


ORIGINAL ARTICLE

# Religious practice in the pandemic of COVID-19 and the nursing diagnoses

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## ABSTRACT

**Purpose:** Identify the elements (defining characteristics, related factors, and risk factors) of the diagnoses of NANDA international impaired religiosity (00169), risk for impaired religiosity (00170), and readiness for enhanced religiosity (00171), in a period of social distancing in the pandemic of COVID-19, and associate them with the behavior of individual and collective religious practice, before and during the pandemic.

**Methods:** Survey study, released via social media to members of religious communities in Brazil. Data collection took place in June 2020, by online questionnaire.

**Findings:** Participants were 719 people, 563 (78.3%) were women, with a median age of 39 years (min 18–max 73), of Catholic religion (64.7%), with a median of 29 years of religious practice (min 0–max 70). The participants were from Southeast 652 (90.68%), South 49 (6.82%), Northeast 13 (1.82%), Midwest 4 (0.56%), and North 01 (0.14%) of Brazil. The increase of individual religious practice was associated with two diagnostic elements and the reduction of individual practice to nine elements. The reduction of collective religious practice was associated with seven diagnostic elements and the maintenance of the practice associated with five elements. The increase of collective religious practice was associated with five diagnostic elements.

**Conclusions:** In individuals who presented during the pandemic reduction of individual religious practice, reduction of collective religious practice, and maintenance of collective religious practice, the elements of the diagnosis impaired religiosity were predominant. In individuals who presented increased practice of collective religious activity during the pandemic, the elements of the diagnosis readiness for enhanced religiosity were predominant.

**Implications for nursing practice:** This study highlights defining characteristics, risk factors, and related factors of the religiosity diagnoses presented due to social distancing in the pandemic; these should be screened during nursing consultations in primary health care.

## KEYWORDS

COVID-19, nursing diagnosis, nursing process, pandemics, religion, social isolation

## INTRODUCTION

Religion is an important cultural asset that affects the thoughts, behaviors, and lifestyles of individuals and can positively impact the life of the human beings, as it directs them to have healthy life habits (Chiang et al., 2020). The terms spirituality and religiosity, although sometimes considered synonymous, constitute distinct nursing diagnoses.

Spirituality has several definitions, since its attributes are considered difficult to define and with a subjective, individual, and complex dimension (Mosque et al., 2017). In the nursing literature, the concept was determined as the search for meaning in life, connection, and transcendence, which is broader than religion, being an important dimension for believers or non-believers (Cabaço et al., 2017). The concept of religiosity refers to religious practices in which the individual seeks to express his spirituality through rituals, symbols, beliefs, cults, and doctrines that bring the individual closer to the sacred or transcendent (Tavares et al., 2018).

Even if closely related to spirituality, religiosity is a subject poorly described by authors, and until recently, a dimension sometimes forgotten and even neglected (Mosque et al., 2017). Philosophers stated that religion would disappear as societies modernized, a fact that did not happen, since it is clear how religion is strengthening in some societies (Bentzen, 2020). The world was more religious in the year 2000 (87.0%) than in 1970 (80.8%), with this trend continuing in 2017 (88.9%), projecting the estimated value of 90.2% for the year 2030 (Grim et al., 2018).

In the study of nursing, it is understood that for some people the involvement in their community of faith, their rituals, and their ministries feeds the spirit; for others, spiritual well-being does not necessarily revolve around participation in a specific religion (Bentzen, 2020; Taylor, 2020). Nurses, in this regard, must provide assistance to their patient, so that they can provide comfort and safety, which spirituality or religion offers (Tavares et al., 2018). For this, the professional needs to recognize the needs of individuals, as well as to observe the implications in the use of standardized nursing language systems to document cares that may involve spiritual and religious aspects (Burkhart & Solari-Twadell, 2008; Tavares et al., 2018).

Since the beginning of 2020, due to the emergence of SARS-CoV-2, countries have decreed a quarantine period for the population, aimed at maintaining social distancing. COVID-19 spread rapidly around the world and was declared a pandemic by the World Health Organization (WHO) in March 2020. Social distancing was one of the measures recommended by the WHO, because there is no established treatment and medication for the control and cure of the disease (World Health Organization, 2020).

Based on the assumption that religiosity implies religious practices of worship and rituals, the social distancing factor harms such practices, since religiosity is directly linked to the idea of gathering in an environment of its own, usually in temples.

The COVID-19 pandemic affected traditions and festivities related to religion and the maintenance of religious practices in Brazil and the world, as well as pilgrimages and religious tourism resulting from them,

where high-visibility religious mass meetings are held (Yezli & Khan, 2020).

Even with the restrictions imposed by distancing, the literature points out that disasters and tragedies lead individuals to connect with some higher being in whom they place their faith. A study pointed to a substantial increase in the search term “prayer” in the pandemic period, reaching unprecedented numbers from mid-March 2020 worldwide, doubling its results for every 80,000 new cases of COVID-19 (Bentzen, 2020).

In the pandemic of COVID-19 it is understood that there was the emergence of new health demands, as well as social, psychological, and spiritual. Investigating nursing diagnoses involving religiosity during the pandemic became relevant, considering the individual as a biopsychosocial-spiritual being.

## Purpose

Given the importance of religiosity in human experience, including the search for balance and hope, and the change of this experience due to social distancing, this study sought to identify the elements (defining characteristics—DC, related factors—ReF, and risk factors—RiF) of the diagnoses of NANDA International (NANDA-I) impaired religiosity (00169), risk for impaired religiosity (00170), and readiness for enhanced religiosity (00171) (Herdman et al., 2021), in a period of social distancing in the pandemic of COVID-19, and associate them with the behavior of individual and collective religious practice, before and during the pandemic.

## METHODS

A survey study was conducted by online questionnaire, in a convenience sample. The research was disseminated via social media (Facebook, Instagram, and WhatsApp), shared in pages and profiles of religious communities in Brazil. A promotional material was posted in social media websites with information about the research and instructions on how to participate. Participants answered the questionnaire via Google Forms. In the electronic questionnaire, the second page had all information about the research, the purpose, the ethical aspects considerations, and the informed consent to participate in the study. To have access and answer the questions, all participants needed to give consent in the electronic questionnaire.

The inclusion criteria were >18 years old and declared to be a member of a religious community. Only participants who answered the questionnaire in full were included. Data collection took place in June 2020.

The theoretical framework of Jean Watson was used, with the presupposition of care practice the integration between biophysical knowledge and human behavior, to generate or promote health. The faith-hope is one of the care factors presented by Watson as essential for the healing process (George, 2011).

Individual and collective religious practices were variables of interest to the study, considering the period before and during the pandemic of COVID-19, also the elements (DC, ReF, and RiF) of the diagnoses impaired religiosity (00169), risk for impaired religiosity (00170), and readiness for enhanced religiosity (00171) (Herdman et al., 2021).

The diagnosis "impaired religiosity," approved in 2004, revised in 2017, with evidence level 2.1 is defined as "impaired ability to exercise reliance on beliefs and/or participate in rituals of a particular faith tradition" (Herdman et al., 2021).

The diagnosis "risk of impaired religiosity" was approved in 2004, revised in 2013 and 2017 with evidence level 2, and is defined as "susceptible to an impaired ability to exercise reliance on religious beliefs and/or participate in rituals of a particular faith tradition, which may compromise health" (Herdman et al., 2021).

The diagnosis "Readiness for Enhanced Religiosity" approved in 2004, revised in 2013, level of evidence 2.1, is defined as "a pattern of reliance on religious beliefs and/or participation in rituals of a particular faith tradition, which can be strengthened" (Herdman et al., 2021).

The measures of central tendency were analyzed, and tests of association between the diagnoses studied and the behavior of the population in individual and collective religious practice were performed. Cox regression models were adjusted to explain the occurrence of individual and collective changes. In the models, associations were considered statistically significant if  $p < 0.05$ . The analyses were performed with Software SPSS 22.

Assuming simple random sampling, type I and II errors equal to 0.05 and 0.20, respectively, allocation ratio of 1:5:1 between reduction, maintenance and increase levels of individual religious practices, allocation ratio of 15:10:1 between reduction, maintenance, and increase in the levels of collective religious practices, assuming a scenario of uncertainty where the prevalence of diagnostic elements oscillates around 33%, and assuming a minimum difference between the levels of individual religious practices of 20%, it is estimated that at least 62 subjects are needed at each level of individual religious practices and at least 62 subjects at each level of collective religious practice.

The research was approved by the Research Ethics Committee in Brazil (Approval Number: 4.059.323) and ethical aspects involving research with human beings were respected. The study followed the STROBE checklist as a recommendation for observational studies.

## Findings

The study included 719 people, 563 (78.3%) were women, with a median age of 39 years (min 18–max 73), of Catholic religion (64.7%), with a median of 29 years of religious practice (min 0–max 70). The participants were from Southeast 652 (90.68%), South 49 (6.82%), North-east 13 (1.82%), Midwest 4 (0.56%), and North 01 (0.14%) of Brazil.

Participants predominantly declared to perform daily individual religious practice before the pandemic (48.7%) and daily practice during the pandemic (55.5%); they indicated maintaining the frequency of individual religious practice during the pandemic (70.8%).

**TABLE 1** Characterization of participants and profile of individual and collective religious practice before and during the COVID-19 pandemic ( $n = 719$ ). Brazil, 2020

	N	%	Median	(min–max)
<b>Gender</b>				
Male	156	21.7		
Female	563	78.3		
<b>Age (years)</b>			39	(18–73)
<b>Years of religious practice</b>			29	(0–70)
<b>Individual religious practice before the pandemic</b>				
Without regular practice	64	8.9		
1–2 days/week	162	22.5		
3 or more days/week	143	19.9		
Every day	350	48.7		
<b>Individual religious practice during the pandemic</b>				
Without regular practice	85	11.8		
1–2 days/week	131	18.2		
3 or more days/week	104	14.5		
Every day	399	55.5		
<b>Changing individual religious practice in the pandemic</b>				
Decreased	93	12.9		
Maintained	509	70.8		
Increased	117	16.3		
<b>Collective religious practice before the pandemic</b>				
Without regular practice	157	21.8		
1–2 days/week	386	53.7		
3 or more days/week	128	17.8		
Every day	48	6.7		
<b>Collective religious practice during the pandemic</b>				
Without regular practice	496	69.0		
1–2 days/week	146	20.3		
3 or more days/week	26	3.6		
Every day	51	7.1		
<b>Changing collective religious practice in the pandemic</b>				
Decreased	402	55.9		
Maintained	291	40.5		
Increased	26	3.6		

Regarding collective religious practice, predominantly before the pandemic, they performed one to two times a week (53.7%), and during the pandemic they did not perform regular religious practice (69.9%); they indicated a reduction in collective religious practice (55.9%).

The characterization of the participants and the profile of religious practice is presented in Table 1.

The reduction in individual religious practice during the pandemic was associated with the following elements: expresses distress about separation from faith community (DC 00169), desires to reconnect

with belief pattern (DC 00169), environmental constraints (ReF 00169, RiF 00170), ineffective caregiving (ReF 00169, RiF 00170), depressive symptoms (ReF 00169, RiF 00170), ineffective coping strategies (ReF 00169, RiF 00170), spiritual distress (ReF 00169, RiF 00170), inadequate transportation (ReF 00169, RiF 00170), and expresses desire to enhance participation in religious experiences (DC 00171).

The increase in individual religious practice was associated with the following elements: anxiety (ReF 00169, RiF 00170) and expresses desire to enhance religious options (DC 00171).

The reduction in collective religious practice was associated with the following elements: expresses distress about separation from faith community (DC 00169), desires to reconnect with customs (DC 00169), desires to reconnect with belief pattern (DC 00169), anxiety (ReF 00169, RiF 00170), ineffective caregiving (ReF 00169, RiF 00170), ineffective coping strategies (ReF 00169, RiF 00170), and expresses desire to enhance participation in religious practices (DC 00171).

The maintenance of collective religious practice was associated with the following elements: difficulty adhering to prescribed religious beliefs (DC 00169), difficulty adhering to prescribed religious rituals (DC 00169), questions religious customs (DC 00169), questions religious beliefs (DC 00169), expresses desire to enhance religious options (DC 00171).

The increase in collective religious practice was associated with the following elements: spiritual distress (ReF 00169, RiF 00170), inadequate transportation (ReF 00169, RiF 00170), expresses desire to enhance forgiveness (DC 00171), expresses desire to enhance use of religious material (DC 00171), and expresses desire to reestablish religious customs (DC 00171).

Table 2 shows the association among the diagnoses impaired religiosity (00169), risk for impaired religiosity (00170), and readiness for enhanced religiosity (00171) and changes in individual and collective religious practice during the pandemic.

## DISCUSSION

In the studied sample, it is noted that the daily individual religious practice increased in the pandemic period, from 48.7% to 55.5%. In collective religious practice from one to two days/week, there was a reduction, from 53.7% to 20.3%, during the pandemic, an impact that may be related to the closure of religious temples and sanitary recommendations for the restraining of agglomerations, in order to promote the attenuation of coronavirus transmission. The same is described in other countries fulfilling the requirements of the responsible agencies in order to contain the spread of the virus in mass meetings, including religious acts, burial rituals, and sporting events (Atique & Itumalla, 2020; Escher, 2020; Hartley et al., 2020; Oxholm et al., 2021; Rodriguez-Morales et al., 2020; Ussai et al., 2020).

A study conducted with Nigerian and Indian participants showed a decrease in religious practice during the pandemic in Nigeria, due to the characteristics of performing them in collective places, contrary to

what was found in India, which keeps them in their homes (Fatima et al., 2020).

A study in Colombia showed that individual religious practice intensified during isolation by the pandemic, in relation to collective practice, with greater evidence in the female population. For non-practitioners, in both sexes, the tendency was not to perform religious activities. For the practitioners, there was a decrease in the time dedicated to their practices, being performed in a simpler and shorter way (Meza, 2020).

Some conflicts arose around the world when health institutions did not consider religious temples as essential, since, for example, in some U.S. states, certain stores that sell alcoholic beverages maintained their operations and were considered essential. In some European countries, practitioners held protests when they view the closure of temples as a violation of their rights to worship. The continuity of religious practice in temples during the pandemic is conflicting, as it must follow measures to contain biological risk. In the opposite direction to the recommendations of sanitary institutions, some religious leaders defend the need for the opening and maintenance of the operation of temples (Capponi, 2020; Quadri, 2020). It is inferred that religiosity after the pandemic may change the forms of practice (Norman & Reiss, 2020).

The diagnostic elements associated with the reduction of religious practice, both individual and collective, highlight negative feelings such as distress about separation from faith community, desire to reconnect with belief pattern, environmental constraints, ineffective caregiving, depressive symptoms, anxiety and discouragement, difficulties in coping with problems and spiritual distress. These feelings identified in the population give us clues about the impact of social distancing and the possible influence of the reduction of religious practice, whether collective or individual, on human behavior. Feelings such as distress, disconnection, decreased self-care, and coping with difficulties can give us warnings about signs of psychic suffering.

A Brazilian study showed increased religious and spiritual practice during the pandemic, with an impact on the improvement of the mental health of the population, lower rates of sadness, fear and concern, and higher levels of hope (Lucchetti et al., 2020). Belief in the sacred and positive spiritual experience induces the individual to a state of peace, healing, contentment, hope, and joy (Del Castillo, 2021). Spiritual well-being is a protective factor for symptoms such as depression, anxiety, and posttraumatic stress disorder during the coronavirus pandemic. The negative impact of the pandemic on the mental health of the population and the measures adopted of social isolation influence negatively these symptoms (González-Sanguino et al., 2020). For this reason, religion can offer coping mechanisms in times of stress and anxiety, producing a feeling of hope in moments of doubts and uncertainties, and can be justified as a means of support and security in extreme situations, such as the COVID-19 pandemic (Barmania, 2021a, 2021b).

There are reports of spiritual renewal after individuals experience critical moments and uncertainties, when people experience feelings of fear, suffering, and illness. It is possible that there is a new generation of experiences regarding spirituality, faith, and religion after the coronavirus pandemic worldwide (Kowalczyk et al., 2020).

**TABLE 2** Association between diagnosis elements of impaired religiosity (00169), risk for impaired religiosity (00170), and readiness for enhanced religiosity (00171) and the change in individual and religious practice during the COVID-19 pandemic ( $n = 719$ ). Brazil, 2020

Diagnosis elements	Individual religious practice						<i>p</i>	Collective religious practice						<i>p</i>
	Decreased ( <i>n</i> = 93)		Maintained ( <i>n</i> = 509)		Increased ( <i>n</i> = 117)			Decreased ( <i>n</i> = 402)		Maintained ( <i>n</i> = 291)		Increased ( <i>n</i> = 26)		
	<i>N</i>	%	<i>N</i>	%	<i>N</i>	%		<i>N</i>	%	<i>N</i>	%	<i>N</i>	%	
Expresses distress about separation from faith community (DC 00169)	46	49.5	142	27.9	28	23.9	<0.001	157	39.1	51	17.5	8	30.8	<0.001
Desires to reconnect with customs (DC 00169)	51	54.8	227	44.6	63	53.8	0.060	244	60.7	82	28.2	15	57.7	<0.001
Desires to reconnect with belief pattern (DC 00169)	25	26.9	48	9.4	15	12.8	<0.001	69	17.2	18	6.2	1	3.8	<0.001
Difficulty adhering to prescribed religious beliefs (DC 00169)	3	3.2	20	3.9	5	4.3	0.924	6	1.5	22	7.6	0	0.0	<0.001
Difficulty adhering to prescribed religious rituals (DC 00169)	1	1.1	25	4.9	4	3.4	0.213	9	2.2	20	6.9	1	3.8	0.011
Questions religious customs (DC 00169)	9	9.7	63	12.4	15	12.8	0.738	28	7.0	59	20.3	0	0.0	<0.001
Questions religious beliefs (DC 00169)	12	12.9	57	11.2	14	12.0	0.883	34	8.5	48	16.5	1	3.8	0.002
Anxiety (ReF 00169, RiF 00170)	35	37.6	135	26.5	52	44.4	<0.001	141	35.1	74	25.4	7	26.9	0.023
Inadequate social support (ReF 00169, RiF 00170)	3	3.2	14	2.8	6	5.1	0.420	14	3.5	9	3.1	0	0.0	0.614
Environmental constraints (ReF 00169, RiF 00170)	11	11.8	15	2.9	7	6.0	0.001	20	5.0	12	4.1	1	3.8	0.855
Cultural barrier to practicing religion (ReF 00169, RiF 00170)	1	1.1	10	2.0	1	0.9	0.624	5	1.2	7	2.4	0	0.0	0.397
Ineffective caregiving (ReF 00169, RiF 00170)	26	28.0	80	15.7	15	12.8	0.007	80	19.9	39	13.4	2	7.7	0.035
Depressive symptoms (ReF 00169, RiF 00170)	24	25.8	59	11.6	20	17.1	0.001	65	16.2	35	12.0	3	11.5	0.282
Pain (ReF 00169, RiF 00170)	11	11.8	40	7.9	9	7.7	0.428	37	9.2	22	7.6	1	3.8	0.519
Ineffective coping strategies (ReF 00169, RiF 00170)	16	17.2	38	7.5	15	12.8	0.006	48	11.9	19	6.5	2	7.7	0.055
Insecurity (ReF 00169, RiF 00170)	21	22.6	91	17.9	30	25.6	0.125	82	20.4	53	18.2	7	26.9	0.501
Inadequate sociocultural interaction (ReF 00169, RiF 00170)	2	2.2	19	3.7	5	4.3	0.691	15	3.7	8	2.7	3	11.5	0.07

(Continues)

**TABLE 2** (Continued)

Diagnosis elements	Individual religious practice							<i>p</i>	Collective religious practice							<i>p</i>
	Decreased ( <i>n</i> = 93)		Maintained ( <i>n</i> = 509)		Increased ( <i>n</i> = 117)		Decreased ( <i>n</i> = 402)		Maintained ( <i>n</i> = 291)		Increased ( <i>n</i> = 26)					
	<i>N</i>	%	<i>N</i>	%	<i>N</i>	%	<i>N</i>		%	<i>N</i>	%	<i>N</i>	%			
Fear of death (ReF 00169, RiF 00170)	14	15.1	49	9.6	19	16.2	0.063	46	11.4	32	11.0	4	15.4	0.796		
Spiritual distress (ReF 00169, RiF 00170)	20	21.5	29	5.7	11	9.4	<b>&lt;0.001</b>	40	10.0	16	5.5	4	15.4	<b>0.047</b>		
Inadequate transportation (ReF 00169, RiF 00170)	10	10.8	21	4.1	10	8.5	<b>0.014</b>	31	7.7	6	2.1	4	15.4	<b>0.001</b>		
Expresses desire to enhance connection with a religious leader (DC 00171)	8	8.6	33	6.5	9	7.7	0.718	32	8.0	16	5.5	2	7.7	0.448		
Expresses desire to enhance participation in religious experiences (DC 00171)	26	28.0	99	19.4	32	27.4	<b>0.054</b>	100	24.9	54	18.6	3	11.5	0.06		
Expresses desire to enhance participation in religious practices (DC 00171)	20	21.5	127	25.0	30	25.6	0.748	118	29.4	52	17.9	7	26.9	<b>0.002</b>		
Expresses desire to enhance religious options (DC 00171)	2	2.2	15	2.9	9	7.7	<b>0.033</b>	9	2.2	17	5.8	0	0.0	<b>0.026</b>		
Expresses desire to enhance forgiveness (DC 00171)	17	18.3	92	18.1	22	18.8	0.983	76	18.9	44	15.1	11	42.3	<b>0.002</b>		
Expresses desire to enhance use of religious material (DC 00171)	22	23.7	145	28.5	39	33.3	0.302	120	29.9	73	25.1	13	50.0	<b>0.019</b>		
Expresses desire to reestablish religious customs (DC 00171)	19	20.4	121	23.8	32	27.4	0.500	101	25.1	60	20.6	11	42.3	<b>0.032</b>		
Expresses desire to reestablish belief patterns (DC 00171)	13	14.0	77	15.1	16	13.7	0.901	65	16.2	36	12.4	5	19.2	0.306		

DC, defining characteristics; ReF, related factor; RiF, risk factor; 00169, diagnosis impaired religiosity; 00170, diagnosis risk for impaired religiosity; 00171, diagnosis for enhanced religiosity.

Bold results with statistical significance.

Religion can contribute to the promotion of health in the collective sphere, because it approaches the perspectives of life and death in different aspects. The support of religious leaders to disseminate reliable information to the population could be part of health policy strategies, assisting the population in health promotion, which should be improved and strengthened, considering the rapid communication with the religious population, when compared with government communication (Barmania, 2021a, 2021b).

Although religious leaders adapt to maintaining collective religious practices using electronic communication channels, such as radio broadcasting and other innovative technologies such as videos, virtual conferences, online broadcast sermons and prayers, religious followers in Brazil find it difficult to maintain the usual practice by these means (Ameyaw et al., 2020; Barmania, 2021a, 2021b; Frei-Landau, 2020). In some countries, there is experience of implementing actions such as telephone calls by health professionals and religious leaders with the

objective of analyzing people at high risk of negative impacts on mental health, for referrals to specialized services, and also religious support using prayer (Galiatsatos et al., 2020; Ribeiro et al., 2020).

The link between religious leaders/religious institutions/religious communities, health authorities, and health professionals has extreme relevance to contain emergencies in the field of public and collective health, and plays an important role in the prevention and protection of the population in relation to coronavirus (Ameyaw et al., 2020; Miller et al., 2020). Communication must be effective and act to promote health education; otherwise the population will be at risk, as they will hardly comply with measures to contain the spread of coronavirus (Barmania, 2021a).

Religious leaders are expected to have a social responsibility to disseminate scientifically based information, in addition to promoting psychological, social, economic, sentimental, religious and spiritual support, and maintaining the interaction of their institutions with governments and health institutions, resulting in the realization of holistic care to the individual (Hashmi et al., 2020; Modell & Kardia, 2020; Roman et al., 2020; Weinberger-Litman et al., 2020).

Among those who manifested increased individual and collective religious practice, it was present feelings such as anxiety, desire to enhance religious options, spiritual distress, desire to enhance forgiveness, desire to enhance use of religious material, and desire to reestablish religious customs.

An American study that evaluated religious confrontation among the Orthodox Jewish population in the United States during the COVID-19 pandemic found that positive religious confrontation, intrinsic religiosity, and trust in God are associated with less stress and greater positive impact. Another factor related to exposure to coronavirus is the increasing of religious practice as a coping mechanism in situations of adversity (Pirutinsky et al., 2020). Other strategies to cope with stress during the pandemic include recreation activities, exercises, relaxation, sleep quality, weighing and maintaining healthy eating, in addition to staying hydrated, listening to music, practicing online learning activities, practicing yoga, meditation, and prayer (Fatima et al., 2020; Koenig, 2020; Puyat et al., 2020).

Positive religious confrontation strengthens the individual's relationship with God and is beneficial especially in the case of depressed people, as it generates a sense of support and guidance to face the challenges of life. Therefore, it is essential to implement collective coping strategies to provide the well-being and emotional, social, physical, and spiritual resilience of the population (Koenig, 2020; Mahamid & Bdier, 2021). Other religious/spiritual interventions evidenced the synchronicity of these institutions with the confrontation of the pandemic with other health institutions (Del Castillo et al., 2021).

In line with Watson's theory, the science of caring is seen as complementary to the science of healing. When science has nothing more to offer, the nurse can continue to use faith-hope to provide a sense of well-being through beliefs that are meaningful to the individual. Strategies to enable individuals to practice their religion and faith during social isolation, while respecting health recommendations, are nursing care that favors better health outcomes for the individual and the population (George, 2011).

Studies investigating spirituality could also broaden the understanding of the phenomenon studied, as well as the reach of representativeness of all states of the country, considering the cultural characteristics involved.

Some limitations in the study can be considered. The study sample was predominantly concentrated in participants from the Southeast region of Brazil. The number of participants in the group that showed an increase in collective religious practice during the pandemic was lower than suggested by the sample calculation, a plausible factor given the current recommendations for social distancing. Information on educational level and employment status was not presented, which could support the interpretation and discussion of the results. A risk of selection bias can be considered, as it was restricted to people with access to social networks and the internet. People with lower educational level and less access to information technologies may not have been represented in the sample.

## CONCLUSIONS

There was an increase in daily individual religious practice during the pandemic; however, most of the participants maintained the frequency in individual religious practice. Collective religious practice showed a significant reduction in the studied population during the pandemic.

In individuals who presented during the pandemic reduction of individual religious practice, reduction of collective religious practice and maintenance of collective religious practice, the elements of the diagnosis "impaired religiosity" were predominant. In individuals who presented increased practice of collective religious activity during the pandemic, the elements of the diagnosis readiness for enhanced religiosity were predominant.

## Implications

*Implications for nursing practice:* This study sheds light on nursing phenomena that are latent in the population during the recommendations of social distancing and the restriction of religious practice in churches and temples. Negative feelings in individuals, due to social distancing and the pandemic, may be influenced by religious practices in the proposal to improve health outcomes. This study highlights defining characteristics, risk factors, and related factors of religiosity diagnoses that should be screened in nursing consultations.

*Implications for health policies:* The results of this study may influence the construction of public health policies to consider that religiosity may be a relevant factor to human experience, with positive impacts on health, when considered with respect to individual beliefs and values.

*Implications for research:* There are still few studies involving nursing diagnoses that investigate human religiosity in the population. This study contributes to the construction of knowledge about the prevalence of religiosity diagnoses and their impact due to social distancing and the pandemic.

**Implications for education:** Nursing education is still predominantly directed to biological aspects; it is considered that factors involving religiosity related to health are still little explored in the preparation of nurses for clinical practice.

#### AUTHOR CONTRIBUTIONS

Dayane Caroline Novaes contributed to the study conception, acquisition of data, and in the writing of the manuscript. Mariana de Freitas Grassi contributed to the acquisition of data, analysis, interpretation of data, and in the writing of the manuscript. Tayomara Ferreira Nascimento contributed to the acquisition of data, analysis, interpretation of data, and in the writing of the manuscript. Meire Cristina Novelli e Castro contributed to the study conception, design, acquisition of data, analysis, interpretation of data, and in the writing of the manuscript. Rodrigo Jensen contributed to the study conception, design, acquisition of data, analysis, interpretation of data, and in the writing of the manuscript.

#### CONFLICTS OF INTEREST

The authors declared no potential conflict of interest with respect to the research, authorship, and publication of this article.

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