Research Paper

Cultural and Social Context for Patients' Coping with COVID-19: Experiences from Tehran Hospitals

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Abstract

Two years after the beginning of the pandemic, various strains of COVID-19 continue to affect relatively all regions and countries in the world. Each country responded to the pandemic based on its facilities, approaches, beliefs, and costumes. The main objective of this research is to study the responses, as well as the social and cultural approaches of COVID-19 patients in Iran. Twenty patients, who recovered from COVID-19 in Tehran, participated in this phenomenological and descriptive-interpretative-based research. The extracted profile includes social black holes, individual and social reactions to COVID-19, as well as outlooks on the different aspects of COVID-19 and post-traumatic growth. The findings of the study suggest that the patients face problems such as economic difficulties that coincided with the pandemic, as well as a lack of adequate medical equipment. This led them to ambivalence, which in turn prepared them for change; patients eventually reached a degree of acceptance and achieved post-disease growth.

Keywords: COVID-19, Culture, Generational differences, Post-traumatic growth, Social compatibility

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1. Introduction

One of the newly emerged diseases of our time is COVID-19, which is caused by a virus from the Corona virus family, formerly known with SARS[1] and MERS[2] (Ciotti et al., 2019). The first case of COVID-19 was diagnosed on December 31, 2019 in China and a quarantine was enacted on January 23, 2020 (Eroğlu, 2021). On February 11, 2020 the World Health Organization officially named this contagious disease as COVID-19. This spreadable disease is the greatest epidemic of the past several decades (Yesudhas, Srivastava, & Gromiha, 2021). Over time, this virus mutated multiple times and the announcement of these new strains produced extensive psychological and social consequences, which are unique and thus important to research. Different factors play a role in a pandemic. In the present research, the relationship between cultural and political factors, and compatibility with the pandemic have been studied. Numerous researchers have studied the impact of culture and politics on compatibility with COVID-19. For instance, the U.S. and Japan have been compared in this regard (Haas, Hoeft, & Omura, 2021). The two countries have different approaches toward nature, which have an impact on compatibility with crises and overcoming natural disasters including pandemics. In Japan, acknowledging and accepting the defeating force is regarded as natural and showing positive emotions in face of the natural forces is widespread, whereas, in the U.S., the primary goal is to overcome the nature and negative emotions in face of nature's defeating forces are more common (Guan, Deng, & Zhou, 2020). The disposition to overcome the nature, and the inability in doing so create a cognitive inconsistency which is difficult to resolve.

1. Severe acute respiratory syndrome.
2. Middle East respiratory syndrome.

Sensitivity towards cognitive inconsistency is more commonly observed among U.S. citizens. Countries that deal with nature in a more accepting manner are more tolerant toward a barely controllable situation (Furlong & Finnie, 2020).

Studies have shown that being exposed to natural environments reduces chances of aggressive responses to rejection (Gupta, Shoja, & Mikalef, 2021), self-control (Kumar, 2021), and depression (Spicer, 2020). People's way of thinking about the natural world is associated with several psychological structures, including welfare, satisfaction with life, and vitality (Ng, Chow, & Yang, 2021). Being quarantined limits presence in the nature, which reduces compatibility particularly among urban communities.

Confronting the spread of a virus depends on the performance of the policymakers. Russia fines individuals who do not obey the protocols. The Philippines and India are among countries where individuals are arrested for violating social distancing protocols (Cao, Li, & Liu, 2020). Instead of strict rules, some countries employ media tools to promote their policies for 'pressuring' people into observing social distancing. Policymaking has other aspects as well. Some states assume that making information available can reduce political trust (Bond, 2021) and accordingly censor evidences. Consequently, individuals in such societies may tend to believe in misleading information that would lead, in turn, to making wrong decisions regarding the pandemic (Abdelrahman, 2020).

A study by Cénat et al. (2020) revealed that there is an inconsistency of attitudes in terms of social distancing in the 51 surveyed countries. According to this study, Peru had the largest number of individuals choosing the option "I have stayed home the

past week". The findings of the study matches google analytics, as well. The research reveals a literature regarding the relation between authoritarian and despotic countries, and enforcing social distancing. A common belief is that authoritarian states have been more successful in reducing people's movement to contain the spread of COVID-19. Democratic countries are equally strict in imposing social distancing rules; however, they were only 20% successful in enforcing social distancing and stay-home laws (Haas et al., 2021). Nevertheless, the findings in this regard are contradictory and they do not indicate an obvious impact. What explains these contradictions is the culture of the people. Communities with collective cultures are different from those with individualistic cultures. Communities with vertical individualism (wherein individuals make efforts for progress and success), directly or indirectly believing in conspiracy theories and developing a feeling of helplessness, are less likely to observe social distancing. Communities with vertical collectiveness (wherein individuals support collective interests regardless of their personal interests) demonstrated highest tendency to observe social distancing. This is while communities with a culture of horizontal collectiveness (wherein individuals fit in the crowd in order to obtain information and conform) show little tendency to obey the protocols due to a feeling of helplessness and despair (Kowal et al., 2020). The differences between developed and developing countries were also the subject of certain studies. For instance, indigenous communities around Australia were assessed as highly risky in terms of hygiene and health, while Australians responded to xenophobia. In all cultures, there are members with a low level of identity, who may oppose the shared norms or the collective measures of a nation. For example, even in a collective culture, there are individuals who prefer their personal interests over public

interests and disobey collective measures such as evading quarantines, hoarding essential health products, or concealing health information (for example Zu, Lu, & Change, 2020).

Job instability and being an immigrant are also considered as important cultural risk factors preventing adaptation to the conditions resulted from the COVID-19. There has not been any research thus far on how patients adapted to the disease in their cultural and social contexts. The present research therefore intends to study the different aspects of social and cultural reactions by Iranians who contracted COVID-19 at some point. People's beliefs about, perceptions of, and reactions to the disease in their social and cultural contexts can help outline a pattern of adaptation to epidemics in the Iranian culture.

2. Methodology

The study adopts the qualitative method of descriptive-interpretive phenomenology, which is a systematic approach and is applied to describe and define experiences. 20 individuals were selected through targeted snowball sampling technique from among Iranian who have been infected with COVID-19 and have recovered. It has been attempted to choose a sample with the highest variety in terms of age, education, and gender.

The participants were between 32 and 64 years old. A quarter of the interviewees had a high school diploma or less, 11 had a bachelor's degree and 5 had a master's degree. 13 participants were female and 7 were male. The eligibility criteria for participating in the study was hospitalization in a health facility located in Tehran. Participants were admitted in different hospitals. Participants were

also selected from different economic classes in terms of income in order to achieve varied responses.

Individual semi-structured interviews were conducted with all participants, which asked about the patients' unpleasant experiences during their illness, their feelings and emotional experiences, the use of social media for adaptation and coping with the disease, their experiences of the quarantine and the way in which they coped with it, the factors helped them cope with the difficult situation, etc. All participants were encouraged to talk more about their personal experiences during the disease.

Patients were selected from public hospitals and interviewed via Skype. The survey was conducted in late February and early March 2021 in the city of Tehran. Expect 3 patients, the rest of the surveyed patients spent a minimum of 7 days in the COVID-19 section of hospitals. 8 of the patients had preliminary conditions such as diabetes, heart diseases and hypertension; however, the stage of their disease was not recognized. The research process, outlined through Koh, Ang, and Straub (2004), proposed modeling, which includes comprehensive and direct understanding of raw data, profile formation of the main components, searching for the guiding themes, attaining an extended description, and combined extended description. The findings were presented to three psychology experts and three of the surveyed patients for verification.

3. Findings

The profile of the main components of the participants COVID-19 experiences were formed in terms of social black holes (financial pressures due to the disease, social labelling, being ostracized, and

lack of medical facilities), individual and social reactions to COVID-19 (hypochondriasis or illness anxiety), outlooks on the different aspects of COVID-19 (ambivalent attitudes towards the Internet and quarantine, generational differences in terms of adapting to COVID-19), as well as post-trauma growth (in-depth acceptance of life, immunity against re-contracting COVID-19, thinking about oneself and living facilities, valuing social interactions, deeply thinking about the purpose of life and planning for the future). Each aspect of the profile has guiding themes that explain the profile of the main components. The following table illustrates the main profiles and their themes.

Table1. Summary of Coding, Main Themes and Sub-Themes

Main Profile	Themes	Sub-Themes
Social black holes	Financial pressures relating to COVID-19	
	Social labeling	
	Social isolation and being ostracized	
	Lack of medical facilities	
Individual and Social Reactions to COVID-19	Obsession and fear of COVID-19	Anger and feeling of guilt
		Fear of long-term complications of the disease
		Hypochondriasis
Outlooks on different aspects of COVID-19	Ambivalent attitude towards the Internet	Social networks as destructive factors
		Social networks as the only means of communication
	Ambivalent attitude towards lockdowns and quarantine	Opportunity to make up for wasted times during routine daily life
		Feeling rejected or ostracized
	Generational differences s in terms of adaptation to COVID-19	Distrusting modern medicine
		Acceptance
		Living the moment

Continuation of Table 1

Main Profile	Themes	Sub-Themes
Post-Trauma Growth	In-depth acceptance of life	
	Immunity against re-contracting COVID-19	
	Thinking about oneself and living facilities	
	Valuing social interactions	
	Deeply thinking about the purpose of life and planning for the future	
	Choosing to actively take actions rather than remaining passive	

Source: Authors

3. 1. Social Black Holes

3. 1. 1. Financial Pressures Related to COVID-19

Some of the participants had undergone severe economic problems; some had lost their jobs due to their COVID-19 infection, or feared they would lose their job because of it. Some other patients had experience, for the least, inability to afford medicine and proper nutrition to recover from the disease. These were strong factors that created as much, if not more, stress and despair in the patients.

> *Unfortunately we were not able to afford medicine and sanitary products and this had embarrassed my father (female, 23).*

> *In addition to suffering from COVID-19, thinking about what my family would do without me really hurt me. I didn't know how they would make ends meet in this bad economic conditions without me; even thinking about it was hurtful (male, 46).*

3. 1. 2. Social Labelling

Since COVID-19 is contagious, it often results in social labelling. During the early months of the outbreak, when the disease had not spread as such, these labels were more common. Patients' friends and families would avoid contact with them out of the fear of contracting the disease; even the recovered patients were ostracized. This usually led to a feeling of rejection among the patients and their families and would lead to their disappointment and depression.

> *While quarantining at home, what hurt me and my family the most was people's words, calling us 'corona-infected' all the time. Ever since my family contracted the disease, we got accustomed to the word 'corona-infected'; as if we had done something evil or were morally corrupt. During this time, rumors were made and people said my father had died and been buried; they said whatever pretending they were kidding; they hurt and disappointed my family. My father recovered but during those times, people around us offended me and my family so much with their hurtful words and maltreatment that I have decided to sell my house and properties and just move away from this city (female, 33).*

Scolding individuals for not observing hygiene protocols, not wearing masks, or attending crowded places also represented social labelling. Such scolding and sometimes hurtful words reduced patients' interpersonal interactions as well as their resilience. Moreover, they also resulted in violence and verbal aggression among couples, emotional problems, dissatisfaction with children and family, and a feeling of insecurity. It can be argued that, overall, the aggression was mainly a result of not being accepted by the family.

> *My mother-in-law would not visit the kids and would not send them*

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food, but she would call my husband and would ask him to put the call on speaker so that I would hear her abusive and insulting words; she would call me and tell me whatever she wanted on the phone…My husband repeatedly beat the kids… and he told me he would break my bones once I recovered…maybe because of COVID-19, he wouldn't approach me, otherwise I wouldn't be safe from his beating (female, 31).

3. 1. 3. Social Isolation and being ostracized

One of the themes mentioned by many of the participants was feeling rejected and ostracized: while sick, the patient is placed under compulsory quarantine and undergoes unfavorable experiences.

I locked myself in my bedroom for a month, I could hear my family talking and laughing but I couldn't join them. I didn't feel like reading or listening to music. None of my friends could visit me. Those were difficult conditions (male, 26).

3. 2. Individual and Social Reactions to COVID-19

3. 2. 1. Hypochondriasis and COVID-19 Anxiety

3. 2. 1. 1. Anger and Feeling of Guilt

The participants expressed an extensive amount of anger about the source of the disease. The disease is still unknown in many ways and has complicated repercussions. Developing a feeling of inability to control the situation and the ambiguity that the patients experienced lead to tremendous anger, which was directed towards others or the patient and created a feeling of guilt.

We were one of those families who strictly observed the protocols; we washed our hands and used sanitizers at home and at work all the time and wore two masks. First my husband contracted it and later I did. I wondered how and from where I contracted it. I would hide it from him, but I was very angry at how indifferent he had become (female, 55).

I felt sick and breathed with difficulty. I cursed those who created and spread this virus. I was mad at the capitalist system and pharmaceutical companies who made money out of people's misery and pain... (female, 34).

If vaccines were imported in time, so many people would not contract it. We lost so many of our dear ones; we suffered so much. When I look at the people around me, from relatives and friends, [I see] many people have died of COVID-19; but if they had prevented it on time, they would have all survived (male, 38).

They say you can carry and pass the virus before the symptoms emerge. I went everywhere and I have probably passed it to the people around me. Anyone I have met on the way or just talked to has possibly contracted the virus too and this is all my fault (female, 41).

It should be noted that this disease is relatively new and its long-term repercussions are not yet recognizable. Symptoms may appear acutely within a month or two of recovery, but it is not clear how the effects will emerge in the future. This fear of the disease being unknown can exacerbate the symptoms. Moreover, the fear of vaccines was also a concern raised by the surveyed patients. Some of the patients mentioned that they feared their families would still contract COVID-19 after being vaccinated or may suffer from unknown side effects. They also expressed concern over contracting a mutated strain of COVID. What was evident in the

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interviews with patients was that fearing the unknown aspects of COVID-19 made it difficult for the patients to adapt to it.

> *I have heard that high fevers have long-term complications. I am worried that since I have been so sick, my brain's activity or my kidneys get affected too (male, 44).*

3. 2. 1. 2. Obsession and Fear of Disease

To avoid contracting COVID-19, it is necessary to observe hygiene and wear masks. Excessive fear of the disease causes people who are prone to obsessive-compulsive disorder to show extreme reactions to the disease, which can in turn affect the quality of their life.

> *We observe physical distancing even at home… I think I observed the protocols more than others, it looked abnormal to others and they told me I was obsessive or I should take it easy and this made me even more anxious. They told me I was hurting myself and the kids. The kids became more stubborn and they would not listen to me. They compared themselves [with others]. They asked why our friends went out or traveled but we stayed home all the time (female, 52).*

3. 3. Outlooks on Different Aspects of COVID-19

3. 3. 1. Ambivalent Attitude towards the Internet

The participants had varying opinions about social networks. This variation resulted from the fact that even before the pandemic, some people did not think of social networks positively and they did not consider it an alternative to real interactions. Most social networking applications or sites were merely used for leisure.

However, with the pandemic they were used to fill the social distances. As people were left with no other choice with everything happening rapidly, social networks and messaging applications were introduced as necessary, while there was little chance to challenge them.

3. 3. 2. Social Networks as Destructive Factors

Some of the interviewees did not have a positive opinion about the Internet before the pandemic and considered the news and information on the Internet as harmful. The Internet was regarded as a tool for aggression or access to pornography websites; it seemed that few people visited the Internet to gain information or do research, but used it for leisure or pass time. In addition, children were seldom allowed to use the Internet.

> *Before COVID pandemic, everyone argued about the phones all the time. My father always told us to put the phone away, but now he is usually on his phone too (male, 22).*

> *On social networks, there is both true and false news. One cannot understand whether or not to get vaccinated; whether or not to travel, or if eating out is dangerous or not (female, 33).*

3. 3. 3. Social Networks as the Only Means of Communication

After long lockdowns, social networks and messaging applications represented the only means of communication with others. National media also promoted virtual communication as an alternative to actual communication. Social networks became therefore used for education, interaction, access to news and information, and entertainment. In this way, they played a significant role in facilitating patients' adaptation.

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When I got sick, initially I couldn't use the phone but once I got better and came back home, I isolated myself at home and I would stay in my bedroom. I passed my time watching movies, listening to podcasts and chatting with friends (female, 37).

I had become very sensitive. I searched the internet to see what foods are good or bad for me. I would search the drugs and I was active on social media so that if someone contracted COVID, they would learn what to do or not to do [from my posts] (female, 26).

3. 3. 4. Ambivalent Attitude towards Lockdowns and Quarantine

3. 3. 4. 1. An Opportunity to Make up for Wasted Times during Routine Daily Life

Life continued rapidly and the consequence was that individuals missed living a natural life and indulging in activities that they enjoyed. Compulsory quarantine, lockdowns and working from home gave busy individuals an opportunity to take a short break in their imposed isolation. Patients who spent less time in hospitals and were quarantined at home sometimes described their time in quarantine as pleasant, giving them a chance to catch up with unfinished tasks.

I can't say the quarantine was all bad; it had been a long time that I could not catch up with unfinished tasks and now I had found the opportunity to do so as I didn't go to work or to university and I could finish my school tasks (female, 37).

I have two kids; each day I worked, I had to take them to the nursery. I was worried about them all day. Now because of the lockdown, I spend more time with the kids and I feel at peace since I have time to take care of them (female, 47).

Even though I was sick, staying home was pleasant, as I was busy with studying for the university entrance exam and school (male, 22).

I added exercising to my daily routine (particularly Yoga, even if only for ten minutes per day). And I adopted a cat (female, 35).

3. 4. Feeling Rejected and Ostracized

For individuals who were severely ill or lived in unsupportive environments, the quarantine felt like being in prison. They reported unpleasant feelings during their time in quarantine.

The neighbors talked loudly in the corridors and they were saying they were worried I could pass the COVID-19 to them. I wish they didn't live in our building. One of the neighbors would prevent my husband and kids from leaving the building and he would tell the volunteers to disinfect the stairs every day. After I recovered, the landlord made us leave the building. No one would rent us a place. They wouldn't even let us inside the real estate's office. Since my husband didn't have a job, we had to move to Robat Kareem (female, 48).

Spending 20 days at the hospital while suffering, without anyone to accompany you, is really grueling and exhausting. Even now that I am back home, none of my family members approaches me because they want to observe social distancing while I'm still having difficulty breathing (male, 37).

3. 5. Generational Differences s in Terms of Adaptation to COVID-19

3. 5. 1. Distrusting Modern Medicine

In the face of the ambiguities surrounding COVID-19 and its treatment, most interviewees of older ages had opted for traditional Iranian medicine and said they did not trust modern medicine.

I do not believe in doctors or vaccines. It has been proved that the doctors are incapable of treating COVID-19 and vaccines can lead to unknown diseases. Traditional medicine is a lot more helpful. The older type of medicine is very effective. Not only for COVID-19, but for any illness I follow traditional medicine and I have always been happy with the results (female, 52).

Traditional medicine, along with modern medicine, helped us a lot. While we are in self isolating at home, all family members followed traditional medicine recommendations to treat our illness…I think if recommendations by traditional medicine are placed in a patient's daily routine, the treatment will be faster and it helps the patient in a better way (female, 41).

3. 5. 2. Acceptance

Compared to the younger and older group, participants aged between 40 and 55 adopted an easier acceptance of their condition: they were more willing to accept the situation and find a way to overcome their negative emotions. Their expressions were very different from the two other groups.

You know, I get upset too, with the situation; and I sometimes cry. Then I get mad at myself for getting upset or being weak. I try to confront this suffering and accept it… I try my best to offer help and I don't blame myself when I can't solve a problem (male, 48).

3. 5. 3. Living the Moment

Younger participants who were mostly single university students opted for living the moment and they seldom considered solving the crisis or planning for the future.

In general I'm the type who doesn't care about what will happen in the future. I live the moment. Life is too short. When tomorrow comes, we will think about it (female, 36).

I don't want to think about COVID-19 or any other problem at all, because that would give me anxiety. I try to ignore people's and society's problems (female, 25).

I don't care about other people, whether they'll die or survive. They deserve dying. One less individual to inhale oxygen and the world becomes a better place… I have reached a point where I absolutely don't care (male, 28).

3. 6. Post-Trauma Growth

Some participants reported that that after the illness, they experienced positive changes in themselves and in their lives. The positive effects of the illness had made them feel better about themselves. Facing the majesty of death had managed to fade away other challenges in life and made a deeper acceptance of life.

The experience of being close to death had a profound effect on my life. Things that were previously annoying and painful, became less important to me. My husband's sloppiness is not an issue anymore; at work, I am no longer irritated by my colleagues sabotage at work; I think of God more often and I am thankful to Him for the health and peace that I have (female, 28).

It was believed that individuals who contracted the virus once, would be partially immune to contracting it again.

I feel good; I think contracting this virus for one time has now made my body stronger, at least to some extent, and I don't fear contracting the disease as much now. I am sure my immune system has become stronger... (female, 33).

Thinking about themselves and the living facilities they had made them feel more appreciated.

> *The time in quarantine gave me an opportunity to analyze my family members' relations… it grant me a chance to look at myself and think about myself and where I stand in my life… (male, 37).*

Valuing social interactions had improved relations as well as a tendency to increase social interactions.

> *It highlighted the importance of life and social interactions to me. I realized how people need to effectively interact with one another. From now on I appreciate my friends more than before and I meet them more often. I realized how trifling certain things are… (male, 46).*

> *Just hugging your dear ones was a great blessing we had taken for granted… (female, 33).*

Deeply thinking about the purpose of life and planning for the future were also among the achievements that patients mentioned.

> *Because I had realized, thanks to COVID-19, that life is too short to stay in a toxic relation. This relation was good for him but I was making too many sacrifices for him. The positive thing was that I was given a chance to find myself again. To see what I am doing with my life (male, 34).*

4. Discussion and Conclusion

This paper intended to study the social and cultural reactions and outlooks of Iranian COVID-19 patients. The outlined profile, which was based on the findings included social black holes (financial pressures due to the disease, social labeling, social isolation and feeling ostracized, and lack of medical facilities),

individual and social responses to COVID-19 (Hypochondriasis and COVID-19 anxiety), Outlooks on different aspects of COVID-19 (ambivalent attitude towards the Internet, ambivalent attitude towards the lockdown and quarantine, and generational differences in adaptation to COVID-19), and post-trauma growth (in-depth acceptance of life, immunity against re-contracting COVID-19, thinking about oneself and living facilities, valuing social interactions, deeply thinking about the purpose of life and planning for the future, choosing to actively take actions rather than remaining passive).

Although COVID-19 is a universal disease, it has had different manifestations in different countries and cultures. Each culture has its own sources of coping and vulnerability. In Iran, there are different sources to rely on to cope with this disease. For instance, Iranians have deep religious beliefs. Religious beliefs in Iran are associated with social cohesion. Religious customs have a social aspect and help people establish connections in the society. Even though modernity has caused damage to family structures and functions, family still provides the most important social support for individuals. People in difficult situations voluntarily helped those with disabilities through public institutions. In addition, in Iran, people are rather interested in learning science and actively search for medical information. They improve their health by obtaining up-to-date medical information. Nevertheless, lack of economic resources, as well as international sanctions contributed to poverty and severely damaged the overall health of the society. Sometimes it was difficult to get medicine and maintain a nutritious diet to recover from the illness. These findings are in line with cultural features.

One of the main obstacles against adapting to COVID-19 was

economic problems and lack of the necessary medical facilities. Other studies conducted in countries with limited resources and large populations also confirm the findings in this regard. For instance, Velamoor & Persad (2020) carried out a study on a sample of more than 1066 participants from Bangladesh that showed that unemployment, deprivation, and hunger intensify social conflicts. A weak and fragile governance in health care systems exacerbates public concerns, as shortage of medical resources increases the risk of being left out without treatment. The finding of their study also confirms shortage of food and nutrition among the poorest and most vulnerable groups due to losing livelihood. Another study in West Africa revealed that due to the pandemic, many people lost their jobs and thus they struggled to provide their families with food. Similar research indicated that people's ability to adapt with the pandemic decreases due to the risk of unemployment, and they suggest that the risk of poverty has to be seriously considered and policymakers should make solid plans to prevent it.

Another dilemma caused by the COVID-19 pandemic consisted of the social stigma experienced by some participants. This study confirms the findings of pervious research. For instance. Kniffin et al. (2021) conducted a study in Italy indicating that hospital staff had biases toward COVID-19 patients that made them tired/needed more care. Their study showed that hospital staff had negative perceptions of the patients and this negative perception prevented their adaptation to the situation.

Another finding of this research concerns post-trauma growth, which confirms the few studies previously conducted in this regard. For example, in China, Ji, Khei, Yap, Wang, Zhang, and Hou (2021) studied a sample of 140 patients and concluded that

COVID-19 patients experienced growth after being discharged from hospitals. Since admitted to hospitals until discharged, patients went through several psychological problems, however, after being discharged growth indicators such as boosted self-esteem, more mature coping methods, and improved psychological status were observed. In another study, Frey, Chen, and Presidente (2021) reported that factors such as being young, being female, staying in quarantine, perceiving health problems, and of course experiencing other traumas negatively impact mental health and opposite factors lead to psychological growth.

The present research found that notwithstanding the serious social black holes such as poverty, social labels, and shortage of medical facilities, patients had positive spiritual experiences. Being challenged, facing shortages, and most importantly, suffering from the disease had granted individuals a profound understanding of life and acceptance, such that after all the crises they experienced, they appreciated their belongings more than before and felt more grateful to God for the blessings He had bestowed upon them.

The findings suggest that in Iran, reaction to COVID-19 is influenced by collective wisdom and this collective wisdom determines the path to collective adaptation. In the light of the fact that the people of Iran endure numerous crises and challenges as well as unexpected changes in their national destiny, social comparisons are increasingly needed to understand these changes. Iranian people tend to adopt collective opinions, hence little variety is observed in the responses. This collective wisdom has moved toward ambivalence, which has been reflected in the findings of this research. This ambivalence is revealed in accepting or refusing to accept different aspects of adaptation to the disease. Accepting or refusing to use technology, and demanding or

detesting quarantine are two examples of ambivalent attitudes investigated in this study. Polarized opinions by the participants indicate that changes are to happen in people's attitudes. Such polarized opinions compete until more compatible opinions are formed.

It can be concluded from the findings that people in Iran have undergone economic crises, drug shortages, shortage of medical facilities, social labeling, and loneliness resulted from isolation and quarantine. They have overcome problems through their beliefs and approaches and in the end, personal growth and development has been observed in patients infected by the COVID-19 disease. Between unpleasant experiences and accepting the situation, there exist mechanisms, through which coping with the difficulties is made possible. This process is realized in the context of collective wisdom.

One of the most important limitations of the present study was that the findings were qualitative and it is necessary to verify them with quantitative data. In such research, it is difficult to precisely determine the impact of important variants such as gender, ethnicity, and age in terms of approaches and the degree of adaptation to the disease. For future studies, quantifying the data is recommended. The findings of this study can be significantly useful for policymakers in the healthcare system. It is necessary to take care of the people's living conditions, improve medical facilities and train patients for better adaptation, rather than merely focus on guideline regarding wearing masks and observing social distancing.

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