

RESEARCH REPORT

Health Psychology

Editor

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Eating disorders, COVID-19 and reconfigurations of care: challenges for shared management of health professionals

Transtornos alimentares, COVID-19 e reconfigurações do cuidado: desafios para gestão compartilhada dos profissionais de saúde

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Abstract

Objective

This study aimed to understand the meanings attributed by the team specialized in eating disorders to the reconfigurations implemented in the service during the first wave of the COVID-19 pandemic.

Method

This is a cross-sectional descriptive-exploratory investigation that adopted the clinical-qualitative method and the Psychoanalysis of Bonding Configurations as theoretical reference. Focus groups were conducted with 23 professionals, analyzed from the perspective of Reflective Thematic Analysis, which resulted in the elaboration of three themes.

Results

Professionals report that the outbreak of COVID-19 had an impact on the service, generating a feeling of helplessness, fear and paralysis. The need to provide care continuity led to team movement in order to reorganize, allowing the maintenance of assistance. The retrospective looks shared in the focus groups allowed the team to elaborate the facilitating and hindering factors of the experience.

Conclusion

The results offer support for managers and health professionals to improve health care in crisis situations.

Keywords: COVID-19; Eating disorders; Mental health services; Multidisciplinary care team; Qualitative research.

Resumo

Objetivo

Este estudo teve como objetivo compreender os significados atribuídos pelos profissionais da equipe especializada em transtornos alimentares às reconfigurações implementadas no serviço durante a primeira onda da pandemia de COVID-19.

Método

Trata-se de pesquisa descritiva-exploratória de corte transversal, que adotou o método clínico-qualitativa e a Psicanálise das Configurações Vinculares como referencial teórico. Foram realizados grupos focais com um total de 23 profissionais, analisados na perspectiva da Análise Temática Reflexiva, que resultou na elaboração de três temas.

Resultados

Os profissionais relatam que a eclosão da COVID-19 teve impactos no serviço, gerando desamparo, medo e paralisia. A necessidade de retomar os atendimentos levou a um movimento grupal da equipe de reorganização, permitindo a manutenção da assistência. O olhar retrospectivo compartilhado nos grupos focais permitiu que a equipe elaborasse os fatores facilitadores e dificultadores da experiência.

Conclusão

Os resultados oferecem subsídios para gestores e profissionais de saúde aprimorarem a produção do cuidado em situações de crise.

Palavras-chave: COVID-19; Transtornos alimentares; Serviços de saúde mental; Equipe de assistência multidisciplinar; Pesquisa qualitativa.

The Coronavirus Disease 2019 (COVID-19) pandemic, caused by the Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2) pathogen, has had disruptive impacts worldwide (Santos, Oliveira, et al., 2020); Individual and collective capacity to deal with disruptive events may vary, depending on the government's response to scientific recommendations, the implementation of appropriate social measures at each stage of the disaster, access to the care network available prior to the pandemic, the effectiveness of social support for vulnerable segments of the population, and the unique ways in which people deal with the changes imposed on daily life (W. A. Oliveira et al., 2020). Considering these assumptions, the COVID-19 health emergency has taken on the characteristics of a large-scale disaster, as it combined multiple threats, conditions of vulnerability, and local response capacity (Weintraub et al., 2020).

In this scenario, despite having a public health policy recognized worldwide for its excellence and which ensures universal and free health care access to the population, workers in the Unified Health System, at various levels, from primary to quaternary care, found themselves facing an exponential increase in demand and were challenged by the precariousness of the system that had been ongoing for some time (Santos, Oliveira, et al., 2020). In addition to the overload resulting from the demand for health care (including mental health) from the general population, studies with robust samples indicate that people previously diagnosed with some significant psychological distress and who were being monitored by the services may have had their symptoms aggravated (Moura et al., 2022; World Health Organization, 2021).

Among the specialized services for the care of patients with severe and persistent suffering, we can highlight Eating Disorders (EDs). The EDs are psychopathological configurations that are characterized by their chronicity and by posing significant risks to the physical and psychosocial

health of the person diagnosed, requiring the attention of a multidisciplinary and specialized team, with interdisciplinary practices (Leonidas et al., 2019; Santos, Valdanha-Ornelas, et al., 2020). People with Anorexia Nervosa (AN) and Bulimia Nervosa (BN) have severe distortion of body image and adopt restrictive or purgative eating patterns (AN) or have episodes of binge eating followed by compensatory behaviors (BN) (American Psychological Association, 2014). These patients, as well as other individuals diagnosed with chronic health conditions, suffered worsening of their symptoms during the pandemic (Clark Bryan et al., 2020; Nisticò et al., 2021; Papandreou et al., 2020; Plumley et al., 2021; Schlegl et al., 2020; Termorshuizen et al., 2020).

In the pandemic scenario, physical distancing was one of the only feasible non-pharmacological measures to contain the spread of the virus. Restricting physical contact was one of the measures recommended to contain the virus when there were no vaccines available for collective immunization. Health professionals were challenged by the need to comply with the maintenance of health protocols of physical distancing and, simultaneously, minimize the impact of the discontinuity of care for patients suffering from EDs. In this connection, health services had to be reorganize in order to resume care for the clinical population and, to do so, they needed to reinvent their practices, doing “what was possible” in a context of great social unrest in which there was still little scientific knowledge about the new disease and its means of transmission (Davis et al., 2020; Graell et al., 2020; Plumley et al., 2021).

In Brazil, the scenario of widespread uncertainty was aggravated by denialism and erratic management of the health crisis, due to the lack of clear guidelines and the inaction of the Ministry of Health. Professionals on the front lines of the combat against the pandemic were exposed to stressful conditions and experienced significant suffering, with a significant number of health workers losing their lives or becoming infected at the workplace (Kang et al., 2020).

At the international level, several qualitative, descriptive and documentary studies were published in the heat of the moment, addressing the experience of specialized EDs services during the first stage of COVID-19. The studies report the need to reorganize the care provided by healthcare professionals (Datta et al., 2020; Davis et al., 2020; Graell et al., 2020; Plumley et al., 2021). However, no reports were found on the adaptation of Brazilian EDs services to the new context. The studies available focus basically on the physical and mental health issues of service users, and not on the role of healthcare agents who planned and coordinated the adaptation and adjustment of the care model to the new reality.

Understanding and reflecting on the experience of healthcare teams in the transition of the healthcare template can have strategic value, since they are the technical players who were on the front lines during critical moments of exhaustion of the local healthcare systems and who had to resize their practices to deal with that public health emergency. Not to mention that the multidisciplinary team also assumes a leading role in the gradual transition to the post-pandemic scenario, marked by the need to assess the consequences of the traumatic event and invest in the construction of mechanisms to prevent natural disasters and health disasters in the future (Weintraub et al., 2020). Based on these considerations, it is important to understand how professionals experienced this transition process, since they worked with vulnerable populations and, at the same time, were also exposed to physical and mental illness due to stress and work overload (Brolese et al., 2017; Santos, Oliveira, et al., 2020).

From this perspective, this study aimed at understanding the meanings attributed by professionals from the specialized EDs team to the reconfigurations implemented in the service during the first wave of the COVID-19 pandemic.

Method

This is a descriptive-exploratory, cross-sectional study with a qualitative approach (Flick, 2019), using the Clinical-Qualitative Method (Turato, 2013) as a methodological reference and the Psychoanalysis of Link Configurations (Berenstein & Puget, 2008) as a theoretical framework. The Clinical-Qualitative Method is based on the confluence of clinical, existentialist and psychoanalytic positions and constructs. It is appropriate for research problems that emanate directly from health practices, offering interpretations and analyzing meanings that patients and professionals elaborate in their shared experiences of the health-illness-care process. Psychoanalysis of Link Configurations is a Franco-Argentine theoretical strand of psychoanalysis, which integrates the triple dimension of links: the subjective space, the intersubjective space – that is, between one subject of the unconscious and another subject, and the transubjective space – which is the sociocultural space.

The investigation was conducted at a specialized care service for EDs located in a university teaching hospital linked to the Unified Health System. The service has professionals, researchers, residents and interns from five areas of knowledge: Psychology, Psychiatry, Occupational Therapy, Nutrition and Nutrology. Health actions are guided by the Singular Therapeutic Project of each patient and discussed in weekly team meetings. Interventions are conducted individually and in groups and include patients and family caregivers. The investigator was immersed in the field for eight months prior to data collection in order to acquire familiarity with the environment and its players, as recommended by the Clinical-Qualitative Method (Turato, 2013).

Participants

The sample consisted of 23 participants, who had been part of the team from March 2020 to May 2022, namely: Psychology (12), Nutrition (4), Nutrology (3), Psychiatry (2) and Occupational Therapist (OT) (2), all with experience in the area of EDs ranging from one to 24 years. All eligible team members were invited and only one professional declined the invitation. Thus, the convenience sample ensured the inclusion of different areas, specialties and time of experience in the service, covering almost the entire universe (Table 1).

Table 1

Characterization of participants (n = 23) according to specialty, length of professional experience, length of experience in the area of eating disorders and institutional affiliation

N	Knowledge area	Length of professional experience – minimum and maximum (years)	Time of experience in the EDs area – minimum and maximum (years)	Institutional link
12	Psychology	> 1 to 24	> 1 to 22	Eight interns, three volunteer psychologists/researchers and one teacher/researcher
4	Nutrition	2 to 34	2 to 24	Three volunteers/researchers and one teacher/researcher
3	Nutrition	3 to 30	> 1 to 8	Two resident doctors and one teacher/researcher
2	Psychiatry	2 and 5	> 1 and 1	Two resident doctors
2	Occupational therapy	2 and 17	1 to 8	One resident OT and one contracted OT

Note: N: Number of participants; EDs: Eating Disorders; OT: Occupational Therapist.

Instruments

Two instruments were applied: 1) *Sociodemographic Data Form*, containing information to characterize the participants, such as gender, age, profession and time of experience; and 2)

Focus Group Thematic Guide (FG). The FG was chosen as a data collection strategic tool because it is a well-established method in health research and because it allows the collection of collectively produced meanings about a given subject or phenomenon of interest. This resource allows us to grasp the more general meanings developed in the group dynamics, in addition to allowing us to access nuances and unique aspects through the elaboration of specific questions (Barbour, 2009; Borges & Santos, 2005). The FG script posed questions about the participants' experiences at the beginning of the pandemic, how they restructured the service and reorganized their personal routine, and what they learned from the experience.

Procedures

Data collection was carried out between April and May 2022, favoring the remote mode, complying with the requirements of COVID-19 prevention health protocols. The online FG used the mediation of a digital platform to bring together participants, in order to optimize resources and save maximum people's time, favoring their comfort (Barbour, 2009; J. C. Oliveira et al., 2022). Two FGs were applied, each lasting approximately 60 minutes. The groups were coordinated by the investigator, as mediator; there was also another investigator on the spot who acted as note-taker-observer.

The verbal interactions that occurred in the FGs were recorded digitally and were later transcribed verbatim by the two field investigators. The transcripts totaled 147 A4 pages, written in Times New Roman font size 12 and single-spaced. Codes were assigned to identify each participant: Psy1, Psy2... for psychology professionals. Psyc1, Psyc2, for psychiatry professionals. Nutri1, Nutri2... Nutrition. Nutro1, Nutro2... Nutrology. OT1, OT2, Occupational Therapy.

The transcribed material was reviewed by two independent investigators, from the perspective of Reflective Thematic Analysis (Braun & Clarke, 2013). The data were reviewed from a perspective that explored the meanings attributed by the team to the experiences of reconfiguring care for service users in the context of the COVID-19 pandemic.

To operationalize the Reflexive Thematic Analysis, the six methodological steps recommended by Braun and Clarke (2013) were followed: Phase 1: Familiarization with the data – Exhaustive and repeated readings were carried out, aiming at immersion in the material in depth and breadth. Phase 2: Generating initial codes – The reports were reread and coded by the investigators, taking as a guide general aspects that were relevant to respond to the investigation objective, identifying repetitions and singularities between the phenomena, situations and contexts reported, taking care to differentiate one from the other, that is, to discriminate convergences and divergences highlighted by the participants. The coding, supported by the Atlas-Ti software, allowed the labeling and naming of segments classified in each code, which formed the basis of the repeated patterns (themes). Phase 3: Searching for themes – Combination of different codes formed a comprehensive theme and its subthemes, without losing the general data context. Phase 4: Reviewing the themes – Cleanse the themes, checking whether there were sufficient data to support the themes. Phase 5: Defining and naming the themes – With the themes already defined and refined, a thematic map of the data was produced. The contents were organized into a consistent and coherent whole, ensuring that there would be no theme overlapping. In addition, the themes generated were discussed with the research group and with an external evaluator to ensure results consistency. Phase 6: Producing the report – The writing sought to weave an attractive analytical narrative that would allow going beyond the mere description of the data. From an epistemological point of view, thematic analysis is compatible with the clinical-qualitative methodology, since it values the data analysis from the participants' point of view.

This study was developed in accordance with the guidelines of the Consolidated criteria for Reporting Qualitative research (Tong et al., 2007). The reliability criteria recommended by Creswell and Poth (2013) were followed, such as the detailed description of the methodological steps, analysis of the empirical material by more than one investigator familiar with the field and the data were reviewed by an investigator with expertise in the specific field of study.

The ethical precautions recommended by Resolution No. 466/12, which set regulations for research involving human beings, were upheld. The guidelines established by the Federal Council of Psychology (CFP No. 016/2000) were also followed, as well as the guidelines on ethics in research in virtual environments (Fundação Osvaldo Cruz, 2021). The project was approved by the Research Ethics Committee (CAAE: No. 5492821.4.0000.5407).

Results

The results allow us to understand the meanings attributed by the health team to the reconfigurations implemented in the specialized ED service during the first wave of the COVID-19 pandemic. The assessment corpus was divided into three themes: 1) The day the earth stood still: feelings in the face of the unexpected; 2) Let's not stray too far, let's go hand in hand: decision-making and service reorganization; 3) Nothing will be the same again: looking at the past, thinking about the future. The themes, subthemes and excerpts of the talks have been summarized in Chart 1.

Chart 1

Themes, subthemes and excerpts from participants' talks

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Theme	Subtheme	Talk excerpts
<i>The day the earth stood still: feelings in the face of the unexpected</i>	Feelings of surprise and fear	"My impression is that the impact was great. The strangeness is that it was something unplanned" (Nutri3) "I was also very afraid. I didn't know, you know, what could happen to my health." (OT2) "And then I had an experience... I identified with what she [Psy3, participant] said, about fear, uncertainty, changes" (Psy7)
	Paralysis and resistance to change	"The first moment was very strange, because I couldn't imagine how we would see patients online in a way other than face-to-face" (Nutri3) "It was really difficult... A tragedy, actually, because patients would ask: 'What am I going to do in online occupational therapy? How are we going to work?', right? [laughs]. And I didn't know much about that either" (OT2) "So, I thought it wouldn't work because it was so new, even I was a bit stuck. How could you start an online group? My God! It was so absurd! I couldn't believe that we were going to start an online ED group" (Psy2) "I was particularly prejudiced and I always heard my... my teachers telling me that it was impossible to see a patient without being present, right?" (Nutro2)
<i>Let's not stray too far, let's go hand in hand: decision-making and service reorganization</i>	Realizing the need to resume activities	"So we scheduled the first online meeting. We talked and saw what we were going to do with the outpatient clinic because it was impossible for patients to go for who knows how long without care. We had to try to keep things running at least a little bit" (Psy2) "So, it was Saturday night, I had no one to talk to, and then I said: 'it's not possible, we can't do this way' (...) I told the team what had happened and that I thought we should get back together somehow" (Psy1)
	Shared management: team decision-making	"Our outpatient clinic is very complex, in terms of having four or five teams working together in a very integrated way (...) We needed to define some things. It wasn't the impact that paralyzed us, right? I think we managed to... take some actions among ourselves" (Nutro3) "The whole team worked in a way that said: 'look, we're here building something, seeing what can be done'. Because it was something new for everyone. That was something that made things easier and helped a lot" (Psy7)
<i>Nothing will be the same again: looking to the past, thinking about the future</i>	Importance of maintaining continuity of care	"When you look back and think about the conditions and the entire configuration of that context, that moment... having continued, I think that's a very positive point" (Psy7) "I felt, in a way, active at the time of this pandemic because of being in the service, right? Because I was able to participate in a way that I thought was very innovative, like, in patient care, so I thought it was really cool" (OT2)
	Flexibility is the key	"I had a word in my head, which I think is flexibility. I think that, during the pandemic, there is no way around it, you have to be flexible, otherwise nothing would be possible, right? But, I think that, sometimes, in a more general way, not just here, right, I think that in public services it is difficult to have this flexibility to change what is already more established" (Psy9)

Chart 1*Themes, subthemes and excerpts from participants' talks*

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Theme	Subtheme	Talk excerpts
	Losses and gains of online team meetings	<p>"I thought that the case discussion meetings worked well online, everyone contributed a little, and everyone talked about the cases they were working on, it was possible to follow along... I thought it worked quite well" (OT1)</p> <p>"I increasingly think that this is a method that is here to stay. Meetings with very large groups work, sometimes they even work better than when we are together in person, right? This thing where you have to raise your hand, of the chat" (Psy1)</p> <p>"I felt very welcomed, but I don't think I got to know the people, I had that feeling and that must have been created by the online mode" (Psyc1)</p> <p>"I think that things are definitely lost, right? We saw in this last meeting, which was in person, the giggles that happened, the sometimes parallel conversations that arise, which I think we don't have online yet, it's a shame, right? It's missing" (Psy7)</p>

Theme 1: The Day the Earth Stood Still: Feelings in the Face of the Unexpected

The team's professionals narrated their experiences during the first months of the pandemic, mentioning the impact, surprise and frustration they experienced when they were faced with sudden changes in the outpatient clinic routine:

Yes, I think it was quite scaring. It's something that was indeed unexpected, unplanned (...). And I think the impact, I think it was very big for everyone (...) an uncertainty of how we were going to do it, how we were going to work, what conduct we were going to adopt. (Nutro3)

A statement from a Nutritionist who was a participant of the OT highlighted her feelings, such as uncertainty and fear of the disease: "I also felt very similar. So, it was quite frightful, very intense, for being inside the hospital, right at a time when no one knew what was going to happen" (OT2). A participant from the Psychology department recalled the last day she attended the outpatient clinic in person, before the adoption of health measures to control the pandemic:

The pandemic had already started, there had already been a case, two cases in Brazil, and I was in the elevator, going up to the service meeting. Then two doctors came in, I think, and said: 'Oh, did you hear that there was a case here?' Then the other one said: 'There was a case here?' And they started talking, and I was like, right [expression of disbelief]. And there were no masks, there was nothing to protect us, and everyone was scared to death of COVID, and I was in the meeting thinking: 'My God, is everyone here going to get COVID?'. (Psy8)

Other participants shared that feeling, at that time they felt "lost", afraid and "not knowing where to go": "I kept thinking about how this pandemic has affected everything, like that" (Psy3); "I remember the feeling at the beginning, like, fear and caution. And I think that tends to lead us to a paralyzing condition, you know?" (Psy7).

This last statement led some other members of the FG to report their resistance to change, as they could not even imagine what an intervention would be like in a different way from what they were used to:

Everything I had learned, everything I had experienced over the years (...) it all went down the drain, so I had to learn a different way of working. (OT2)

It won't be the way it was anymore, it will be very different. (...) I was really resistant, because I didn't want to deal with this change, you know? I think that, speaking of my individual resources, it was very difficult. (Psy3)

Theme 2: Let's not Stray Too Far, Let's go Hand in Hand: Decision-Making and Service Reorganization

After an initial moment of perplexity and disbelief, the team members were able to reorganize themselves and began to think about what to do in the scenario that was materialized:

I think we started to draw in our heads, at first, how we would actually make this transition. It was the biggest challenge. (Nutri3)

Then, after [the shock], I began to adapt and understand that there was a different way of working. But it was very difficult. (OT2)

I think we managed to (...) feel the situation, realize how we could act in light of what was happening, how we could work. I think it always takes us a while to digest and think about what can be done. (Nutro3)

For one of the psychology professionals, the trigger to start searching for new paths came after she experienced an emergency situation with a patient with anorexia, when in-person care had already been suspended. This service user contacted a former intern, saying that she had attempted suicide. She was referred to several emergency services in the health network, but they were all full or had exclusive demand for patients with Severe Acute Respiratory Syndrome. The professional stated: "I felt alone without the support of the team. (...) And then I thought that we couldn't work with such a serious disorder and suffering at this level without the help of the team" (Psych1).

In mid-May 2020, the team met online and decided to remodel the service, offering what was possible at that time: online care: "When I made the proposal: 'look, we need to go back, we need to resume', I think the team really bought into that idea, so... they agreed to try it online" (Psy1). At the same time, it was decided to resume weekly team meetings mediated by the use of a digital platform. To resume contact with patients, an online questionnaire was created, "asking how they were doing, what was their need, which professional on the team they would like to talk to (...) and they had good responses in the questionnaires" (Psy1).

The professionals reported that the application of the instrument, which included questions about physical and mental health, and which also asked whether or not the service users needed any specific care, provided an overview of the reality at that time. In this way, it was possible for the team to gradually resume care, first with those who had requested help or who were considered a priority in the first contact. Over time, the specialists resumed their consultations: Nutrition and Psychiatry, with consultations carried out mainly by phone. The Nutrition team also continued with individual consultations via video calls, although it maintained the suspension of group sessions. Occupational Therapy activities were resumed, also in the individual online format. The Psychology team, on the other hand, transferred group activities to the remote format, in meetings mediated by video calls, with one group for patients and the other for family members, in addition to maintaining individual consultations, also online. The participants reported on this situation:

But we didn't freeze, right? We managed to think of strategies, of ways to deal with the situation, right? Despite everything that was imposed at that moment. (Nutri3)

The service was restructured quickly, the team came together very quickly to think of another model. (Psy10)

It is worth highlighting the fact that, during the discussion of the two FGs, mutual support between team members was valued, supporting the creation of joint solutions and welcoming the anxieties and insecurities of each member:

I am very grateful that the service was online, but I think what happened [laughs] was not so much my merit, you know? (...) I keep thinking, if it were up to me, I wouldn't have stopped, because it was really difficult for me. Then I felt that the team's movement was what managed to get me going, and I managed to organize myself as well. (Psy3)

Other group participants also highlighted the support offered by the team as a facilitating factor for change, especially at that time of so much uncertainty and insecurity, when everyone felt as if they were "changing the car's wheel while the car was moving" (Psy7).

Theme 3: Nothing Will be the Same Again: Looking at the Past, Thinking About the Future

When we investigated what team members considered to be positive aspects of the experience of reorganizing the service during the pandemic, both groups mentioned the possibility of continuing to provide care to people, even under such difficult conditions. "The mere possibility of starting to provide online care seemed to have brought a certain comfort. As to me (...) it was a way of maintaining contact with patients, in the way that was possible" (Nutro3).

In addition, the possibility of offering care regularly, generated in some participants, a feeling of internal organization:

For me, it was a very good experience to be in the service at that time, because while everything was in chaos, a general mess, it was one of the first things that started to get structured again, of course within a new, different model. (Psy10)

It really got structured very quickly there, compared to other services. So, I think it really is a very positive point. (Nutri4)

What comforted me was being in the service (...) I am part of this service, but I am also part of other outpatient clinics (...). And it was the only outpatient clinic, which operated online, where patients really had the opportunity to continue, in a way. (OT2)

In one of the FGs, it was discussed how to reorganize with flexibility the appointment schedule which at that time served as a learning opportunity for professionals. Services that have a long tradition in the area can often continue to maintain the same clinical practices for years, without reflecting on them.

The possibility of rethinking the way of doing the service is what I thought was cool. (...) The service, sometimes, has been going in a certain way for a long time, right? Somehow it works, and then something like this comes along, and then we say: "Wow, there are a lot of things that work, but I think we can even change a few things". And we changed and it did work. (Psy2)

Other participants agreed with this point of view: "Then change one thing there, because now it's getting too heavy, change another thing here, because this other point didn't work. I think that this team flexibility is also something to be highlighted as a positive factor" (Psy7). One participant made an interesting reflection. She observed that the flexible way in which the team allowed itself to deal with adverse circumstances contrasted with the rigid pattern of functioning of patients with AN/BN. "That's why I don't think we started to function in a way that's similar to them, of sometimes becoming very rigid like them" (Psy9).

The fact that each professional maintained contact with the team in weekly meetings, mediated by digital platforms and messaging application groups, was valued by participants as an alternative that should be preserved in the future, as well as the inclusion of scientific meetings, in which recent publications in the area and research carried out in the service were discussed:

We started with the scientific meetings, which were cool because we also presented our research, and perhaps there was no space in the meeting before for a personal presentation. (Psy2)

I think this proximity, the fact that it is no longer just on Fridays and we can have contact on other days of the week, also made the bond more crossed, right. (Nutri1)

On the other hand other participants pointed out that the fact that the meetings were held online, could make it difficult for the team members to get closer. In the FGs, this feeling was reported by residents and interns, who have a different insertion in the service:

I managed to be part of the team, but I didn't feel like I really knew the staff (...) So, I think that was reasonably frustrating for me. (Psyc1)

I didn't know the people, it seems like I didn't interact with the team as much as I would have liked. (Psyc6)

I ended up having a more tenuous, less close contact with the team. (Psy7)

In both focus groups, participants pointed out that the experience taught them that online care is possible and can be of great value for assisting with EDs, despite the difficulties encountered over the two years (from May 2020 to April 2022) in which the service operated in this format:

I see benefits and I see some obstacles: I increasingly think that this is a modality that is here to stay. So, in some cases, we have already seen that it works (...) So, today my position is as follows: the priority is in-person. If it is not possible to do it face-to-face, we will do it online. (Psy1)

Another participant pondered along this line: "Sometimes, the patient is at a point where he or she is much worse off". So, he or she thinks, "If I'm really bad, I can't go to the hospital". This patient might benefit, or has benefited, from online care (Psyc1).

It is worth highlighting that the online service experience was clearly perceived as different from the previous model, implying both potential and difficulties, like any other service model:

It is impossible for us to think that, in two years in which we did it in a different way, we will not incorporate some of that. (Nutri2)

A lot of things work, just as a lot of things went wrong in person. So, I think this is often linked to the complexity of the cases we handle, and not just to the method we use to achieve the results. (Nutri1)

Discussion

The first impact described by participants was a reaction of surprise and disbelief, when they realized that it was no longer possible to continue on the usual path. When COVID-19 cases began to increase exponentially in the country and non-pharmacological measures to contain the virus were enacted, including physical distancing, some common reactions could be seen across the population, such as the fear of getting sick, of losing loved ones, of having to be away from loved ones, or even the fear of transmitting the infection to acquaintances in vulnerable groups. These emotional reactions were also shared by professionals, as were negative feelings such as frustration, helplessness, irritability, anguish, and sadness (Weintraub et al., 2020).

Among healthcare professionals, these reactions may have been even more exacerbated, as reported by the group of participants in this study. At that time, faced with the unpredictable, many professionals reported having felt "paralyzed", feeling that they lacked the resources to deal with such a challenge, experiencing uncertainty, fear and insecurity. In fact, the combination of the COVID-19 pandemic with other diseases and the incidence of psychological distress generated

consequences from a socio-environmental point of view, further increasing the vulnerability of the population (Weintraub et al., 2020).

One of the most significant disruptive consequences was the disruption of care networks. Physical distancing, as a basic measure to contain the pandemic, dismantled personal support networks, restricting support from family and close friends, as well as social protection networks in the field of public policies, such as schools and access to health services (Birman, 2020; Fundação Oswaldo Cruz, 2020). Once the population's care network was weakened, experiences of suffering at an individual and collective level became enhanced, triggering stress, anxiety and feelings of impotence and helplessness in the face of an unknown and frightening threat to the continuity of life (W. A. Oliveira et al., 2020).

The sudden outbreak of a state of public calamity and the loss of the world as we knew it can lead to the emergence of what Puget (2005) calls an event. For the author, an event refers to events that exceed a given previous structure of containment and that introduce a disruptive novelty, significantly changing or breaking the world that was assumed to be ensured, in a temporality that is typical of Kairós and not of Chronos. It is a time of decision in the here and now, which introduces a fracture in the linearity of chronological time. Abrupt changes in social life and objective events with a high destabilizing potential have serious subjective consequences, since they plunge individuals into the chaos of the world's unpredictability.

Puget (2015) argues that every bond involves a quantum of unpredictability, which the author called the Principle of Uncertainty. Although present in all of us and inherent to social coexistence, we usually endure uncertainty because we have groups to which we belong that provide us with some minimum guarantees of survival, with a certain prediction of continuity (Santos, Valdanha-Ornelas, et al., 2020). In this sense, when some specific event breaks the usual chronology of existence as we knew it, imposing a cut, an inflection point in which rupture, discontinuity, the unpredictable and the feeling that we are facing an irremediable fact prevail, a traumatic situation ensues.

Trauma, according to Freud (1920/2010), occurs when an experience of high emotional intensity exceeds the psyche's capacity for metabolization and containment. Puget (2015) adds that experiences of discontinuity, such as the health crisis triggered by the new coronavirus, can mobilize a traumatic dimension at the social level, as uncertainty exceeds the group's capacity for containment, both at the intersubjective and transsubjective levels, and is unable to maintain the continuity of the sense of belonging and social protection necessary for the psychic processing of the traumatic event.

Birman (2020) argues that the discontinuity experienced, especially throughout 2020, had the potential to radically transform modes of existence and sociability, especially in their temporal dimension, reconfiguring the experience of linear and chronological historicity. In fact, in view of the results of this study, we can state that the challenges and difficulties of health workers were heightened at that time. Experiencing discontinuity and without being able to count on support from the institutional and government agents, or from the health system, which was overwhelmed and on the verge of collapse, professionals found themselves in a "leaky network", subjected to a situation of profound helplessness.

According to Laplanche and Pontalis (1998), this state of discomfort refers to the early development phase of the human newborn who is completely dependent on others to satisfy his/her basic needs and to establish the foundations of his/her subjectivity. In the adult who can count on a fully developed psychic apparatus, the state of helplessness can be experienced as a prototype of the traumatic situation, since it refers to the archaic states of tension and anguish triggered by

the loss and separation of the primary object. The feeling of helplessness becomes clear when one of the professionals says that she was unable to obtain support from her personal base network in the face of an emergency situation she experienced with a patient and that, in light of this, she realized that she would not be able to face that type of challenging situation without the support of the multidisciplinary team.

While patients found themselves deprived of their support networks, which may have been an aggravating factor for their health condition (Clark Bryan et al., 2020; Nisticò et al., 2021; Papandreou et al., 2020; Schlegl et al., 2020; Termorshuizen et al., 2020), professionals also perceived their personal networks as weakened. According to the reports obtained, group work was a pillar that proved essential to sustain resilience in the face of the helplessness to which they were subjected. For the psychic apparatus to remain intact, minimum social guarantees are required that support the continuity of the feeling of belonging and bonding work, which nurtures the conditions that allow the individual to deal with the uncertainty inherent in the encounter with otherness (Puget, 2015; Santos, Valdanha-Ornelas, et al., 2020).

From the perspective of the Psychoanalysis of Bonding Configurations, belonging can be conceptualized as a feeling and intimate conviction that we are part of a group (family, group, community or social), fueling an expectation of reciprocity based on the sharing of similar characteristics among group members and the identification of aspects that differentiate us from others, as postulated by Freud (1921/2011) with the narcissism of small differences (Nunes, 2021). Therefore, the protection produced by belonging to the group seems to have allowed professionals to not have to cling so tenaciously to their defensive mechanisms in the face of the scenario of uncertainties introduced by the pandemic. This seems to have favored the team to start working towards seeking to produce joint and innovative solutions. Participants highlighted that the pandemic showed the importance of group unity and to cultivate a cooperative spirit to maintain the continuity of care, offering another model of care to people using the service.

It was possible to notice that some participants realized, at different times, that nothing would ever be the same again, since the professionals, as individuals, and the team as a whole had been touched and transformed by the experience. Faced with the socio-humanitarian crisis, they realized that the transformations can be thought of in two ways: what they had to change in order to metabolize the stress during the crisis and, on the other hand, what these changes produced as an effect on their subjectivities, that is, what consequences the disruptive experiences had on the way they related to themselves and the world.

One of the lessons learned by participants was that, through the shared management of emotions and group work, it was possible to forge a possible way to move forward with care. According to one participant, the crisis triggered by the pandemic was different from previous crises, although it also brought potential and openings for change, since it led the team to reflect on how they would organize themselves as players and agents promoting health.

Resumption of team meetings online and the possibility of talking with other team members via messaging appears to have helped strengthen the horizontal bond between team members. With the return to in-person activities, some of the changes experienced in the previous period were incorporated into the service, such as maintaining groups on social media and using online resources for meetings when necessary. This reality followed the trend of other health services in the country and around the world (Datta et al., 2020; Davis et al., 2020; Graell et al., 2020; Plumley et al., 2021), which incorporated strategies for remote meetings between teams during the health crisis.

Another lesson learned was to have the necessary flexibility so that care could be reconfigured under the conditions prevailing at the time, since professionals had not received prior training in the use of digital platforms for care purposes. As one FG participant pointed out, the patients treated at the service have very rigid personality characteristics and difficulty in socializing and forming and maintaining a therapeutic bond (Oliveira-Cardoso & Santos, 2019; Santos, Valdanha-Ornelas, et al., 2020). Therefore, the flexible posture of professionals proved to be an essential requirement for apprenticeship because, contrary to the patients' usual way of functioning, it was able to favor relational openness and availability for dialogue and, consequently, favored the therapeutic bond (Simonds & Spokes, 2017), an essential ingredient both for treatment and for the well-being and mental health of team members (Souza & Lopes, 2022).

From a bonding, intersubjective perspective, Roussillon (2019) corroborates this idea, arguing that, given the "anorexia" of affective relationships and the fragility of patients' ability to transform and metabolize their affective-emotional experiences, the clinician needs to develop genuine contact. This contact is made possible by a Malleable Medium (the clinician himself), which can gradually favor transformations and enable access to symbolization processes.

Conclusion

This clinical-qualitative study sought to understand the meanings attributed by professionals from the team specializing in EDs to the reconfigurations implemented in the service during the first wave of COVID-19. Through data collected in sessions with focus groups with 23 professionals from a reference service, these meanings were revealed and they were divided into three thematic axes: at the beginning dominated by perplexity and paralysis in the face of uncertainty; then the time the health team reorganized itself as a group and set about the task of reinventing itself, initiating the reconfiguration of care; and finally, when it was possible to implement and calibrate technology-mediated care and learn from the new experience as it developed.

Regarding the first theme, it was possible to perceive that the excess of uncertainty and instability generated a scenario of uncertainty, in which there was the combined effect of the health crisis, the damage caused by neoliberal policies in the precariousness of the health system and the negligence of the federal government in the reckless management of the pandemic. This "perfect storm" environment generated intense perplexity and increased the level of uncertainty experienced by health professionals. The unusual situation caused suffering among professionals, as reported in the groups, configuring a *continuum* of traumatic experiences of loss and unacknowledged grief.

Healthcare professionals were exposed to extreme circumstances during the pandemic and faced challenging situations with virtually no support or clear guidelines on how to proceed, especially since the chaotic scenario of the first year of the pandemic only gradually became clearer. In this context of helplessness and *uncertainty*, the multidisciplinary team, as one of the groups to which healthcare workers belong, was able to join forces and offer the minimum guarantees necessary to come up with creative and innovative solutions to ensure the continuity of care. Healthcare is built on a network, and the network proved to be very fragile and markedly unstable. However, the team's cohesion appears to have been a promising factor that allowed hope as well as revitalization of the bonds. This provided sufficiently good conditions to rethink the care model and enhance confidence in its effectiveness.

Once the critical phase was over, the team members were able to ask themselves: what are we going to derive from this extreme experience? The professionals thought: we have lost a lot and

we still have a lot of grieving overcome, but we have also survived these two years and learned a series of skills that have made us stronger. This liminal context acted as a driving force, which drove the paradigm shift with the discovery of new ways of sharing to take care of life: our own and that of other vulnerable people.

Among the lessons learned, the participants in this study highlighted three points: 1) The essential nature of sharing and group cohesion for decision-making, providing support to cope with individual insecurities and enabling the maintenance of service; 2) It is possible to make good use of the online modality, despite its limitations, and the service was able to reinvent its practices and “change wheels while the car is moving”; 3) The importance of being flexible, realizing that impasses can admit different solutions, and that this difference can bring both difficulties and potentialities that were previously unthinkable.

Through the investigators’ interaction with the health professionals who collaborated with the research, a consistent set of data was produced and reviewed, highlighting the potential of the bonds established and reconfigured between team members, which redesigned the clinical practice developed with patients with EDs. The participants reflected on the clinical practice of EDs, articulated from their multidisciplinary practice remodeled throughout the COVID-19 pandemic crisis. In this sense, the use of the group as a dialogic context seems to have favored a relational space that allowed professionals to reflect on the changes in their practices; at the same time this was a moment of sharing and mutual recognition of the potentialities and weaknesses faced.

The findings brought to the fore the usually silenced voice of health team members. By cultivating a space for listening to the multiple experiences and feelings experienced in the processes of caregiving, the results offer support for managers and health professionals committed to strengthening the Unified Health System, helping them to improve encounters with users in caregiving in crisis situations.

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