers in the treatment of COVID-19, one effect is that the formal care space becomes a developmental environment, that is, it becomes a context in which the person can develop. This allows more people to be cared for within the formal system, which increases the chances of a more successful response in terms of healing and restoring health.

However, one aspect that must be discussed is that all bodily contact between the health care team and the patient ends up being weakened, mediated by essential protective equipment and that, in some way, ends up moving away from these individuals in the interaction. Not only contact mediated by equipment, but also these professionals' fear of becoming infected during consultations and treatments can compromise the health care they provide, generating withdrawal, stigma and lack of welcoming. Regardless of the rules and protocols for protecting patients and health care teams, these characteristics of health care in a pandemic context can be considered, in a closer reading, as dehumanizing. Thus, R/S can be an aspect to be worked on by the teams and with the patients themselves[4,16], and it can function as a dimension on which we can reflect in search of intelligibility, in search of comfort not offered, as through touch and greater bodily proximity.

R/S can be an element contributing decisively to the humanization of care, since health care professionals will increasingly be in contact with this dimension when caring for their patients. If R/S is an element mentioned as situations evoking greater emotion emerge or when death draws near, such as in palliative care[4], it is suggested that COVID-19, due to its diverse effects, can bring together health professionals from different types of care with these elements. Thus, R/S would be both a dimension more often evoked in health care and a possible repercussion of the pandemic in collective life, as it would also be more present in the professionals' routine precisely because day-to-day life is increasingly permeated by questions about death and dying, as discussed in the next category.

One last thing to be mentioned in this category refers precisely to the possibility of health care professionals who have been working to combat the pandemic getting in touch with your own R/S. In a situation of emergency care and proportions beyond what is expected and outside everyday experience in most health care facilities, these professionals can benefit from greater contact with the transcendent for several reasons[4]: (a) possibility of greater understanding of the current situations and the importance of the role of health care professionals in trying to combat the pandemic; (b) possibility of experiencing in R/S an understanding of their own professional role[4], expressing empathy for patients and those using these services; (c) possibility of using knowledge of R/S for better contact with patients in a context that arouses great emotion[5]; (d) use R/S to deal with increased exposure to patient death; (e) use R/S to deal with the greater frequency of situations in which health care professionals' way of handling things may not promote any relief or in which professional performance comes up against irreversible conditions, opening up the possibility of greater contact with unexpected situations in which professional knowledge cannot provide answers.

These conditions can make health care professional more open not only to the use of R/S in health care but also to the use of their own R/S in self-care, in an attempt to create intelligibility during a pandemic in which many responses are ineffective. It is postulated that contact with R/S itself can bring these professionals experientially "closer" to their patients, which can have a positive effect when we analyze the care provided[4]. In a context in which a great deal of knowledge is being developed and for which protocols are being created and recreated at an ever increasing rate, R/S seems to be an effective aspect for the greater humanization of care[1-2,4], because it is a dimension which, regardless of conditions, continues to produce responses with greater capacity to meet us and our different needs.

R/S as a resource for understanding situations of grief

As it is a disease with high mortality, especially in the population aged over 60 and with comorbidities, such as chronic diseases, discussions about the processes of death, dying and mourning are becoming increasingly pressing. The grieving process has been the subject of reflection by philosophers, psychologists and a range of health care professionals throughout history. They are increasingly interested in how this event can be both a response to extreme suffering and a trigger for maintaining that suffering, possibly progressing to a pathological condition[25]. Thus, meanings emerge that both link mourning to an organism's response to loss and an element that can accompany the mourner, causing several losses to adapt to a new context, in which losses and death are, in some way, inevitable, which applies to the pandemic.

Mourning strategies include R/S, which can be a response to suffering, both offering explanations about this phenomenon, as well as providing an opportunity for such experience, explained within more porous intelligibility to the individual, promoting comfort and welcoming in the awareness that this situation cannot be reversed. Although the concept of R/S does not necessarily involve a response, it is an important mechanism to provide the individual with an explanation and a comprehensive possibility[3,25]. Thus, R/S can support us in suffering precisely because it starts with explanations that are more palatable to the world we experience[5,22]. When we become understood in this suffering we can deal with this event in a more mature way.

Because of the current situation, contact with death becomes a daily occurrence, not only close to each of us but as a global event, marked on the news, in the different media and a whole repertoire of information produced daily about COVID-19. Given the news updates every day the number of new infections and deaths worldwide, it can be said that contact with the dimension of death has become something every day which can be apprehended in different ways.

One of these refers to the automation and naturalization of processes related to death and dying[25]. As a result of this, grief or mourning becomes an experience that is no longer individual but also collective, permeating the community. Although each person may develop a particular way of dealing with this grief, depending on their past experiences, the lost loved one and the conditions of that loss, among other factors, grief has become a common experience, shared by different people, in different countries.

Although death has never been an isolated or separate experience from the human condition, nowadays a notion has emerged here of the omnipresence of death. Research on COVID-19 will certainly lift the stigma related to death that emerges as a condition, while grief also becomes a collective element promoting, by extension, the sharing of a symptom.

It is at this moment of greatest helplessness in the search for explanations and ways to alleviate the suffering that R/S can be used. However, this use should not aim to mask reality, but rather to bring the individual and the community to a real consideration of R/S in the experiences of living and dying. In addition to classic roles of R/S, especially in times of crisis and greater hopelessness, such as in serious illnesses and palliative care, so well portrayed in the scientific output in Nursing[22-23], there is the possibility of a more natural reading of R/S as if the meaning of this connection with the transcendent could be something of which we are constituted.

Based on the reflections addressed here, it is postulated that R/S is not exclusively a resource, as developed widely in this study, and consolidated in the literature[1,18], but a dimension of the human being. By embodying R/S as a reality and not necessarily as a resource, we can allow ourselves a more integrating experience, less anxious for answers, tools, and ways to reduce or mask inevitable suffering, especially in a pandemic that has caused a range of reflections that remain unresolved.

CONCLUSIONS

Based on the aspects covered in this theoretical reflection, it is recommended that R/S be used not only to explain the emotional repercussions of the disease but as a strategy that can promote more humane and integrated care in the face of an impermanent pandemic situation. Therefore, it must be considered both a coping strategy and an element of reality. Assuming this reality it is to be open to readings that do not conceive of R/S as something external to the person but fundamentally integrated with human experience. The effects of the pandemic are still poorly known, so different knowledge is being produced to offer more answers to a situation of uncertainty that characterizes life right now, in the

face of this serious health event, with undeniable repercussions on all dimensions of human life.

So, in this impermanent situation, uncertainties and many unanswered questions, the R/S can be a strategy that does not necessarily offer an answer but may offer a place of comfort in face of what is not yet known and a future which seems to be surrounded by new problems every day. In the face of what is unknown, what is unseen, and how much can happen, the R/S seems to be a dimension that conflict this 'unknowing' precisely because it offers a place for these reflections to be welcomed and addressed. Taking care of this space can be a powerful and humanizing strategy, linking people, contexts, and processes in the same developmental circumscriber.

REFERENCES

1- World Health Organization (WHO). Division of mental health and prevention of substance abuse. WHOQOL and spirituality, religiousness and personal beliefs (SRPB). Genève: World Health Organization; 1998.

2- Moreira-Almeida A, Van Rensburg BJ, Sharma A, Verhagen PJ, Cook CCH. WPA position statement on spirituality and religion in psychiatry. World Psychiatry 2016;15(1):87-8. DOI: 10.1002/wps.20304

3- Koenig HG. Religião, espiritualidade e psiquiatria: Uma nova era na atenção à saúde mental. Rev Psiquiatr Clín. 2007;34(supl 1):5-7. DOI: 10.1590/S0101-60832007000700002

4- Cunha VF, Scorsolini-Comin F. Best professional practices when approaching religiosity/spirituality in psychotherapy in Brazil. Couns Psychother Res. 2019;19(4):523-32. DOI: 10.1002/capr.12241

5- Espíndula JA, Valle ERM, Bello AA. Religião e espiritualidade: Um olhar de profissionais de saúde. Rev Latino-Am Enfermagem 2010;18(6): 1229-36. DOI: 10.1590/S0104-11692010000600025

6- Melo CF, et al. Correlação entre religiosidade, espiritualidade e qualidade de vida: uma revisão de literatura. Estud Pesqui Psicol. 2015 [citado em 15 jan 2017]; 15(2): 447-64. Available in: http://pepsic.bvsalud.org/scielo.php?script=sci_arttext&pid=S1808-42812015000200002&lng=pt&nrm=iso

7- Organização Panamericana de Saúde. Folha informativa – COVID-19 (Doença causada pelo novo coronavírus). Brasília, DF: OPAS, 2020.

8- Mahase E. China coronavirus: What do we know so far? BMJ 2020;368:308. DOI: 10.1136/bmj.m308

9- Munster VJ, Coopmans M, et al. A novel coronavirus emerging in China-key questions for impact assessment. N Engl J Med. 2020; 382(8):692-94. DOI: 10.1056/NEJMp2000929

10- Yuen K-S, Ye Z-W, Funge S-Y, Chan C-P, Jin DY. SARS-CoV-2 and COVID-19: The most important research questions. Cell Biosci. 2020;10(1):1-5. DOI: 10.1186/s13578-020-00404-4

11- World Health Organization (WHO). Coronavirus. Genève: WHO; 2020.

12- Tian S, Hu N, Chen K, Kang X, Xiang Z, Chen H, et al. Characteristics of COVID-19 infection in Beijing. J Infect. 2020;80(4): 401-06. DOI: 10.1016/j.jinf.2020.02.018

13- Wilder-Smith A, Freedman DO. Isolation, quarantine, social distancing and community containment: Pivotal role for old-style public health measures in the novel coronavirus (2019-nCoV) outbreak. J Travel Med. 2020;27(2):1-4. DOI: 10.1093/jtm/taaa020

14- Xiang Y-T, Yang Y, Li W, Zhang L, Zhang Q, Cheung T, et al. Timely mental health care for the 2019 novel coronavirus outbreak is urgently needed. Lancet 2020;7(3):228-9. DOI: 10.1016/S2215-0366(20)30046-8

15- Wang C, Pan R, Wan X, Tan Y, Xu L, Ho CS, et al. Immediate psychological responses and associated factors during the initial stage of the 2019 coronavirus disease (COVID-19) epidemic among the general population in china. Int J Environ Res Public Health. 2020;17(5):1729. DOI: 10.3390/ijerph17051729

16- Kang L, Hu S, Chen M, Yang C, Yang BX, Wang Y, et al. The mental health of medical workers in Wuhan, China dealing with the 2019 novel coronavirus. Lancet 2020; 7(3):e14. DOI: 10.1016/S2215-0366(20)30047-X

17- Scorsolini-Comin F. Guia de orientação para a iniciação científica. São Paulo: Atlas; 2013.

18- Silva GCN, Reis DC, Miranda TPS, Melo RNR, Coutinho MAP, Paschoal CS, et al. Coping religioso/espiritual e a angústia espiritual em pessoas com câncer. Rev Bras Enferm. 2019;72(6):1534-40. DOI: 10.1590/0034-7167-2018-0585

19- Akinola O. Boko Haram insurgency in Nigeria: Between Islamic fundamentalism, politics, and poverty. African Security 2015;8(1):1-29. DOI: 10.1080/19392206.2015.998539

20- Tomkins A, Duff J, Fitzgibbon A, Karam A, Mill EJ, Munnings K, et al. Controversies in faith and health care. Lancet 2015;386(10005):1776-85. DOI: 10.1016/S0140-6736(15)60252-5

21- Melo CF, Sampaio IS, Souza DLA, Pinto NL. Correlação entre religiosidade, espiritualidade e qualidade de vida: Uma revisão de literatura. Estud Pesqui Psicol. 2015 [citado em 15 jan 2017]; 15(2):447-64. Available in: http://pepsic.bvsalud.org/scielo.php?script=sci_arttext&pid=S1808-42812015000200002&lng=pt&tlng=pt

22- Gomes MV, Xavier ASG, Carvalho ESS, Cordeiro SC, Ferreira SL, Morbeck AD. "À espera de um milagre": Espiritualidade/religiosidade no enfrentamento da doença falciforme. Rev Bras Enferm. 2019;72(6):1554-61. DOI: 10.1590/0034-7167-2018-0635

23- Guerrero GP, Zago MMF, Sawada NO, Pinto MH. Relação entre espiritualidade e câncer: Perspectiva do paciente. Rev Bras Enferm. 2011;64(1):53-9. DOI: 10.1590/S0034-71672011000100008

24- Courtin E, Knapp M. Social isolation, loneliness and health in old age: A scoping review. Health Soc Care 2017;25(3):799-812. DOI: https://doi.org/10.1111/hsc.12311

25- Bowlby J. Perda: Tristeza e depressão. 3a ed. São Paulo: Martins Fontes; 2004.

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