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Research Paper

# Religious Coping Strategies in Patients With Post-traumatic Growth Due to COVID-19: A Qualitative Study

**Alireza Fazeli Mehrabadi[1*], Hadi Bahrami Ehsan[1], Seyed Hasan Adeli[2], Ali Bayat[3]**

*1. Department of Psychology, Faculty of Education and Psychology, Tehran University of Medical Sciences, Tehran, Iran.*
*2. Department of Internal Medicine, School of Medicine, Qom University of Medical Sciences, Qom, Iran.*
*3. Research Institute of Hawzah and University, Qom, Iran.*

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## ABSTRACT

**Background and Objectives:** The COVID-19 crisis has caused a wave of stress, psychological disorders and physical problems in the world, but some people experience post-traumatic growth despite these problems. The aim of this study was to explain the religious coping strategies of growth based on the experiences of patients with COVID-19.

**Methods:** A qualitative research design was conducted using content analysis method. Twenty-five participants were selected using purposive sampling and interviewed using semi-structured and in-depth interviews. Purposeful sampling was used to achieve data saturation. Data were analyzed according to the step-by-step process of Brown and Clark content analysis using MAXQDA software.

**Results:** Data analysis resulted in 386 primary codes, 18 basic themes, 11 organizing themes. Religious coping strategies of post-traumatic growth in patients with COVID-19 were: "Spiritual reflection", "Positive religious framing", "Prayer", "Religious benevolence", "Invocation", "Trusting", "Religious hope", "Religious modeling", "Religious acceptance", "Preparation for Death", and "Seeking Religious support".

**Conclusion:** Positive religious coping strategies significantly contribute to post-traumatic growth in patients with COVID-19. The findings of the present study can be used to design scales for measuring religious coping strategies, design and effectiveness of intervention programs to help COVID-19 patients to cope with disease stress and facilitate post-traumatic growth.

*** Corresponding Author:**
*Alireza Fazeli Mehrabadi, PhD Student.*
***Address:*** *Department of Psychology, Faculty of Education and Psychology, Tehran University of Medical Sciences, Tehran, Iran.*
***Phone:*** *+98 (912) 5535539*
***E-mail:*** *alifazeli.m@gmail.com*

## Introduction

Since the first patient with COVID-19 was identified in December 2019, the world has been living in an unprecedented scenario in which an acute illness spread rapidly around the world and has faced the world with numerous crises, including the physical and mental health, economic, social, and political crisis [1]. Until February 19, 2021, more than 422 million people worldwide have been infected with this disease, of which 5 894 237 people have died due to this disease. In Iran, according to official statistics to date, more than 6 million people have been definitively diagnosed with this disease, of which 134 607 of them have died [2].

In addition to posing a threat to people's physical health and lives, COVID-19 disease has caused several psychological disorders, including panic, anxiety, depression [3], and post-traumatic stress disorder [4]. Extensive prevalence of COVID-19, unpredictability, high transmission rate, multiple mutations along with 5 worrying strains under the titles of alpha, beta, gamma, and its latest strain called "Omicron" [5], acute respiratory problems in patients, lack of effective drug treatment, and ultimately mortality from this disease are the most crucial factors that severely threatens the mental health of people in the community and patients with COVID-19 [3, 6].

In addition to the negative aspects, many researchers believe that traumatic events, such as COVID-19 are not only perceived as threatening and lacking but also provide opportunities for growth and change [7, 8]. The term "Post-Traumatic Growth (PTG)" is a relatively new concept in psychology, first introduced to the literature of psychology by Tedeschi and Calhoun and, attracted much attention in the last two decades. This term was used in contrast to post-traumatic stress disorder [9].

When a person experiences a trauma or traumatic event, there may be three psychological reactions, such as surrender to the stressor (or post-traumatic stress disorder), resilience or recovery, and PTG. In resilience, individuals return to a functional baseline before a stressful event occurs, and recovery occurs, which is like pre-traumatic conditions but in PTG, individuals go beyond the previous level and grow [10]. PTG is often the result of post-conflict with major life crises. Thus, PTG means positive changes and a positive outlook arises after traumatic events [9].

One of the most important predictors of growth after trauma or psychological disorder is how to deal with the disease [11]. The concept of confrontation was proposed by Lazarus in 1966. Lazarus believes that how a person perceives and evaluates the environment determines which stimulus is stressful. He believes that what causes different emotional reactions in people is a person's assessment of the meaning of events, which includes two components of primary assessment and secondary assessment. In the primary assessment, the person encounters a potentially stressful situation and examines that situation in terms of being harmful to his health but the secondary assessment refers to the resources and facilities available to control and reduce possible harm and threat [12]. In other words, coping means individuals' cognitive and behavioral efforts to prevent, manage and reduce stress [13].

The results of various studies [14, 15] show the relationship between coping styles and PTG. In a review study on the factors that enhance PTG, the results showed that problem-oriented coping style, avoidant coping style, spiritual coping style, and positive marketing and self-care are effective factors in PTG [15]. Pratty and Petrantoni [16], in a meta-analysis of 103 studies examined the role of optimism, social support, and coping styles on PTG. Religious confrontation and positive re-evaluation had the greatest effect. Social support, spirituality, and optimism were moderately associated with PTG. In addition to general coping styles, religious coping strategies and styles are effective ways to deal with stressful situations [11].

In a religious coping, a person confronts stress, threat, or loss through religious beliefs and rituals. In this regard, Pargament [17] studied the role of religion in achieving a sense of personal control in situations where a person feels helpless and vulnerable. According to him, different styles of using religion to deal with life stresses include collaborative coping, deferring coping, self-directive coping, pleading coping, benevolent reappraisal, punishing reappraisal, demonic reappraisal, the reappraisal of God's power, spiritual discontent, interpersonal religious discontent, religious forgiving, seeking spiritual support, seeking congregational support, rites of passage and religious conversion [17].

Limited studies have examined coping strategies in COVID-19 patients, some of which had mentioned below. Studies have examined the relationship between religious coping strategies and anxiety and depression among medical personnel during the COVID-19 epidemic. The results showed that negative religious cop-

ing is associated with increased anxiety and depression. While positive religious coping plays a decisive role in reducing anxiety and depression [18].

In another study, researchers examined positive religious coping among Muslim and Christian residents in the early stages of the national response to the COVID-19 epidemic. The results showed that Muslims reported higher levels of positive religious coping compared to their Christian counterparts. Overall, positive religious coping was inversely related to having a history of mental disorders. Among the Muslim group, positive religious coping was inversely related to depressive symptoms and a history of mental disorders. The researchers concluded that positive religious coping during an outbreak of infectious diseases may help some people reduce their risk of developing depression. They suggested that national programs against COVID-19 focus on promoting positive religious coping [19].

As far as the researcher investigated, no qualitative research was found on religious coping strategies and PTG after the COVID-19 disease. Given the widespread prevalence of this disease, on the one hand, the importance of how to deal with the stress of this disease as a predisposing factor for growth or disorder on the other hand, and due to the lack of research on religious coping strategies in COVID-19 patients and PTG, it is necessary to identify religious coping strategies in patients with PTG due to COVID-19.

## Methods

The method of this research is qualitative content analysis. Sampling was non-probabilistic and purposeful. The statistical population of this study included patients with COVID-19 in Qom, Tehran, and Mazandaran Provinces, Iran. The initial selection of the subjects was done by placing notices at hospitals in Qom City, Iran and publishing them on social networks in Tehran and Mazandaran Provinces. In this step, approximately 190 subjects were selected voluntarily. In the next step, subjects were screened by completing a list, Post-Traumatic Growth Inventory (PTGI) of Tedeschi and Calhoun [20], and an initial interview to determine PTG conditions. The screening results led to the selection of 25 participants to participate in the interview. The purpose and method of the study were explained to each of the subjects and the consent of each of them was obtained by explaining the confidentiality of their personal information.

The method of data collection was a quasi-structured interview. Also, interviews were conducted in person and by telephone, each lasting from 90 to 120 minutes, depending on the subject. The interview protocol was designed based on the objectives and research questions. This protocol is based on the principles of protocol making [21] and consists of four sections, including "start text", "questions", "clues", and "final text". The first step of the interview, after stating the objectives of this study, the confidentiality of information, and obtaining the subject's consent, began with questions about the length of hospitalization, age, symptoms, the physical and mental condition of the patient, and the challenges and problems involved with the disease.

In the next step, while examining his life history and personality-psychological characteristics, he was asked, what were your religious strategies for coping with this disease? What religious methods did you use to reduce the physical and psychological stress caused by this disease? If necessary, the patient was asked to assist us in identifying the religious coping strategies of patients with PTG by further explaining or giving an example of what he or she was saying. The validity of the interview protocol was confirmed by five experts according to the objectives and research questions.

After collecting the data, Brown and Clark's step-by-step content analysis process was used to analyze them. This process consists of 6 main steps, including familiarity with data, generating initial coding, searching for themes (convert basic codes to themes), reviewing themes (which this step leads to drawing a network of themes), and defining themes (content analysis), and producing the report. According to the first step of content analysis, interviews were conducted, recorded, and implemented. After a repeated review of the data, coding began. The third stage led to the formation of themes by analyzing and finally combining different codes.

At this point, some codes were not assigned to any theme, or some codes were assigned to multiple themes. In the next step, by categorizing, combining, and summarizing the theme obtained in the previous step, the theme network was drawn. The thematic network, based on a specific process, systematizes the basic themes (codes and key points of the text), the organizing themes (obtained by combining and summarizing the basic themes), and the general themes (the principles governing the text as a whole). Then, these themes in the form of web maps show the highlights and themes of each of these three levels along with the relationships between them [22, 23].

Finally, Lincoln and Gaba's methods were used to confirm the results [24]. For this purpose, the credibility, conformability, dependability, and transferability of each data were achieved. For data reliability, the analysis results of each interview were given to the participant to confirm the accuracy of the analysis and correct it if necessary. To validate the results, the researchers tried not to interfere with their assumptions as much as possible in data collection.

To ensure the data dependability, the text of the interviews, codes, themes, and theoretical model was derived from the data, presented to 5 experts in the form of the evaluation form, and approved. For data transferability, efforts were made to ensure that participants were sufficiently diverse in terms of social status, education, and culture.

## Results

The interviewees in this study were 25 people, including 13 men and 12 women with an average age of 8 to 40 years, and the duration of their involvement with COVID-19 disease was at least 14 days to 28 days. According to Table 1, 84% of the participants were married and had a bachelor's degree or higher.

In the first stage, after writing the interviews and the initial study and re-reading of the data, word-by-word and line-by-line coding of the data resulted in 386 primary codes. In addition, similar codes were removed and merged, if necessary, resulting in 68 original codes. Among the primary codes, the order of prayer (25), appeal to Imams (AS) (23), hope in God (20), and asking for prayer from others (20) were the most abundant.

After coding, the primary codes were again compared to each other on the one hand and with the data on the other hand. The result of this step was the integration of some primary codes with each other and finally the formation of basic themes. Among the basic themes, the order of prayer with God (50), recourse to the sacred (46), spiritual hope (41), neglect (28), reliance on God (25), and social protection (24) were the most common.

After examining and controlling the compliance of the basic themes with the extracted codes, by combining the basic themes, 11 organizing themes under the headings of "spiritual reflection", "positive religious framing", "prayer", "religious benevolence", "recourse", "trust", "religious hope", "religious modeling", "religious acceptance", "ready to die", and "religious protectionism" were registered with frequencies of 30, 49, 64, 31, 46, 25, 41, 12, 12, 29 and 32, respectively. Therefore, the style of prayer, which includes two sub-themes of prayer with God and communication with the Ahl al-Bayt (AS) with 64 frequencies, had the most code. Then, positive reli-

**Table 1.** Demographic characteristics of interviewed patients with COVID-19

| Variables | | No. (%) |
|---|---|---|
| Gender | Man | 13(52.0) |
| | Female | 12(48.0) |
| Marital status | Married | 21(84.0) |
| | Single | 4(16.0) |
| Age | Younger than 40 years | 13(52.0) |
| | Older than 40 years | 12(48.0) |
| Education | Diploma and under diploma | 4(16.0) |
| | Bachelor's degree | 9(36.0) |
| | Master | 6(24.0) |
| | PhD. | 6(24.0) |
| Duration of the disease | 10 to 20 days | 14(56.0) |
| | 20 days and up | 11(44.0) |

**Table 2.** Basic codes and themes to organize themes of religious coping strategies in patients with post-traumatic growth due to COVID-19

| Row | Basic Codes | Values | Basic Themes | Organizing Themes |
|---|---|---|---|---|
| 1 | Accuracy in Quranic concepts | 5 | Religious reflection | Spiritual reflection |
| 2 | Review of religious narrations | 3 | | |
| 3 | Comparative study of related verses | 2 | | |
| 4 | Writing Quranic verses | 1 | | |
| 5 | Remembrance and recitation of the Qur'an | 3 | | |
| 6 | Contemplation on Quranic verses | 4 | | |
| 7 | Thinking about the meaning of life | 8 | Existential reflection | |
| 8 | Existential questions | 4 | | |
| 9 | Divine test | 14 | Religious meaning | Positive religious framing |
| 10 | Rewards | 2 | | |
| 11 | Forgiveness of sins | 3 | | |
| 12 | Death means joining loved ones | 2 | | |
| 13 | The reawakening | 8 | | |
| 14 | The importance of absurd issues in the past | 5 | Neglect | |
| 15 | Seeing the blessings | 6 | | |
| 16 | The greatness of God | 9 | | |
| 17 | Prayer | 25 | Prayer with God | Prayer |
| 18 | Zikr | 4 | | |
| 19 | Conversation with God | 3 | | |
| 20 | Prayers to God | 6 | | |
| 21 | Remember God | 5 | | |
| 22 | Getting energy from prayer | 2 | | |
| 23 | pray | 4 | | |
| 24 | Love of prayer | 1 | | |
| 25 | Prayers to Imams | 10 | Prayers with Ahlul Bayt | |
| 26 | Conversation with Imams | 4 | | |
| 27 | God's guidance | 4 | Belief in divine benevolence | Religious benevolent style |
| 28 | Belief in divine goodness | 8 | | |
| 29 | The best divine destiny | 5 | | |
| 30 | Belief in the divine expediency | 5 | Belief in the divine expediency | |
| 31 | Pay attention to the wisdom of God | 6 | | |
| 32 | Trust in God | 3 | | |
| 33 | Appeal to the Imams | 23 | Recourse to the sacred | Invocation style |
| 34 | Vow | 6 | | |
| 35 | Charity | 4 | | |
| 36 | Begging God | 9 | | |
| 37 | Covenant with God | 4 | | |
| 38 | Trust in God | 20 | Divine trust | Trusting style |
| 39 | Relying on God in difficult times | 2 | | |
| 40 | Belief in fate and predestination | 3 | | |

| Row | Basic Codes | Values | Basic Themes | Organizing Themes |
|---|---|---|---|---|
| 41 | Hope to God | 20 | Spirituality hope | Religiously hope style |
| 42 | Belief in God's care | 2 | | |
| 43 | Pay attention to being an observer of God | 1 | | |
| 44 | Faith in loving God | 2 | | |
| 45 | Believe in God's help | 3 | | |
| 46 | A reminder of the nearness of God | 1 | | |
| 47 | Remember the power of God | 5 | | |
| 48 | Reminders of God's kindness | 2 | | |
| 49 | Imams Help | 6 | | |
| 50 | Paying attention to the hardships of the Imams (as) | 7 | Religious models | Religious modeling style |
| 51 | Reminder of ethical points | 3 | | |
| 52 | Listening to religious sermons | 2 | | |
| 53 | Accepting God's will | 7 | Accepting God's will | Religious acceptance style |
| 54 | Acceptance of divine destinies | 5 | | |
| 55 | Belief in the Absolute Will of God | 2 | | |
| 56 | Belief in life after death | 8 | Acceptance of immortality | |
| 57 | Eternity of the Hereafter | 5 | | |
| 58 | Believe in the imminence of death | 12 | Cognitive readiness | Death preparation style |
| 59 | Belief in mortality, | 3 | | |
| 60 | No fear of death | 3 | | |
| 61 | Debt settlement | 3 | Behavioral readiness | |
| 62 | Write a will | 4 | | |
| 63 | to ask for [religious] pardon | 4 | | |
| 64 | Seeking divine support | 5 | Divine support | Religious support style |
| 65 | Grace of God | 3 | | |
| 66 | Ask for prayer from others | 20 | Social support | |
| 67 | Help from friends | 4 | | |
| 68 | Support for religious groups | 2 | | |
| Total | - | 386 | - | - |

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gious framing and recourse, each with frequencies of 49 and 46, ranked second and third among the original codes. On the other hand, religious modeling with 12 frequencies had the lowest frequency among the data. Table 2 presents basic codes, basic themes, and organizing themes.

## Discussion

This study aimed to investigate PTG coping styles based on the lived experience of patients with COVID-19 using the thematic analysis method. This study results showed that 11 religious coping strategies, such as "spiritual reflection", "positive religious framing", "prayer", "religious philanthropy", "recourse", "trust", "religious hope", "religious modeling", "religious acceptance," "preparation for death" and "religious protectionist style" are the vital styles of religious coping strategies developed by people after COVID-19.

"Spiritual reflection" occurs when a person "collects and compares verses of the Qur'an" during illness and to deal with the stress of illness, reviews the verses of the Qur'an and pays attention to the meanings of these verses. To cope with the stress caused by the illness, patients engaged in "spiritual reflection" and this "deep thinking" led to the discovery of new meanings in patients, and as a result, their stress was reduced. This result is consistent with previous research [11, 25]

that deep thinking, via deliberate rumination about the traumatic event and reflection on the past, makes sense and facilitates PTG.

"Positive religious framing" was one of the most vital coping strategies of individuals with PTG. These people used different semantic methods. Some considered illness to be "a divine test", "forgiveness of sins", "reward", and as a result, "spiritual meaning". One of the patients with PTG stated, "When I was sick, what helped me was the belief that all the hardships I am going through now, such as shortness of breath, cough, fever, and chills, and all my suffering, will be rewarded by God, and God will forgive me, so I was happy to at least do something for the hereafter."

Others considered COVID-19 as a means of "neglecting" the cause of "coming to one's senses," "seeing the greatness of God", and paying attention to the "blessings of life". This result is consistent with the parchment theory [17], in which a positive religious framework contributes significantly to individuals' adaptation by creating new meanings. Meaningful religious explanations are useful for solving problems and regulating emotions. Religious reality is the only way to give meaning to pain [26].

Among the religious coping strategies are "prayer style" and "recourse". When people are faced with a deadly and unknown disease such as COVID-19, they perform prayerful behaviors such as reciting "prayer", "remembering", "talking to God", "praying", "vow", "appealing to Imams" and they deal with "praying to God" and in this way, they achieve physical and mental peace.

Prayer is often considered the core of faith. Religious activities, especially prayer, are often considered positive adaptive tools used to solve problems and facilitate personal growth. Some psychologists consider prayer as a means of regulating human emotions. Others consider it an effective mechanism for dealing with problems. Prayer can perform problem-oriented and emotion-oriented functions [17, 26].

In the "trustworthy strategy", the patient relies on "God" and "the mainstay of the patient" is God. Of course, patients with PTG also had an active role for themselves and paid attention to medical treatments. This result is consistent with previous research that helps prevent the symptoms of low mood and uses positive religious coping strategies as an effective way to increase PTG in cancer patients.

For many patients, religious and spiritual beliefs can be a support and a unified and powerful force that provides a framework for interpreting life problems. Positive spiritual and religious confrontations due to the positive evaluation of life events can be one of the main factors in helping patients overcome psychological problems [27].

Patients in "religious hope strategy" through "belief in God's help", "belief in God's goodness", "hope in God's mercy", "reminder of God's power" and "faith with the help of the Imams", nurtured "spiritual hope" in themselves. Patients with "belief in God's guidance", "belief in divine benevolence", "attention to God's wisdom", and "belief in divine interest" had a "religiously benevolent" coping style.

Hope and benevolence were the two main elements for coping with stress and disease development in these patients. This result is consistent with previous results that patients with advanced disease had characteristics, such as optimism and hope, while patients with non-advanced cancer were pessimistic, hopeless, moody, and sad [28]. Konik [29] believes that religion has a shocking role against death anxiety because it gives hope that death is not the end.

In "religious modeling", the patient is modeled on "religious models" by "remembering and paying attention to the hardships of the Imams", "remembering moral points", and "listening to religious lectures". This result is consistent with Albert Bandura's theory on the importance of role modeling and personal efficiency in overcoming life challenges [30].

In "religious acceptance" the patient accepts the "God's will" and the "divine destiny" and even accepts the "possibility of death" and believes in "immortality after death". Researchers believe that the coping strategy of acceptance has a significant functional effect [31]. They stressed that the ability to accept situations that cannot be changed is crucial to adapting to uncontrollable or unchangeable events. Some patients with PTG are cognitively and behaviorally prepared for death after accepting death as a fact.

They reduced the death anxiety by believing in "mortality" and "imminence of death", "writing a will", "paying off debts", and "asking for forgiveness". Religious psychologists believe that faith is the crucial tool that protects man from the thought of imminent death. This supportive and beneficial work is done not only by guaranteeing life after death but also by creat-

ing value and respect for the person in this world. Extremely religious people consider death as a window to a future life that is rewarding [26, 29].

Patients with PTG due to COVID-19 used a "style of religious advocacy strategy" to cope with the stress of the illness. They actively "sought divine support." They also sought to "gain social support" by "asking for prayer from others" and "getting help from friends". Religious people with PTG were more socially supported by attending religious services. This result is consistent with previous research on the importance of seeking emotional support [32].

Researchers [33] believe that religious confrontation can have different positive consequences for people in their daily lives. Religious confrontations play a vital role in PTG by giving meaning to negative events, creating a sense of control and comfort in difficult times, strengthening social relationships via religious communities, and helping individuals make fundamental life changes. In general, the lived experience of acute illness shows the importance of beliefs, attitudes, tendencies, and spiritual support [34].

## Conclusion

Overall, the results of this study showed that patients use various religious coping strategies during illness, which leads to PTG. This study, in line with other empirical studies, highlights the importance of spiritual coping strategies in helping individuals maintain and enhance mental health in times of crisis. Spiritual confrontations are a distinctive resource for people facing crucial challenges and critical situations. It is necessary for the health system and policymakers in this field to use religion and spirituality as effective and empirically supported factors not only to deal with the stress of the disease but also for growth and development after health crises, such as the COVID-19 epidemic. And at various levels of society, including physicians, nurses, health professionals, and the public, they use scientific data and cultural and media tools to educate and promote effective spiritual and religious confrontation. Also, it is suggested that the study's results be used to design scales to measure religious coping strategies, and design and effectiveness of intervention programs to help COVID-19 patients cope with the stress of the disease and facilitate PTG.

### Research limitations

Considering that this study was conducted with a qualitative method and non-probabilistic sampling only in three cities of Tehran, Qom, and Mazandaran and with a small volume, it is suggested that future research be randomly conducted with a wider statistical population.

## Ethical Considerations

### Compliance with ethical guidelines

Observance of ethical instructions of this research has been approved by the Research Ethics Committee of the Tehran University of Medical Sciences (IR.UT.PSYEDU.REC.2020.002).

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### Authors' contributions

Supervision and Methodology: Hadi Bahrami Ehsan; Conceptualization and Writing-original draft: Alireza Fazeli Mehrabadi; Investigation, and Writing-review & editing: All authors; Data collection: Alireza Fazeli Mehrabadi and Seyed Hasan Adeli; Data analysis: Alireza Fazeli Mehrabadi and Ali Bayat.

### Conflict of interest

The authors declared no conflict of interest.

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### References

[1] Pirutinsky S, Cherniak AD, Rosmarin DH. COVID-19, mental health, and religious coping among American orthodox jews. J Relig Health. 2020; 59(5):2288-301. [DOI:10.1007/s10943-020-01070-z]] [PMID] [PMCID]

[2] No author. Coronavirus cases [Internet] 2022. [Cited 2022 Sep 12]. Available from: [Link]

[3] Luo M, Guo L, Yu M, Jiang W, Wang H. The psychological and mental impact of coronavirus disease 2019 (COV-

ID-19) on medical staff and general public - A systematic review and meta-analysis. Psychiatry Res. 2020; 291:113190. [DOI:10.1016/j.psychres.2020.113190] [PMID] [PMCID]

[4] Qiu J, Shen B, Zhao M, Wang Z, Xie B, Xu Y. A nationwide survey of psychological distress among Chinese people in the COVID-19 epidemic: Implications and policy recommendations. Gen Psychiat. 2020; 33(2):e100213. [DOI:10.1136/gpsych-2020-100213] [PMID] [PMCID]

[5] Karim SS, Karim QA. Omicron SARS-CoV-2 variant: A new chapter in the COVID-19 pandemic. Lancet. 2021; 398(10317):2126-8. [DOI:10.1016/S0140-6736(21)02758-6] [PMID] [PMCID]

[6] Bo HX, Li W, Yang Y, Wang Y, Zhang Q, Cheung T, et al. Posttraumatic stress symptoms and attitude toward crisis mental health services among clinically stable patients with COVID-19 in China. Psychol Med. 2021; 51(6):1052-3. [DOI:10.1017/S0033291720000999] [PMID] [PMCID]

[7] Ikizer G, Karanci AN, Gul E, Dilekler I. Post-traumatic stress, growth, and depreciation during the COVID-19 pandemic: Evidence from Turkey. Eur J Psychotraumatol. 2021; 12(1):1872966. [DOI:10.1080/20008198.2021.1872966] [PMID] [PMCID]

[8] Cordova MJ, Riba MB, Spiegel D. Post-traumatic stress disorder and cancer. Lancet Psychiatry. 2017; 4(4):330-8. [DOI:10.1016/S2215-0366(17)30014-7]

[9] Jayawickreme E, Blackie LE. Exploring the psychological benefits of hardship: A critical reassessment of posttraumatic growth. Cham: Springer; 2016. [DOI:10.1007/978-3-319-47989-7]

[10] Hefferon K, Boniwell I. Positive psychology: Theory, research and applications. New York: McGraw-Hill Education; 2011. [Link]

[11] Tedeschi RG, Shakespeare-Finch J, Taku K, Calhoun LG. Posttraumatic growth: Theory, research, and applications. New York: Routledge; 2018. [DOI:10.4324/9781315527451]

[12] Lazarus RS, Folkman S. Stress, appraisal, and coping. New York: Springer; 1984. [Link]

[13] Tamres LK, Janicki D, Helgeson VS. Sex differences in coping behavior: A meta-analytic review and an examination of relative coping. Personal Social Psychol Rev. 2002; 6(1):2-30. [DOI:10.1207%2FS15327957PSPR0601_1]

[14] Cao W, Qi X, Cai DA, Han X. Modeling posttraumatic growth among cancer patients: The roles of social support, appraisals, and adaptive coping. Psychooncology. 2018; 27(1):208-15. [DOI:10.1002/pon.4395] [PMID]

[15] Henson C, Truchot D, Canevello A. What promotes post traumatic growth? A systematic review. Eur J Trauma Dissociation. 2021; 5(4):100195. [DOI:10.1016/j.ejtd.2020.100195]

[16] Prati G, Pietrantoni L. Optimism, social support, and coping strategies as factors contributing to posttraumatic growth: A meta-analysis. J Loss Trauma. 2009; 14(5):364-88. [DOI:10.1080/15325020902724271]

[17] Koenig HG. Handbook of religion and mental health. Elsevier; 1998. [DOI:10.1016/B978-012417645-4/50075-4]

[18] Chow SK, Francis B, Ng YH, Naim N, Beh HC, Ariffin MAA, et al. Religious coping, depression and anxiety among healthcare workers during the COVID-19 pandemic: A Malaysian perspective. Healthcare (Basel). 2021; 9(1):79. [DOI:10.3390/healthcare9010079] [PMID] [PMCID]

[19] Thomas J, Barbato M. Positive religious coping and mental health among Christians and Muslims in response to the COVID-19 pandemic. Religions. 2020; 11(10). [DOI:10.3390/rel11100498]

[20] Tedeschi RG, Calhoun LG. The posttraumatic growth inventory: Measuring the positive legacy of trauma. J Trauma Stress. 1996; 9(3):455-71. [DOI:10.1007/BF02103658] [PMID]

[21] Baniasadi A, Salehi K. [Introduction on the principles and process of construction and validation of the interview protocol (Persian)]. High Educ Lett. 2019; 12(46):177-203. [Link]

[22] Braun V, Clarke V. Using thematic analysis in psychology. Qual Res Psychol. 2006; 3(2):77-101. [DOI:10.1191/1478088706qp063oa]

[23] Abedi Ja'fari H, Taslimi MS, Faghihi A, Sheikhzade M. [Thematic analysis and thematic networks: A simple and efficient method for exploring patterns embedded in qualitative data municipalities (Persian)]. Strateg Manag Thought. 2011; 5(2):151-98. [DOI:10.30497/smt.2011.163]

[24] Tedley C. Basics of mixed research: Combining quantitative and qualitative approaches [Azar A, Jahanian S, Persian trans]. Tehran: Jahad Daneshghahi. 2016. [Link]

[25] Morris BA, Shakespeare-Finch J. Rumination, post-traumatic growth, and distress: Structural equation modelling with cancer survivors. Psychooncol. 2011; 20(11):1176-83. [1176-1183. [DOI:10.1002/pon.1827] [PMID]

[26] Hood Jr RW, Hill PC, Spilka B. The psychology of religion: An empirical approach. New York: Guilford Publications; 2018. [Link]

[27] Sarizadeh M, Heydarzadeh M, Ghahramanzadeh M. [A survey on posttraumatic growth on the basis of demoralization syndrome and religious coping among cancer patients referring to Reza radiotherapy and oncology center in Mashhad in 2018: A descriptive study (Persian)]. J Rafsanjan Univ Med Sci. 2019; 18(6):557-72. [Link]

[28] Fazel M, Salimi BH, Farahbakhsh K, Esmaeili M. Post traumatic growth model in cancer patients: A grounded theory study. Counsel Culture Psycotherap. 2017; 8(29):79-105. [DOI:10.22054/qccpc.2017.17946.1422]

[29] Cohen AB, Pierce Jr JD, Chambers J, Meade R, Gorvine BJ, Koenig HG. Intrinsic and extrinsic religiosity, belief in the afterlife, death anxiety, and life satisfaction in young Catholics and Protestants. Journal of research in personality. 2005; 39(3):307-24. [DOI:10.1016/j.jrp.2004.02.005]

[30] Castillo FA, Sarmiento PJ. A systematic review on spiritual modeling: Opportunities and challenges in religious education. Int J Christian Educ. 2022; 26(1):6-17. [DOI:10.1177/20569971211038968]

[31] Zoellner T, Maercker A. Posttraumatic growth in clinical psychology: A critical review and introduction of a two component model. Clin Psychol Rev. 2006; 26(5):626-53. [DOI:10.1016/j.cpr.2006.01.008] [PMID]

[32] Hays K, Lincoln KD. Mental health help-seeking profiles among African Americans: Exploring the influence of reli-

gion. Race Soc Problems. 2017; 9(2):127-38. [DOI:10.1007/s12552-017-9193-1]

[33] Pargament KI, Koenig HG, Perez LM. The many methods of religious coping: Development and initial validation of the RCOPE. J Clin Psychol. 2000; 56(4):519-43. [DOI:10.1002/(sici)1097-4679(200004)56:4<519::aid-jclp6>3.0.co;2-1] [PMID]

[34] Momenifar S, Habibi Asgarabad M, Abbasi M. Explanation of the spiritual experiences of breast cancer patients: A hermeneutic phenomenological study. Health Spiritual Med Ethics. 2020; 7(2):9-19. [DOI:10.29252/jhsme.7.2.9]