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Social representations of Covid-19 among hospitalized adults and older adults

Representações sociais da Covid-19 entre adultos e idosos internados

Representaciones sociales de la Covid-19 entre adultos y adultos mayores

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ABSTRACT

Objective: to analyze the social representations of Covid-19 among adults and older adults who had been hospitalized due to the disease. **Method**: this qualitative, descriptive, and exploratory study applied Social Representations Theory with a procedural approach. Thirty-two individuals previously hospitalized for Covid-19 in a public hospital in Northern Brazil were interviewed via telephone between June and August 2021. The data were analyzed with the aid of the IRAMUTEQ software. The Institutional Review Board approved the study. **Results**: scientific knowledge influenced participants' practices and daily routines. Six categories emerged: protection, spirituality, adaptation, knowledge, images and attitudes, symptoms, and the health system. **Final Considerations**: social representations were anchored in the concept of a respiratory, contagious, and severe disease, and were objectified in preventive practices. This study highlights the need for health professionals and managers to consider the psychosocial profile of patients in future crises.

Descriptors: Nursing; Psychology, Social; Inpatients; COVID-19; Social Representation.

RESUMO

Objetivo: analisar as representações sociais da Covid-19 entre adultos e idosos que estiveram internados pela doença. **Método:** estudo qualitativo, descritivo e exploratório, utilizando a Teoria das Representações Sociais com abordagem processual. Entrevistaram-se 32 pessoas que estiveram internadas por Covid-19 em hospital público do Nordeste brasileiro, entre junho e agosto de 2021, de modo virtual. Os dados foram analisados com o auxílio do software IRAMUTEQ. O projeto foi aprovado pelo Comitê de Ética em Pesquisa. **Resultados:** o conhecimento científico foi refletido no cotidiano e nas práticas dos participantes. Observaram-se seis categorias com conteúdos referentes às medidas de proteção; espiritualidade; adaptação; conhecimentos, imagens e atitudes; sintomas e ao sistema de saúde. **Considerações finais:** as representações sociais estavam ancoradas no conceito de doença respiratória, contagiosa e grave e objetivaram-se nas práticas preventivas. O estudo contribui a que, em futuras crises, o perfil psicossocial do grupo seja considerado por profissionais e gestores de saúde.

Descritores: Enfermagem; Psicologia Social; Pacientes Internados; COVID-19; Representação Social.

RESUMEN

Objetivo: analizar las representaciones sociales de la Covid-19 entre adultos y adultos mayores que estuvieron internados por la enfermedad. **Método**: estudio cualitativo, descriptivo y exploratorio, utilizando la Teoría de las Representaciones Sociales con abordaje procesual. Se entrevistaron 32 personas que estuvieron internadas por Covid-19 en un hospital público del Noreste brasileño, entre junio y agosto de 2021, de modo virtual. Los datos fueron analizados con el auxilio del *software* IRAMUTEQ. El proyecto fue aprobado por el Comité de Ética en Investigación. **Resultados**: el conocimiento científico fue reflejado en el cotidiano y en las prácticas de los participantes. Se observaron seis categorías con contenidos referentes a las medidas de protección; espiritualidad; adaptación; conocimientos; imágenes y actitudes; síntomas; y, sistema de salud. **Consideraciones finales**: las representaciones sociales estaban ancladas en el concepto de enfermedad respiratoria, contagiosa y grave y se objetivaron en las prácticas preventivas. El estudio contribuye para que, en futuras crisis, el perfil psicosocial del grupo sea considerado por profesionales y gestores de la salud.

Descriptores: Enfermería; Psicología Social; Pacientes Internos; COVID-19; Representación Social.

INTRODUCTION

The coronavirus disease 2019 (Covid-19) pandemic, which emerged in 2020 and was caused by the SARS-CoV-2 virus, had multidimensional consequences worldwide. Beyond its direct impact on physical health, the pandemic and the resulting social isolation affected psychological, social, economic, and political domains. The effects varied across countries, depending on circulating virus variants, national policies, response capacities, and access to countermeasures[1]. Social groups swiftly established and regulated new health behavior norms, adapting them to their geographic and social contexts[2].

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SARS-CoV-2 continues to evolve, maintaining widespread transmission and spreading without predictable seasonal patterns. This ongoing evolution may lead to more severe variants, increase the risk of post-Covid-19 conditions, and require the reintroduction of public health measures such as social distancing, isolation, and personal protective equipment[3]. Five years after the onset of the pandemic, more than 777 million cases and over 7 million Covid-19-related deaths have been recorded worldwide. Brazil, one of the most affected countries, has reported more than 37 million cases and approximately 700,000 deaths[4].

The populations at most significant risk of complications and hospitalization due to Covid-19 included people with multimorbidity, obesity, kidney disease, type 2 diabetes mellitus (DM), systemic arterial hypertension (SAH), and asthma[5]. Regarding age group, the highest mortality rate at the beginning of the pandemic was among individuals over 50 years of age, especially those over 60[6]. In that same period, approximately 70% of people hospitalized in Brazil for Severe Acute Respiratory Syndrome (SARS) were over 40 years of age[7]. Currently, people aged 65 and over continue to be the most vulnerable to severe forms of illness and death from Covid-19[1]. During hospitalization, due to this new and contagious disease, people faced several negative subjective experiences, such as feelings of fear, stigma, and anxiety associated with family separation and isolation[8]. Other experiences included anguish in the face of isolation and the possibility of death of oneself and others, helplessness, and discomfort with the disease and the hospital environment[9].

Given its social relevance and pervasive influence on communication and social practices, Covid-19 has become a subject of social representation (SR) development. SRs are "*programs of perception [...], which serve as a guide for action and an instrument for reading reality; systems of meanings that allow us to interpret the course of events and social relations; which express the relationship between individuals and groups with the world and others*" [10:10] (free translation). Understanding Covid-19 through the lens of Social Representations Theory (SRT) is crucial due to its specificities in globalization, the continuous flow of academic information, media coverage, social networks, and the behaviors it has triggered. As noted, the pandemic *"offers itself as a paradigmatic case of illustration of the close relationship between scientific knowledge, political strategies, social discourse, common sense, and existential experience in relation to risk and contagion"* [11:1]. Moreover, this perspective enables the exploration of both individual and societal dimensions of the phenomenon[12].

At the onset of the pandemic, a study involving more than 4,400 individuals from 17 countries found that the general population held multiple SR of Covid-19. These included external zoonotic and ecological factors (such as unhygienic Chinese habits and the overexploitation of natural resources), controversial conspiracy theories (the virus as a bioweapon), elite manipulation (elites deceiving and profiting), and personal responsibility (the belief that negligent individuals deserved to be infected)[13]. In the Brazilian population, the genesis of Covid-19 SR was primarily shaped by concerns related to its spread, prevention, and psychosocial and emotional implications[14]. However, researchers noted that the disease was often anchored in past epidemics, associations with foreign nations, unhygienic practices, and marginalized groups. It was also objectified through war metaphors, portraying scientific experts and healthcare professionals as heroes, the media, businesspeople, pharmaceutical companies, and careless individuals as villains, and the elderly and impoverished populations as victims[15].

The motivation for investigating Covid-19 from the Social Representations Theory (SRT) perspective was to understand how the disease became an object of social thought and how society constructed its meaning and symbolism. Additionally, this study aimed to examine how communication and behaviors were shaped in the daily lives of individuals hospitalized with the disease based on their own experiences. Its relevance lies in generating evidence to support the preparation of healthcare professionals and managers, particularly nursing professionals, in responding to potential crises[16], ensuring care that considers the psychosocial profile and experiences of those affected. Furthermore, it seeks to contribute to developing interventions aimed at reconstructing meanings and practices for managing future pandemics, improving public communication, and reducing fear, anxiety, and associated stigma[17]. This study aimed to analyze the SR of Covid-19 among adults and older individuals hospitalized due to the disease.

METHOD

This qualitative, descriptive, and exploratory study emerged from a Master's thesis in Nursing, grounded in the theoretical framework of SRT in its procedural approach. This approach emphasizes the dynamic and interactive nature of SR, focusing on collective social interactions within their cultural and historical context[18]. The data collection was carried out by the principal author, a nurse who, at the time of the research, was a master's student and a member of a research group with experience in the theoretical and methodological framework. Due to the sanitary conditions at the time, interviews were conducted via telephone between June and August 2021. Participants were individuals previously hospitalized with a diagnosis of Covid-19 in a public hospital specializing in infectious and parasitic diseases in Recife, Northeast Brazil. There was no prior relationship between the interviewer and interviewees. Participants were

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informed about the researcher's credentials and study objectives, and the researcher also conveyed her motivation, emphasizing the phenomenon's social and scientific relevance.

Inclusion criteria comprised individuals aged 40 or older, regardless of gender, who had been hospitalized due to Covid-19 and discharged at least three months prior. The exclusion criterion was the inability to establish telephone contact after three attempts at different times. The age range was justified by the epidemiological profile of individuals hospitalized with SARS in Pernambuco, Brazil, as most hospitalized patients during the analyzed period were over 40 years old[7]. The post-hospital discharge phase was considered an appropriate timeframe for participants to become familiar with the object of representation and to develop practices related to the disease.

Convenience sampling was adopted for data collection. The methodological process began with in-person consultations at the hospital's Medical Archive and Statistics Service (SAME in Portuguese), the department responsible for managing and organizing patient medical records. With the collaboration of SAME employees, the physical medical records of hospitalized individuals were accessed to identify and retrieve contact details of eligible candidates based on the inclusion criteria. Subsequently, the researcher made telephone contact from her residence to request participation in the study and initiate data collection. An attempt was made to interview at least 30 participants, following recommendations from the literature on SR, establishing as "*the minimum necessary for recovering a cognitive and social construction about an object*"[19:3] (free translation).

Two instruments were used: a sociodemographic and clinical characterization form and a semi-structured interview script. Data collected with the first form were analyzed using descriptive statistics. A database was created in an electronic spreadsheet, and each variable's absolute and relative frequencies were calculated. The semi-structured interviews explored guiding themes related to participants' perceptions and knowledge about the disease and their experience with the diagnosis, hospitalization, and recovery. The interviews were conducted in a private setting, ensuring silence and active listening to mitigate the potential impact of the lack of eye contact on participants' expressions. Regarding the presence of non-participants, one individual preferred to be accompanied by a family member during the interview. All interviews were recorded with participants' consent and transcribed verbatim, ensuring confidentiality.

A pilot test was conducted with three participants, and as the script proved adequate, the information collected was incorporated into the study data. Participants were given the option to receive the interview transcript for validation, and one unedited transcript was returned. Field notes were taken during the interviews, and no interviews required repetition.

The software *Interface R pour les Analyses Multidimensionnelles de Textes et de Questionnaires* (IRAMUTEQ), version 0.7 alpha 2 – 2020, was used to assist in the analysis of the interviews. This software provides a range of tools for describing and analyzing textual data. The Descending Hierarchical Classification method was selected, which classifies text segments based on vocabulary and generates classes that allow for the creation of a dendrogram, a graphical representation of content. The material was prepared in a monothematic manner, following the specific guidelines outlined in the usage tutorial[20]. No manual coding of the data was performed.

The study was approved by the hospital's Institutional Review Board. It followed the guidelines for research involving human subjects and those for research conducted in virtual environments. Verbal consent to participate was obtained and recorded during the phone calls.

RESULTS

Thirty-two individuals participated in the study. A total of 203 medical records of individuals hospitalized for SARS were retrieved from SAME, of which 35 met the eligibility criteria. Three individuals declined to participate. Table 1 presents the characterization of the participants.

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Table 1: Participants' sociodemographic and clinical characterization. Recife, PE, Brazil, 2021.

Variables		n	f (%)
Sex	Man	18	56.2
	Woman	14	43.7
Age group	Between 40-59 years old	17	53.1
	Between 60-79 years old	14	43.7
	80 years old or older	1	3.1
Education	No formal education	1	3.1
	Primary/Middle school	17	53.1
	High school	10	31.2
	Bachelor's degree	4	12.5
Occupation	Employed	19	59.3
	Unemployed	5	15.6
	Retired	8	25
Monthly income	No income	4	12.5
	Between R$ 1.00 and R$ 2,000.00	19	59.3
	Between R$2,001.00 and R$4,000.00	4	12.5
	Between R$4,001.00 and R$6,000.00	3	9.3
	Over R$ 6,001.00	1	3.1
	Not reported	1	3.1
Marital Status	Married	20	62.5
	Single	8	25
	Separated	2	6.2
	Widowed	2	6.2
Religion	Catholic	17	53.1
	Evangelical	11	34.3
	Spiritist	2	6.2
	No religion	2	6.2
Hospitalization due to Covid-19			
Length of Hospital Stay (days)	≤ 10	12	37.5
	Between 11 and 20	15	46.8
	Between 21 and 30	1	3.1
	Between 31 and 40	2	6.2
	≥ 41	2	6.2
Hospital Unit and Use of Assisted Ventilation	Nursing ward/No ventilation	17	53.1
	ICU/no ventilation	8	25
	ICU/ventilation	7	21.8

Participants' age ranged from 40 to 81 years, with a mean of 56 (standard deviation ± 11.1), and a similar distribution between adults and older adults. Older adults were defined as individuals over 60 years old[21]. Male participants were the majority. Regarding clinical characteristics, most participants (78.1%) had at least one chronic disease, primarily DM or SAH. Additionally, the majority (71.8%) experienced sequelae from Covid-19, including fatigue, shortness of breath, cough, memory changes, weakness, or pain in various body parts, such as the legs, spine, or head.

The interviews lasted an average of 17 minutes. IRAMUTEQ divided the texts into 791 segments, achieving a 90.5% utilization rate. Six classes were established within three thematic blocks, named based on interactions within the corpus, text segments, and vocabularies, as illustrated in the dendrogram in Figure 1.

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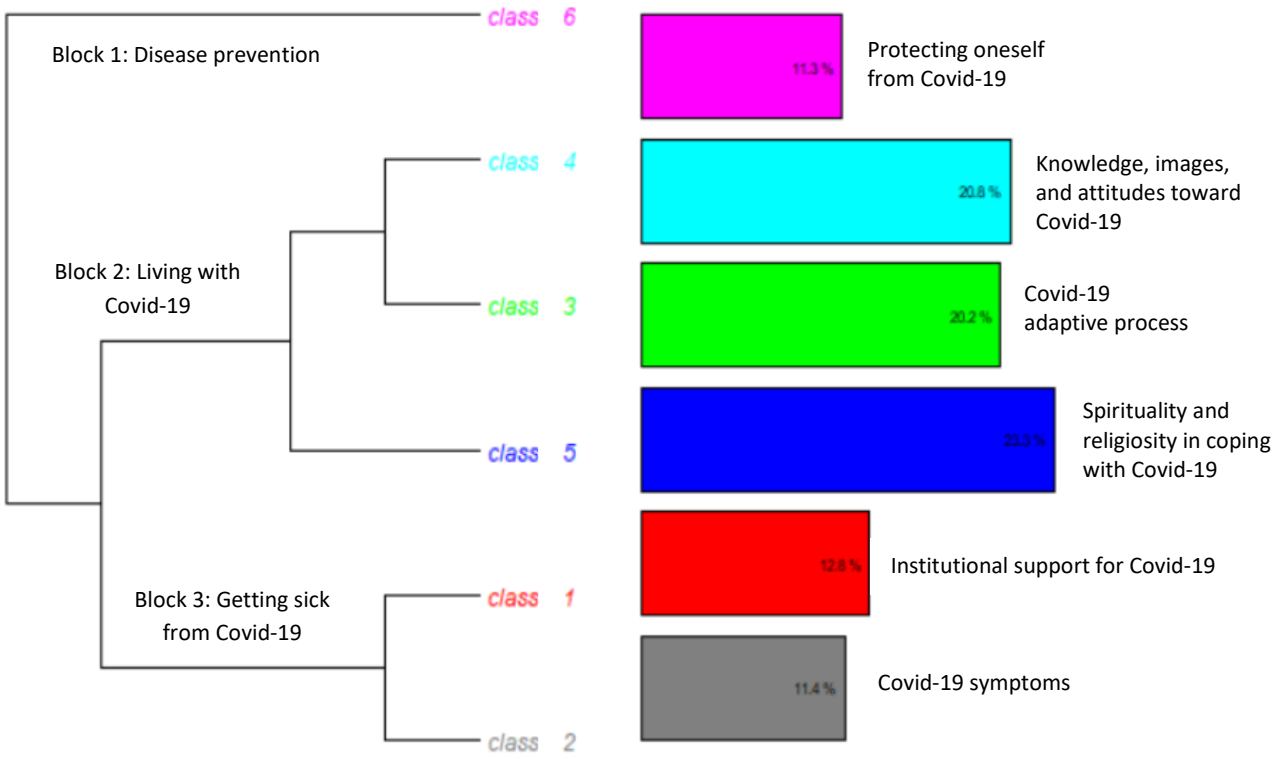

Figure 1: Dendrogram with blocks and class names generated by IRAMUTEQ. Recife, PE, Brazil, 2021.

The program provides the number of text segments containing each word within a class (frequency), the association of text segments with the class (χ^2), and the significance level of this association (p)[20]. For the analysis, words with a frequency greater than 4, $\chi^2 \geq 3.84$, and $p < 0.001$ were considered. The significant vocabulary representing each class is presented in Table 2, which includes the ten most representative words for each class and their respective χ^2 values.

Table 2: Significant vocabulary for each class. Recife, PE, Brazil, 2021.

Class 2		Class 1		Class 5		Class 3		Class 4		Class 6	
Words	**χ^2**	**Words**	**χ^2**	**Words**	**χ^2**	**Words**	**χ^2**	**Words**	**χ^2**	**Words**	**χ^2**
Fever	143.5	Air	137.5	God	263.5	To work	65	To think	87.8	Mask	381.1
Pain	98.5	Exam	112.4	Thanks	121.7	To change	47	Disease	48.2	To use	254.6
Symptom	87.1	Lack	104.2	To recover	90.5	Home	44.7	To see	44	Hand	229.2
Leg	62.1	Test	75.1	To thank	62.5	Task	30	Severe	32.5	To wash	201.9
Cough	60.9	PHC unit	68.3	To mean	46.9	To leave	27	To kill	30.7	Alcohol gel	153
Body	60	Blood	61.8	Victory	36.7	Service	26.5	People	28.6	Care	123.1
Head	48.7	To breath	47	Father	29.9	Thing	24.2	Person	25.6	Alcohol	103.3
To improve	38.5	Positive	44.1	History	26.6	To drink	22.6	Difficult	25.1	Crowd	102.7
Time	36.3	To oxygenate	43.3	To sit	24.5	To walk	20.5	World	23.5	Use	87.61
To feel	35.8	Nose	36	Big	24.3	To like	19.8	Complicated	23	To keep	55.35

The classes and excerpts from participants' interviews will be presented to illustrate the content, with each participant represented by the letter "p," followed by the interview number, "f" for female or "m" for male, and their age in years.

Block 1 represents the first partition of the corpus and consists solely of Class 6, “Protecting oneself from Covid-19,” which exhibits a more specific vocabulary compared to the other classes. The data highlight participants' broad knowledge of protective measures, as all interviewees reported how they protected themselves, emphasizing social distancing, wearing facemasks, hand washing, and surface disinfection. Some individuals only adopted these measures

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after being hospitalized and observed that others did not take the necessary precautions. While some participants were unable to define or articulate their understanding of Covid-19, they knew how to protect themselves.

> *The precautions we should take are not to spend too much time in crowds, not to be on the streets, to wear a mask, to always stay at home, to wash our hands with soap, and to use alcohol gel. (p. 13, f, 81 years old)*
>
> *But people are stubborn. I know a lot of people here where I live who don't wear masks, don't use alcohol gel, and are constantly surrounded by others. People should be a little more aware. (p. 29, m, 48 years old)*

Block 2 comprises the three largest classes- 5, 3, and 4- and explores the disease's symbolism. The largest, Class 5, "Spirituality and religiosity in coping with Covid-19" highlights how these concepts influenced the experience of illness and recovery. Participants viewed their recovery as a victory and an opportunity for which they explicitly expressed gratitude to God.

> *Having recovered from the disease means a second chance that God gave me to do things differently and learn how to live better than before. (p. 09, m, 42 years old)*

Class 3, "Covid-19 adaptive process" addresses both negative and positive changes in response to the disease at personal and collective levels. The group that contributed the most consisted of older adults who had been hospitalized for more than 11 days in the Intensive Care Unit (ICU) and experienced lasting after-effects. Widespread changes in daily life were reported, with one of the most significant being the need to adapt to a new reality characterized by reduced engagement in daily activities, sports, and leisure.

> *I feel sad when I think about what happened to me because I was very active. [...] Just walking around the house, lying down, or sitting to watch a soap opera or a news report—this is what my life has become. I'm stuck. (p. 26, m, 63 years old)*

Participants faced economic and occupational difficulties, which were also linked to the broader political and economic system.

> *I virtually spent a year without working [...]. The worst part is the government's neglect—they don't pay us. We contribute, and they don't pay us. A year unemployed, sick, and without any income, unfortunately. (p. 27, m, 58 years old)*

Some differences were observed among participants depending on the unit where they were hospitalized and, consequently, the severity of their condition. Those admitted to the nursing ward with milder symptoms reported no significant changes in their lives after Covid-19. They remained independent and did not express excessive concern about the disease. In contrast, individuals who spent part of their hospitalization in the ICU and experienced more severe after-effects reported feeling fearful upon diagnosis and continued to experience fear, along with more significant difficulties in their daily lives.

Positive changes included an increased focus on self-care, such as an improved diet and a reduction or even cessation of alcohol consumption. Among adults, the most notable changes were engaging in new activities and developing a greater appreciation for others. Experiencing the death of others often led to a heightened desire to value life, seek personal growth, change habits, help others, abandon egocentrism, cherish family and simple moments, and explore new activities.

> *We are no longer what we were before [...]. I think that if you were good before, now you have to be even better. (p. 22, f, 40 years old)*

Class 4, "Knowledge, images, and attitudes toward Covid-19" presents more diffuse content than the other classes, as it was one of the last to be defined. Participants emphasized that Covid-19 is a serious and deadly disease caused by a highly contagious virus. Adults, in particular, described it as a new disease caused by a virus that emerged to destroy and kill.

> *I think that Covid is a severe disease that causes after-effects on people, victimizes many and kills. I know that Covid is a virus, an infection, and if it reaches the lungs, it is almost a death sentence. (p. 24, m, 47 years old)*

Older adults referred to Covid-19 more emotionally, describing it as a complex, challenging, and dangerous experience.

> *I think that Covid is a very sad and painful disease. When I woke up, I thought I was dying. It's horrible, very sad. I know that Covid is a virus—a very bad and contagious virus. (p. 31, f, 72 years old)*

When examining the sources of information through which participants learned about the disease, the media was the most frequently mentioned, followed by health professionals and conversations with others. Participants hospitalized in the nursing ward primarily reported receiving information through mass media, whereas those admitted to the ICU obtained information directly from health professionals.

> *I heard it on television and the Internet; wherever we go, we always see it. (p. 23, f, 48 years old)*

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However, related to prior knowledge, the diagnosis was associated with fear of the possibility of death.

> *When I found out I had Covid, I felt like I was going to die. My concern was that I looked back and said, 'I'm going, and I'm not coming back.' I thought I wouldn't return home. It was hard. (p. 05, f, 75 years old)*
>
> *As we see a lot on TV, a lot of people dying. When they diagnosed me with Covid, I was afraid of death. I felt fragile. (p. 09, m, 42 years old)*

This fear was particularly strong regarding the possibility of reinfection, especially among those who experienced severe cases, required ICU admission, and needed mechanical ventilation.

> *I'm afraid of going out, afraid of catching something from the street, afraid of waiting in line at the bank, afraid of going to a store. I'm afraid because I think I'll catch it again, and if I do, I don't think I'll have the same chance. I'm afraid. (p. 21, f, 42 years old)*

On the other hand, vaccination emerged as an essential topic when discussing the disease, with all participants expressing a positive stance and stating that they had been vaccinated. Additionally, two participants suggested that Covid-19 was an invented disease or created for destructive purposes.

The last block includes Classes 2 and 1, focusing on the illness, its symptoms, and the hospitalization experience. Class 2, "Covid-19 symptoms," was primarily composed of men with chronic comorbidities who experienced mild sequelae and were hospitalized in the nursing ward. Most participants reported severe symptoms at the onset of the disease, including high fever, respiratory distress, and pain. At that moment, they perceived the possibility of having Covid-19 as an encounter with a new reality, leading them to self-medicate, isolate themselves, deny the illness, or seek medical assistance. In contrast, a smaller group experienced mild symptoms, did not immediately associate them with the disease, and responded to the diagnosis and hospitalization with greater tranquility.

Class 1, "Institutional support for Covid-19," was the last and addressed the mobilization of institutional health resources to manage the disease, the hospitalization experience, the relationship with healthcare professionals, and the care received. During hospitalization, participants expressed feelings of concern, helplessness, fear, and frustration as they faced the prospect of death and witnessed others in severe conditions, experiencing uncertainty, pain, and illness.

> *You look at situations worse than yours, you see people in severe conditions, and you think, "Will I end up like that?" (p. 02, f, 67 years old)*

Isolation caused distress, particularly among those under 60, due to both loneliness and concern for their loved ones. Additionally, two participants reported feeling excluded, attributing this perception to the novelty of the disease and the attitudes of peers and healthcare professionals.

> *When they told me I had Covid, I panicked [...]. I felt embarrassed because of my neighbors—everything becomes an event out here in the countryside. It always attracts curious people. They came to look, people were scared, and they said, "Oh, she's sick, she has Covid [...] that's it, she'll die soon." (p. 21, f, 42 years old)*

However, as interpretation systems, SR allowed individuals hospitalized with Covid-19 to construct explanations for the disease, perceiving it as a significant challenge that requires collective action to overcome. Regarding the processes that shaped these representations, Covid-19 was anchored in the concept of a respiratory, contagious, and severe disease. It was objectified through the materialization of shared knowledge in preventive practices, thereby transforming it from the unknown into the familiar[22].

The group attained stability and predictability in their experience through a reaction of fear and helplessness in the face of the possibility of death. Consequently, they turned to God as a superior being who provides care and determines outcomes, thereby reducing uncertainty. They also sought to move forward with their lives despite the negative changes. They ultimately expressed gratitude, viewing recovery as an opportunity to embrace new ways of living and to appreciate life more.

The dissemination of information, focus, and pressure to infer stand out as determining factors in the conditions under which SR are conceived and formed[23]. In the case of Covid-19, data were both abundant and, at the same time, insufficient, with constant and diverse updates from different sources, making it an extremely recurrent topic. This scenario made distinguishing scientific information from unverified or informal knowledge difficult. The people who fell ill had a remarkable involvement with the subject, focusing their attention on the severity of the disease and the challenges they faced. The context led the group to develop new ways of communicating, fostering inference, where, despite uncertainties, people continually exchanged messages they had not previously shared.

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DISCUSSION

The results enabled an analysis of the various factors shaping the representational content, encompassing knowledge, images, attitudes, experiences, and practices related to Covid-19 among individuals who had been hospitalized. Initially, the content addressed the formation of preventive measures against Covid-19, which were adopted by the entire group (class 6). The adoption of these measures was linked to the understanding that failing to take precautions could lead to reinfection, hospitalization, or even death. The perception of risk influenced practices in response to vulnerability and fear, as these actions are positively associated with knowledge and the effectiveness of the response[24]. Although the SR of Covid-19 appears to have a paradoxical nature, this does not seem to affect the stance or practices of individuals who experienced severe stages of the disease, despite the abundance of information and the "multiple voices" from different sectors[25].

Spirituality and religiosity in class 5 were considered essential resources for coping with the crisis. These aspects helped individuals face Covid-19 with less uncertainty and a reduced sense of helplessness during the initial phases, recovery, and post-Covid-19 adaptation. Many participants turned to or reconnected with these resources, developing a greater appreciation for life and a deep gratitude. They expressed that God enabled healthcare professionals to care for them appropriately. In this context, the key factors influencing their perspective and ability to overcome the disease during hospitalization included spiritual experiences, positive thinking, perceived support from the healthcare team, and the presence of family[26]. Likewise, remembering God, praying, and maintaining contact with friends and family proved beneficial. After recovery, changes were strongly associated with increased faith in God, strengthened human relationships, and greater respect for healthcare and safety professionals[27].

In this context, similarities can be observed between the fight against Covid-19 and the experiences of people living with HIV/AIDS (PLWHIV), as both diseases are infectious, pandemic, and marked by uncertainty. In the SR of PLWHIV, spirituality, and religiosity have been recognized as important tools for giving meaning to life and providing a reason to live after diagnosis, as they are linked to well-being, social relationships, and dialogue with divinity[28].

During their experience with the disease, participants faced the need to adapt to a new reality imposed by Covid-19 (class 3). Most reported significant disruptions to their daily routines, encountering difficulties in performing instrumental activities of daily living, which led to limitations or dependence. The severity of the disease was a key factor in intensifying these adverse effects[29,30]. Although hospitalization for Covid-19 was initially marked by fear, denial, and stigma, the experience ultimately contributed to psychological growth. As shown by the results, this growth was reflected in an increased ability to face challenges with gratitude, a greater appreciation for life and family, and the belief that overcoming Covid-19 made individuals stronger and more resilient[31].

In the economic sphere, this study highlights the profound impact of the pandemic on public health and the Brazilian labor market. In addition to the paralysis of productive activities and widespread layoffs, there was an increase in informal employment and deterioration in livelihood conditions, further exposing the reality of a historically and structurally unequal society[32,33].

Class 4 focused on interconnected elements that contributed to the dimensional analysis of SR. Participants possessed extensive information from various media sources about the disease and the pandemic, enabling them to take a stance and identify as a group. When analyzing their sources of information and attitudes toward vaccination, differences emerged between this study's population and the general population[34,35], likely due to the former's level of involvement with the subject. Participants in this study were in favor of vaccination. In contrast, individuals who had not been directly affected by the disease and whose knowledge came primarily from social media or health professionals' recommendations perceived the situation as less severe and were less likely to get vaccinated[34]. Among the reasons for vaccine hesitancy in the Brazilian population were distrust of vaccines, underestimation of the pandemic's severity, misinformation, skepticism about political involvement, and fear of adverse reactions[35].

Reports of fear, death, isolation, and other negative aspects associated with Covid-19 have been recurrent in the literature on SR across different population groups[36–45]. From a structural perspective, studies have identified that the central core of the SR of the pandemic among the general Brazilian population initially comprised the categories "fear, social distancing, health and prophylaxis, and disease"[36]. Over time, "fear and social distancing" remained central, alongside "politics and government" and "death"[37], as well as the terms "death, suffering, care, anxiety-anguish, and vaccine"[38]. Similarly, in the early phases of the pandemic in Spain, "fear" played a significant role in shaping the representation of Covid-19[39]. In France, SR were structured around central negative elements such as "fear," which

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varied depending on individuals' perceptions of the virus's origin, while "death and contagion" remained stable and structuring components of the core[40].

Similarities were found in the older adult group[41-43]. The core of the SRs among Brazilian women was composed of the expressions "death, fear, disease, sadness, and mask"[41]. In Mexico, at the beginning of the pandemic, the elements identified were "confinement, death, disease, fear, pandemic, and danger"[42]. In Spain the group trusted the guidance of scientists and doctors while criticizing the government and the mass media for providing insufficient and contradictory information; feelings of fear, nervousness, uncertainty, restlessness, and insecurity emerged in this group, as well as feelings of loneliness and isolation, associated with death[43].

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Class 2 was characterized by representational content that suggests the initial encounter with this new reality, with symptoms similar to those found in the literature[46–47]. Finally, Class 1 addressed healthcare resources and the complexity of hospitalization. Like the Brazilian health system, the global health system faced high demand and operated with insufficient human and material resources[48]. The group made a positive assessment of healthcare and expressed gratitude upon realizing that the quality of care influenced their recovery while acknowledging the challenges faced.

The group of nursing professionals who provided care to patients with Covid-19 during the first year of the pandemic experienced psychological distress, with "fear and isolation" at the core of the disease's SR[49]. This fear was associated with personal and family circumstances, as well as subjective and objective work conditions, exposure to the virus, and social distancing. These challenges occurred within a context of novelty and adaptation, driven by a lack of knowledge about the disease[50–51]. Finally, the perception of discrimination by healthcare professionals, although less prevalent, was identified in this study and the literature[52]. Given the heightened stress and workload these professionals face, it is essential to recognize and eliminate such practices to promote more humanized care.

Study limitations

The absence of telephone contact information in many medical records limited the ability to reach more participants, resulting in a heterogeneous group. Additionally, challenges related to remote interviews, such as the inability to establish visual contact and fluctuations in connection and audio quality, represented further limitations.

FINAL CONSIDERATIONS

The analysis of the SR of Covid-19 among adults and older individuals who had been hospitalized due to the disease indicated that scientific knowledge, widespread knowledge and informal understanding was integrated into their daily lives, becoming part of their routines. This knowledge guided their actions in response to Covid-19. The participants' strong engagement with the subject and their perception of risk led them to translate this knowledge into preventive practices while also seeking to raise awareness among "other people" who were possibly less directly involved with the disease.

The group constructed an image of Covid-19 as a severe, challenging, and deadly respiratory disease caused by a virus that required special precautions to prevent contagion. From an affective-attitudinal perspective, the disease evoked feelings of helplessness and fear due to its nature and the possibility of death. Participants recognized the magnitude of Covid-19, its signs and symptoms, and the importance of isolation, vaccination, and prevention. This information was widely disseminated in sufficient quantity and quality for individuals to consider it essential. The media played a crucial role in communication during the pandemic, extensively broadcasting this content. However, the group placed greater trust in the recommendations of healthcare professionals, particularly at the time of hospital discharge.

Studying the social and cognitive construction of Covid-19 contributes to improving healthcare and nursing care in future crises, emphasizing the need for clinicians and managers to continue providing health education and reinforcing self-care and preventive measures. Additionally, it is essential to address the negative consequences of social isolation, maintain surveillance of pre-existing conditions in the population, limit exposure to extreme and conflicting information about the pandemic, and prevent political polarization from negatively impacting health. A comprehensive,

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empathetic, and dialogical approach is crucial during hospitalization to shield patients from the distress of witnessing the death of others, facilitate communication with their loved ones, encourage religious and spiritual expression, and ensure that multidisciplinary teams implement rehabilitation and monitoring measures.

Due to the dynamic nature of SR, this framework offers broad possibilities for future studies, depending on variations in historical and temporal contexts. One example is the longitudinal analysis of SR among those affected, which would allow for observing changes in interpretations and group adaptations to the new post-pandemic context.

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Conceptualization, C.S.P.G., D.A.F. and F.M.S.A.; methodology, software, C.S.P.G. and D.A.F.; validation, C.S.P.G., D.A.F. and F.M.S.A.; formal analysis, C.S.P.G., D.A.F., D.C.O., A.M.C. and F.M.S.A.; investigation, C.S.P.G., D.A.F. and F.M.S.A.; resources, C.S.P.G.; data curation, C.S.P.G.; manuscript writing, C.S.P.G.; review and editing, C.S.P.G., D.A.F., D.C.O., A.M.C. and F.M.S.A.; visualization, C.S.P.G.; supervision, F.M.S.A.; project administration, C.S.P.G. and F.M.S.A.; funding, C.S.P.G. All authors read and agreed with the published version of the manuscript.

Use of artificial intelligence tools

Authors declare that no artificial intelligence tools were used in the composition of the manuscript "Social representations of Covid-19 among hospitalized adults and older adults".

Data repository

Authors declare that the research database with the transcription of the interviews conducted is available in the Figshare repository, DOI: https://doi.org/10.6084/m9.figshare.27126393.v1