Religious Coping in Iranian Mothers of Children With Cancer: A Qualitative Content Analysis

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Abstract

Objective: Religious coping is one of the most frequently used coping methods in parents of children with cancer. This study aims to explain dimensions of religious coping in mothers of children with cancer in Iran. Methods: In this qualitative content analysis, using purposeful sampling, 8 mothers of children with cancer were selected and interviewed. When saturation was achieved, data were analyzed through directed content analysis. Primary and secondary codes were placed in prelabeled categories and subcategories based on Pargament’s religious coping theory. Results: The participants of the study used coping methods in 4 of the 5 objectives of religious coping, that are meaning, control, comfort, and intimacy with others and closeness to God. Three of the most frequent used coping methods by the participants were “Punishing God Reappraisal,” “Pleading for Direct Intercession,” and “Benevolent Religious Reappraisal,” respectively. None of the participants used religious coping methods for its function of “life transformation.” Conclusions: As suggested by Pargament’s theory of religious coping, the dynamic, multidimensional process of religious coping has a culture-based pattern with unpredictable outcomes. Despite many similarities between religious coping in a Shia Muslim society and other studied ones, some differences are observed. Further studies are needed to show the potential evidence of the concept in relation to cultural diversity and religious differences.

Keywords

mothers, cancer, coping, children, religion, Iran

Introduction

The incidence of cancer in children is estimated about 100 per million children. In Iran, it is 48 to 112 and 51 to 144 per million among girls and boys, respectively (Fathi, Bahadoram, & Amani, 2015). Childhood cancer is one of the most challenging diseases for children and their families (Nikfarid, Rassouli, Borimnejad, & Alavimajd, 2017; Santos, Crespo, Canavarro, Alderfer, & Kazak, 2016). During the process of childhood cancer, the family is at risk for developing psychological and psychiatric problems (Sardi-Brown, Kupst, Brown, & Wiener, 2017; Van Schoors et al., 2016). The emotional challenges of caring for their child, disruptions in daily routines and financial issues are some of the stressors that parents of children with cancer encounter (Compas et al., 2015). In Iran, mothers are the main caregivers of children, and studies show they suffer from many psychological health problems dealing with cancer in their children (Safarabadi-Farahani, Maarefvand, Biglarian, & Khubchandani, 2016; Shamsi, Forouzi, & Iranmanesh, 2016; Taleghani, Fathizadeh, & Naseri, 2012). Some of these problems include uncertainty, depression, anxiety, and chronic sorrow (Nemati, Rassouli, & Baghestani, 2017; Nikfarid, Rassouli, Borimnejad, & Alavimajd, 2015; Nikseresht et al., 2016). A number of coping strategies are used by parents to adapt to the situation (Nemati et al., 2017; Santos et al., 2016). Their ability to cope with their child’s cancer and its challenges affects their child’s quality of life (Nikseresht et al., 2016; Pierce et al., 2016). In addition, the way parents chose to adjust to their child’s cancer diagnosis influences the coping process of the child (Compas et al., 2014).

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Coping is a behavioral and cognitive effort to decrease distress, discomfort, and suffering experienced by people when dealing with a stressful life event (Patterson, Holm, & Gurney, 2004). Some conceptual models have been developed to describe the concept of coping. In the theory of cognitive appraisal, Lazarus and Folkman (1984) attribute 2 approaches for managing stressful events, which are problem-focused and emotion-focused. Emotion-focused approaches are one’s attempts to regulate emotional consequences of a stressful event to maintain emotional stability. Through problem-focused approaches, people try to constructively change or eliminate the source of stress (Nepp, Beyebach, Nuñez, & Martinez-González, 2016). Furthermore, many emotion-focused and problem-focused coping strategies or mechanisms used by people have been described since the introduction of this theory (Pargament & Raiya, 2007).

One of the most frequently used coping methods by Iranian parents of children with cancer is religious coping (Borjalilu, Shahidi, Mazaheri, & Hossein, 2016; Khanjari, Seyedfatemi, Borji, & Haghani, 2014; Nikseresht et al., 2016; Pirbodaghi, Rasouli, Ilkhani, & Alavimajd, 2016). Religious coping is described as the way people cope with trauma, adversities, or stressful/scary events through the comfort found in religious or spiritual practices (Xu, 2016). Conventionally, religious coping has been classified as a passive and emotion-focused form of coping (Cardella & Friedlander, 2004). Pargament (2001) in his theory of religious coping, criticized the current approach regarding religion in the field of health and psychology. He argued that just religious affiliation and religiosity (the intensity of involvement in religion, its practices and behaviors like visiting religious places, etc) are insufficient to explain the concept of religious coping and its role in life tragedies of people. In addition, he believes that the body of knowledge has largely overlooked potentially negative forms of religion and spirituality. However, one such aspect of religion, namely religious struggle, has begun to receive significant attention in the literature (Exline, Hall, Pargament, & Harriott, 2016). He proposed to view the concept as an active coping method used by a person in reaction to a stressful event (Park, Holt, Le, Christie, & Williams, 2017). Subsequently, religious coping can be seen as a multimodal (behavioral, emotional, and cognitive), dynamic (constantly changing over time based on circumstances and context), and ambiguous process which will lead to positive or negative outcomes on mental health (Abu-Raiya, Pargament, & Krause, 2016). He attributed 5 functions or objectives to religious coping. These functions are ”meaning,” “control,” “intimacy with others and closeness to God,” “comfort,” and “life transformation.” He then classified methods of religious coping based on these functions (Pargament & Raiya, 2007). For example, “Benevolent religious reappraisal,” “Punishing God reappraisal,” and “Demonic reappraisal” are of methods categorized under the group of those with the function of search for “meaning.” Based on relevant evidence, Pargament determined possible negative and positive outcomes for some of coping methods. For instance, people who use the method of “Punishing God reappraisal” more likely develop depression or anxiety. Many studies have been done based on this theory but variables related to this multidimensional concept need to be examined more extensively (Pargament, 2001; Pargament, Feuille, & Burdzy, 2011; Pargament & Raiya, 2007). Culture is one of the variables that may affect the process of religious coping (Harrison, Koenig, Hays, Eme-Akwari, & Pargament, 2001). Most of the studies have been conducted on Christian or Jewish people of Western countries (Ano & Vasconcelles, 2005). Studies examining the effect and outcomes of ethnic, religious affiliation, and religiosity as well as the religious coping methods used on the mental health of patients and their caregivers in Muslims have shown different patterns (Abu-Raiya, Exline, Pargament, & Agbaria, 2015). For example, in one such a study, the conclusion was made that Muslims react more socially (ie, seeking social support and external information) than Christians or are more accepting of death, which greatly affects the way a patient and his family view cancer and death (Fischer, Ai, Aydin, Frey, & Haslam, 2010).

Cultural differences can have an effect on the process of religious coping. The type of religion might be another variable. In Iran, the main religion is Shia Islam (one of the 2 denominations of Islam). Most of the studies on Muslims religious coping were done on Sunni Islam populations. In addition, studies that mentioned religious coping in mothers of children with cancer in Iran (Borjalilu, Shahidi, Mazaheri, & Emami, 2016; Hekmatpou, Eghbali, & Memari, 2013; Khanjari et al., 2014) did not use Pargament’s theory. They only consider it as one of the positive coping methods with good results on health. This approach cannot provide a complete explanation for this complicated concept (Hashemi, Razavi, Sharir, & Shahriari, 2007; Khanjari et al., 2014; Taleghani et al., 2012). Therefore, this study was conducted to explain dimensions of religious coping in mothers of children with cancer in Iran to help health care providers deliver more specific care regarding mothers’ coping process. The theoretical framework of the study was Pargament’s theory, and the results of the study can provide more information about the role of the culture and type of religion on religious coping.

**Method**

**Design**

A directed qualitative content analysis design was used to explain religious coping in mothers of children with cancer with the use of coding and extraction of
categories and subcategories from accumulated data (Wildemuth, 2016).

Participants and Setting

Participants consisted of mothers of children with cancer under treatment in 3 pediatric hospitals in Tehran. The inclusion criteria consisted of Persian speaking mothers who are Shia Muslim, have a child with diagnosis of any kind of childhood cancer for at least 6 months according to their oncologist. The mothers with psychiatric diseases, having a child in end stage of the disease and those whose child had another health problem like a chronic disease or disability in addition to cancer were excluded.

Procedure

The participants were selected through purposive sampling. The present study was a part of a mixed methods study that aimed to explain the concept of chronic sorrow in mothers of children with cancer. In the first quantitative part of the study, 264 mothers of children with cancer from 3 tertiary specialized children hospitals in Tehran with oncology wards filled out the validated Persian version of the Kendal Chronic Sorrow Instrument (KCSI). For this qualitative study, we recruited participants of the quantitative part with maximum and minimum score of KCSI to include participants with high and low sorrow based on the scores of this instrument, with this preposition that they have different levels of coping. In addition, to have a more heterogeneous group of participants, others were selected based on their age, education, number of children, and marital state. This could help us explore the religious coping in women with different characteristics, which could in turn help us achieve richer information. The first author collected data through individualized, face-to-face, deep, and semistructured interview. Data saturation generally occurred with 6 interviews, but 2 further interviews were done. Interviews began with some predetermined general open-ended questions such as “how did you cope with the situation of having a child with cancer?” and continued with probing questions to explore the main concept of the study, that is, “How do you see your religiosity after the disease happened for your child?”, “How does your approach to religion affect your feelings?” The interviews were done in hospitals, lasted between 45 and 60 minutes, and were recorded. The researcher also wrote field note memos during the interviews and during her occupation in the wards, to observe emotional expressions of the participants like crying and sigh during interview, and their communication with the child, other mothers, and nurses. The authors held several sessions to reach a consensus about themes and subthemes. Two external experts in qualitative research, determined by the university as supervisors of the project, constantly evaluated the data analysis process.

Data Analysis

A manual method and a template analysis style were used to organize and manage qualitative data. The researchers listened to the interviews. To achieve a general insight about the entire text, the transcripts were reviewed several times. Primary codes were underlined, then according to their similarities sorted. Using constant comparison, the research team continued coding, and then classified them to secondary codes. According to comparison of the primary codes with characteristics described in Pargament’s theory for each coping method, they were named as a secondary code and placed in prelabeled subcategories. The constant comparison process ensured proper placement of secondary codes in subcategories. Five prelabeled categories were Pargament’s religious coping objectives/functions (Xu, 2016). So secondary codes were also placed in categories based on what they aimed to: to find a supernatural meaning for what has happened (Meaning); to gain a sense of control over the situation (Control); to decrease emotional burden and give a sense of calm (Comfort); to feel a closeness to others and God (Intimacy With Others and Closeness to God); or to achieve a transformational state in life after the stressful event (Life Transformation).

Based on Lincoln and Guba’s (1985) criteria, the methods used to ensure accuracy and rigor of the data include the following: prolonged involvement with the concept of the study and the participants, attempted to create a relationship of trust with the participants, continuous analysis of the data, kept precise records, and constantly reported the process of collection and analysis of the data to the supervisors determined by the university (Morrow, 2005).

Ethical Considerations

This study was part of a nursing PhD dissertation of the first author, approved by the ethics committee of Shahid Beheshti University of Medical Sciences. All participants signed the written informed consent for the objectives of the study, the right of deliberate participation, and confidentiality of the information before participating in the study.

Results

The participants included 8 mothers, aged 24 to 48 years. Table 1 provides demographic characteristics of the participant.

In directed qualitative content analysis, the data analysis resulted in 148 primary codes and 37 secondary codes.
According to Pargament’s defining characteristics for each coping method, secondary codes belonged to 11 of 21 preset “religious coping methods” subcategories and 5 “religious coping objectives/functions” categories. These categories and related subcategories, secondary codes, and possible positive or negative outcome related to health situation proposed by Pargament, are shown in Table 2. Based on the religious coping theory, the participants of the study used coping methods in 4 of the 5 objectives of religious coping, that are meaning, control, comfort, and intimacy with others and closeness to God.

**Meaning**

All the participants looked to their religion to seek answers about the causation of the adversity. They believed that the disease of their child was a retribution for their transgressions and sins, a trial for testing their faith, or something unquestionable given by God. All the participants had noticed changes in their relationship with God. They referred to religious phrases, Quran (the holy book of Muslims) verses, and popular religious allegories prevalent between people in order to explain the reason for what had happened to them. They questioned why God had chosen them for such a tragedy and how they can learn the real reason. “Punishing God Reappraisal” was the most frequently used religious coping method of the mothers in the study.

Participant No. 7 while crying said, “I sleep every night with the hope to dream of someone who will tell me what the sin was for which I have to be punished like this.” The same participant also said, “I see others who do the same sins, so why am I the only one who is punished?”

On the other hand, most of the participants think of the disease of their child as instigation to get close to God or as a test for their faith. Almost all of the participants pointed out that the disease is something of which only God knows why it happens. Participant No. 3 said, “I suffer too much but I know that it is something that God willed to me and I should not say why. It is for my benefit. Maybe I should get closer to God.” Pargament called this approach “Benevolent Religious Reappraisal.” This approach is relatively frequent in some more favorable stages of the process of the disease by all participants, such as remission of the disease.

**Control**

Despite their religious fear and self-blame, all the participants had a sense of hope and faith. Some of the participants attributed success in the management of the disease to their own religious practices. “Active religious surrender” and “pleading for direct intercession” were the 2 coping methods the participants used to gain control over the situation. Most of the participants emphasized that they do what they should, but they depend and rely on God for the results in every stage of the process of the disease.
### Table 2. Categories (Religious Coping Objectives/Functions), Subcategories (Religious Coping Methods), Secondary codes, and Possible Outcomes Based on Directed Content Analysis of the Data of the Study.

<table>
<thead>
<tr>
<th>Directed Content Analysis</th>
<th>Categories/Religious Coping Objectives or Functions</th>
<th>Subcategories/Religious Coping Methods</th>
<th>Secondary Codes</th>
<th>Possible Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Meaning</strong></td>
<td>Benevolent religious reappraisal</td>
<td>• Disease is for our closeness</td>
<td>Positive</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>• Suffering as an opportunity to get close to God</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>• He knows something we do not</td>
<td></td>
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<td></td>
<td></td>
<td>• Seeing good result in treatment because of prays</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>• The disease is a trial</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Punishing God reappraisal</td>
<td>• God’s wrath in lack of worship and religious rituals</td>
<td>Negative</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>• Worsening the situation in lack of worship and religious rituals</td>
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<td>• God’s ignorance in lack of worship and religious rituals</td>
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<tr>
<td></td>
<td>• God’s pertinence in lack of worship and religious rituals</td>
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<td></td>
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<tr>
<td></td>
<td>• Disease of the child as an atonement</td>
<td></td>
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<td></td>
</tr>
<tr>
<td></td>
<td>• Disease of the child as a result of sins</td>
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<tr>
<td></td>
<td>• Fear of consequences of unthankfulness</td>
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</tr>
<tr>
<td></td>
<td>• Constant question from God about why I suppose to suffer more than others</td>
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<tr>
<td></td>
<td>• Fear of asking why from God</td>
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<tr>
<td></td>
<td>• Avoiding negative feeling regarding God as they came from devil</td>
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<tr>
<td></td>
<td>• Hopelessness is a sin</td>
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Demonic reappraisal  
Reappraisal of God’s powers

**Control**

Collaborative religious coping  
Active religious surrender  
Passive religious deferral  
Pleading for direct intercession  

|                | I do my responsibility then I seek help of God | No applicable
<table>
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<th></th>
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<tbody>
<tr>
<td></td>
<td>Invocation</td>
<td>No applicable</td>
</tr>
<tr>
<td></td>
<td>Calling Imams in hard moments</td>
<td>No applicable</td>
</tr>
<tr>
<td></td>
<td>More engagement in religious rituals</td>
<td>No applicable</td>
</tr>
<tr>
<td></td>
<td>Going to religious places more frequently than before</td>
<td>No applicable</td>
</tr>
<tr>
<td></td>
<td>Vow and votive</td>
<td>No applicable</td>
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<tr>
<td></td>
<td>Reading Quran verses during treatment and hard moments of the disease</td>
<td>No applicable</td>
</tr>
</tbody>
</table>

Self-directing religious coping

**Comfort**

Seeking spiritual support  
Religious focus  
Religious purification  
Spiritual connection  
Spiritual discontent  
Marking religious boundaries

|                | Hope and trust to God                         | No applicable
<table>
<thead>
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<tbody>
<tr>
<td></td>
<td>Ask forgiveness</td>
<td>No applicable</td>
</tr>
<tr>
<td></td>
<td>Trying to avoid sins</td>
<td>No applicable</td>
</tr>
<tr>
<td></td>
<td>Trying to get closer to God</td>
<td>No applicable</td>
</tr>
<tr>
<td></td>
<td>Feel religiously close to other mothers of children with cancer</td>
<td>No applicable</td>
</tr>
<tr>
<td></td>
<td>Felt angry on God</td>
<td>No applicable</td>
</tr>
<tr>
<td></td>
<td>Felt being abundant</td>
<td>No applicable</td>
</tr>
</tbody>
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(continued)
Participant No. 1 said,

Doctors told me she is not doing so well and God is your only hope. I called to the Imams (Muslim’s clergymen) from the depth of my heart. I said “please give my peace back. Please heal her.” This calmed me. My daughter got better as well. I don’t know, but these spiritual connections are very helpful.

“Pleading for Direct Intercession,” the second most frequently used method, means to achieve God’s attention through activities such as vowing, reading Quran (Muslim’s holy book), attending religious social rituals, going to clergymen’s mausoleums, and worship.

**Comfort**

All the participants indicated that their faith has been the most important source of calm and peace. They emphasized that despite their feelings of anger toward God, when they felt hopeless, they only wanted to pray and call God, which these behaviors are classified as “active religious surrender.” Some of the participants tried to avoid sins and ask forgiveness in order to avoid a development for the worse. They emphasized their intensification of attendance to religious rituals especially in the early stages of the disease. This “Pleading for Direct Intercession” was another method with many secondary codes.

Participant No. 3 said,

Even though I was devastated, I prayed more than before, I cried, I shouted at God, I adjured him (crying), it was as if only this way I can feel well. When I am extremely upset, I immediately start praying. I try to remember my sins and ask him to forgive me.

The participants also experienced a kind of spiritual connection with others and felt more under control with the situation. For example, when one of them went to a religious ritual she would text the others to inform them that she is naming their children as well to ask a cure for them from the Imams (Muslims’ clergymen) or God. On the other hand, it was inevitable that the researchers would witness “Spiritual Discontent” in very tough moments of the disease especially in the phase of the diagnosis.

**Intimacy With Others and Closeness to God**

All of the participants had experienced the need to ask help from religious sources. They read the Quran (the holy book of Muslims) in order to feel close to God and to feel supported by him. Most of the participants emphasized that they preferred to seek support from religious people as this gave them a sense of trust and assurance. It was usual for them to ask others to pray in a religious group for their child. All of the participants had the experience of resorting to clergymen in the diagnosis phase of the disease, to seek emotional support, explanations, and comfort, which show “Seeking Support from Clergy or Members” behaviors based on Pargament’s theory. It seems that they formed an informal social network in the hospital, and the network’s most frequently used function was to provide religion-based support for each other. Pargament called these behaviors as “Religious Helping.”

Participant No. 5 said,

Only we can understand each other, no one else. I pray for her child when they have to do a bone marrow biopsy. If a child in the ward dies, only one of us can calm the mother, and pray for her. When I go to Mashhad (a holy city in Iran),
I ask a cure from Imam Reza (the grandson of Mohammad who is the messenger of Muslims), for all of them. I name all children, one by one.

Besides the above, some of the participants had found it confusing and disturbing to talk with the clergymen. This was mainly because the clergymen advise mothers to be patient and accept what God has given to them. The participants were referred to some of the religious verses that did not really help them find a clear answer to their questions. Pargament named this as “Interpersonal Religious Discontent.”

Discussion

Religious coping is a frequently used coping strategy by the Muslim parents of children with cancer (Abu-Saad Huijer, Abi Abdallah Doumit, & Naifeh Khoury, 2013; Khoury, Huijer, & Doumit, 2013; Taleghani et al., 2012). The present study explains dimensions of religious coping in mothers of children with cancer in Iran. The results were congruent with other studies that consider religious coping a multidimensional and dynamic process, with unpredictable outcomes (Pargament et al., 2011). Mothers of children with cancer use religious coping as a way to find meaning for their misfortune, to place an external locus of control on the situation, and to gain comfort and intimacy. The patterns may look similar to those explained in other studies (Cardella & Friedlander, 2004; Goldbeck, 2001), though it is necessary to consider cultural issues in explaining underlying factors and causation of the outcomes.

To seek a meaning for stressful events of life is one of the objectives of religious coping. This helps people make sense of their situation in the world (Pargament & Brant, 1998). Religious coping always has been seen related to positive effect on mental health (Hekmatpou et al., 2013), while the results of this study indicate a just support for some other literature, which argues persons do not always see God as a loving and supporting source (Bearon & Koenig, 1990; Pargament, 2001; Pargament & Brant, 1998). Threatening diseases can profoundly target the religious belief system of people and lead to a religious struggle of the person involved (King et al., 2015). Religious struggle means tensions, questions, and doubt about God’s mercy and love, or considering the event as a punishment for sins (Bearon & Koenig, 1990). It has been discussed that religious struggle is a significant predictor for negative outcomes of religious coping; however, there is little knowledge about associated factors (King et al., 2015). In the present study, the feeling that God was punishing them was a dominant attitude in some of the participants. This result is not congruent with the results of other studies in Iran on cancer experiences in adult patients, who concluded that God is more likely a source of support and move toward transcendence (Heidarzadeh et al., 2014; Janbabaei, Esmaeili, Mosavinasab, & Rajbar, 2014; Mehrabi, Hajian, Simbar, & Hoshiyari, 2016; Zamanzadeh et al., 2014). Neither of the studies points out Pargament’s theory of religious coping and its division of positive and negative strategies. So, in the aforementioned studies, any religious approach of participants is categorized as positive and a way of growth. However, the use of some religious coping strategies like “Redefining God’s power to influence the stressful situation” and “pleading to God for a miracle” are known as being related to more negative outcomes on mental health (Abu-Raiya et al., 2015; Pargament, 2001).

On the other hand, the results of the current study support evidence on Muslims in other cultures, indicating that they see God more punishing than Christians do (Abu-Raiya et al., 2015). Pargament theorized that the way people chose to cope, depends on their psycho-socio-cultural context (Pargament, 2001). According to Abu Raiya et al., people use religious coping methods that are acceptable in their culture. So, if a punishing God is a phrase mentioned in Quran (the holy book of Muslims), it is an acceptable idea. Thus, Muslims use it rather than denying God or seeing things sent from an evil source (Abu-Raiya et al., 2015). This is supported with the current study, and none of the participants used methods that imply denying God or giving control to an evil source or any other source of metaphysical power.

This study supports other studies that show Muslims believe in “supernatural causes of diseases” (Arabiat, Al Jabery, Abdelkader, & Mahadeen, 2013; Bahakim, 1987; Hekmatpou et al., 2013; Silbermann & Hassan, 2011). In a phenomenological study to explain the experiences of Iranian parents of children with Leukemia, reliance to God was one of the subthemes. The participants in that study pointed out that they entrusted everything to God (Hekmatpou et al., 2013). There is evidence that collaborative and self-directing religious coping methods are more likely to have a favorable outcome in dealing with negative life events (Pargament & Brant, 1998). Nevertheless, Pargament believes that “pleading direct intercession,” both as an active and passive method, can be favorable in uncontrollable situations. Seeking divine help in uncontrollable events can reduce despair (Pargament, 2001). Overall, the participants of the current study used more passive religious coping methods in the stages of the disease when the situation seemed desperate. Consequently, they used self-directed methods more frequently in the stable phases of the disease. This is consistent with other studies that suggest people do not use only a single religious coping method (Greening & Stoppelbein, 2007). The evidence shows some relationship between whether people chose to be passive or active...
in stressful events and their personality and situation differences. For example, gender is an important factor and women are more likely to use passive ways of coping (Hoekstra-Weebers, Jaspers, Kamps, & Klip, 1998; Houtzager et al., 2004). Type and stage of cancer are also factors that have a distinct effect on the type of coping methods used by parents (Norberg, Lindblad, & Boman, 2005). From another perspective, religious affiliation and culture should also be considered. Based on the fatalistic approach of Muslims to God, they believe he is in control and that they have to accept his will because he always foreordains the best for everyone. This is supported by other studies on Islamic populations (Gaillard & Texier, 2010; Harandy et al., 2009). Moreover, in Iranian culture, people use some phrases of the Quran in everyday life, encouraging the idea that “God is in control.” For instance, it is always said, “Not even one leave will fall off a tree without the permission of God” (al-An’âm 6:59).

The results of the current study are congruent with other studies that show that parents of children with cancer use religious coping methods to modify their anxiety, and comfort themselves and others involved in the situation (Hexem, Mollen, Carroll, Lancot, & Feudtner, 2011). Prayer, personal and group worshipping, and frequenting social religious places are described in researches as effective methods of achieving a sense of calm and comfort (Schneider & Mannell, 2006). In the current study, some other methods, such as avoiding sins, feeling religiously close to other mothers of children with cancer, and trusting God, were the approaches frequently mentioned by the participants to calm them. One of the most comforting ways was to visit the mausoleums of the eighth and third Shia Muslim’s clergymen in Mashhad (a holy city for Muslims in Iran) and Karbala (a holy city for Muslims in Iraq). This, in addition to sharing votive food in religious days, is of the most frequently used methods that give comfort by Iranians who experience adversity and stress in life (Hekmatpou et al., 2013; Jalali, Nasiri, & Abedi, 2015; Seyed, Rezaei, Givari, & Hosseini, 2006). According to such results, some scholars categorize religious coping methods as emotion based (Ano & Vasconcelles, 2005; King et al., 2015). However, Pargament believes that religious coping is multidimensional, including an emotional dimension, but it cannot simply be placed in the category of emotion-based methods are used for calming (Pargament et al., 2011). The appraisal of a person about the situation and locus of control, which changes over time, affects the way he chooses to cope and how he or she will involve religious coping aspects (social, emotional, and spiritual; Pargament & Brant, 1998).

The participants of the study more frequently used positive coping strategies that focused on gaining intimacy with God and others than negative strategies. Most of them tried to get close to other mothers through religion, give and take religious advice, praying for their children, thus calm distressed mothers in their tough moments. According to them, these acts were effective in calming them and giving them comfort. It is suggested that insecure, avoidant individuals are more likely to avoid a close attachment to God (Kirkpatrick, 1999). Results of some studies show that highly religious people approach religion to seek meaning, opposite to less religious persons who practice other life values like intimacy with others (Delbridge, Headey, & Wearing, 1994). In the present study, religious mothers had more tendencies to attend religious practices like reading the Quran in a mosque and going to a mausoleum of Imams (Muslim’s clergymen), while others engaged more in social interactions to encourage each other for praying; and they did the religious rituals individually or attended some mysticism groups encouraging close relationship with cosmos and the source. It is suggested in this study that other coping resources like social and family support can have a synergistic effect on religious coping and lead to more use of positive method ones.

This study suggests that the nature of a religion and how its texts, guidance, and teachings are perceived and practiced by people is the factor that determines the approach of God by a person if he is in stressful situation. In Islamic Shia religion, adversities can occur for different reasons. They could be an award, according to Islamic religious texts. This belief originated in the Islamic religious thought that adversity makes individuals close to God and helps them pay attention to the spiritual dimension within the life of a person (Fajri, 1995). In addition, tragedies and diseases are known as good intentions of God almighty that controls the well-being of human beings. Disease may be a grace for sins too, according to some Islamic texts (Fajri, 1999). It is considered a mercy for purification of beloved believers. In addition, according to an Islamic text, the child’s disease may be seen as a redemption for the parents (Fajri, 1995). Despite many efforts to find a clear optimistic interpretation of this Hadith, the negative interpretation is very common among parents of diseased children in Iran, and it gives them feelings of guilt. Also, disasters are given to believers to test their patience, faith, and obedience (Fajri, 1999).

As one can see, there are a variety of different beliefs about the meaning of disease in Shia Islamic Iranian culture, so people make different interpretations while being in the same situation. Although the ultimate aim of Islam is to encourage a person to move toward sublimity and spiritual transformation, it is inevitable that uncertainty and lack of knowledge about deep and real meaning of Quran verses lead to ambiguity. Such an ambiguity especially in less educated people, who rely on public beliefs regarding religious issues rather than find real meanings in valid resources, can result in negative outcomes. In our
study, the participants were from the low or middle class of society (normally it is concluded because of their level of income and education, and the nature of the hospitals their children are referred to). It is also supported by some studies that when a religious coping method fails to be effective and helpful because of misinterpretation and abuse, other factors like personal traits, level of education, and social class can change the result of application of the method and lead to harmful and negative outcomes (Greening & Stoppelbein, 2007).

Conclusion

The results of this study show that “Punishing God reappraisal” and “Pleading for direct intercession” are the most frequently used methods of religious coping in mothers of children with cancer. The results support the results of other studies on Muslims’ religious coping that show they use more passive and emotion-focused methods of coping. On the other hand, the participants concurrently used a variety of religious coping methods with contrasting ways of approach and outcomes, which this multidimensional, ambiguous nature supports the defined theory of religious coping of Pargament.

Clinical Implications

Similar to results of other studies, the participants of the present study used a variety of religious coping methods, but for positive outcomes on health of mothers, they may need professional interventions. They may need a way to resolve current misunderstandings regarding some religious texts and common beliefs. To plan specific caring interventions for Iranian mothers of children with cancer, in addition to considering the similarities with other populations with the same situation, it is important to be familiar with their cultural-related aspects of religious coping. Since many from this culture use this method of coping, it is important to explore their religious beliefs, to provide support, and, if needed, to provide opportunity to clarify any misunderstandings. Other studies on religious coping of mothers of children with cancer in Iran have identified it as one of the multiple different coping methods; and they did not specifically focus on the functions and possible outcomes of religious coping methods. Therefore, the result of this study can provide a new outlook on this frequently used method of coping in this population.

Study Limitations

Generalization is not a goal of qualitative studies (Speziale, Streubert, & Carpenter, 2011), therefore the sample of this study is not deemed representative of all Iranian mothers with a child with cancer. The results represent the experience of a sample of 3 governmental hospitals; therefore, it may not be representative of other governmental or private settings.

Authors’ Note

This study was part of a nursing PhD dissertation (Project No. 7172/12/25/P) approved by the Ethics Committee of Shahid Beheshti University of Medical Sciences and Health Services.

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