

Abstract

Objective: This study was an attempt to explore the structural relationship between religious involvement, religious struggle, attitude to drugs, social modeling, spiritual well-being, and cigarette and tobacco smoking among students. **Method:** For this purpose, 504 male and female students from Kharazmi University, Agricultural Paradise, and Azad University of Karaj were selected by cluster sampling and they were asked to complete spiritual well-being scale, religious involvement scale, religious struggle scale, social modeling scale, negative beliefs about drugs, and the tobacco section of the high-risk behavior questionnaire. **Results:** The results showed that the effect of religious involvement on cigarette and tobacco smoking was mediated by negative beliefs about drugs, social modeling, spiritual well-being, and incentives for drug use. Similarly, the effect of religious struggle on cigarette and tobacco smoking was mediated by spiritual well-being. **Conclusion:** It seems that religion prevents people joining the unhealthy peer groups by the establishment of moral discipline, internal and external rules, and healthy coping styles; therefore, people get less attracted to cigarette and tobacco smoking. Accordingly, these factors should be paid more attention in prevention programs for drug use, particularly cigarette and tobacco that are considered as the gateway to other drugs.

Keywords: Drug Use, Spirituality, Social Modeling, Attitude to Drugs, Students

Structural Model of Drug Use among Students: The Role of Spirituality, Social Modeling and Attitude to Drugs

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Introduction

Lifetime prevalence of use and abuse of drugs have been reported to amount to 49 percent among adolescents, aged 20-19 years old, and 72 percent at the age of 27 years old (Johnston, O'Malley, Bachman & Schulenberg, 2009; Substance Abuse and Mental Health Services Administration (SAMHSA), 2009). Drug use among adolescents leads to death and injury and it brings about educational problems, conflicts and clashes and sexual behavioral issues for students. Adolescence is not only an important development period and the peak of prevalence of drug use and the problems associated with it, but it is also the stage of entry into adulthood (Arnett, 2005). At the end of this period, many young people start taking the duties and responsibilities of adulthood. Successful transition to adulthood roles is dependent upon absence of substance use and absence of antisocial behavior and delinquency (Ston, Becker, Houber & Catalano, 2012).

Given the importance of substance abuse, the gateway to it should be assigned more importance. Many experts believe that cigarette smoking is a prelude to resort to the use of other substances and refer to it as a gateway to drug use (Schmid, 2001). Tobacco use, mainly in the form of cigarette, holds the highest mortality rate compared to other drugs and alcohol (U.S. Department of Health and Human Services, 2010) and is one of the most widely used substances among adolescents (Johnson et al.). Smoking, especially cigarette smoking, is expected to be the leading cause of death in 2030 (Mecklenburg, 1992). Among the adults who smoke cigarette every day, 82 percent have experienced their first cigarette smoking before the age of 18. Roughly, half of adolescent cigarette smokers continue this act until they die of smoking-related diseases (U.S. Department of Health and Human Services). Study of cigarette smoking among students is of special importance since the smoking behavior of students is a useful indicator of smoking by young people. On the other hand, students being considered a role model to young students plays an important role in increasing or decreasing the prevalence of smoking in the general population (Rigotti, Lee & Wechsler, 2000). In the two decades of research on the prevalence of drug use among students at Iranian universities, cigarette and hookah have gained the first rank among different substances (Sarrami, Ghorbani & Taghavi, 2013). Thus, according to the importance of adolescence, a proper strategy should be devised to immunize adolescents and prevent substance use. Prevention is based on the decrease of risk factors and increase of protective factors in the individual and the environment during the development period (Connell, Boat & Warner, 2009). These factors are psychological, familial and social; here, the role of religion/ spirituality assumes significant individual and social importance since it is dominant over different aspects of human life.

Spirituality and religion are complex, multi-dimensional, and interrelated structures. However, spirituality refers to subjective, experimental, and personal

dimensions of excellence, while religion puts emphasis on social and objective dimensions and presents a cultural framework that helps legislation. Moreover, it is possible to build spiritual experiences by providing culturally acceptable explanatory and enlightened models (Cholz & Valach, 2008). Spirituality can be defined as a search for sacred items and religion is the social fabric of this search (Pargament, 2007). Religion/ Spirituality can be used as an extensive and wide structure with diverse specific areas (Johnson, Sheets & Kristeller, 2008). Religion/ spirituality can be considered in two sub-categories of religious involvement and religious struggle (Johnson et al, 2008). Religious involvement measures general religious beliefs (Drerup, Johnson & Bindle, 2011). Religious struggle also refers to the incompatible physical and emotional effects that are caused by the feeling of being punished by God, feeling of God's anger and discontent, and feeling of rejection by God (Pargament et al., 2005). Another term that is at play in connection with spirituality and mental health is spiritual well-being that is considered as the mediator of religion/ spirituality and drug use, as well (Drerup et al., 2011). Spiritual well-being refers to the sense of harmony and solidarity towards the self, others, the world, and the perceived supreme power (Ackley & Ladwig, 2002; cited in Toftthagen, 2006). Johnson, et al. (2008) found that religious involvement anticipates high levels of spiritual well-being whereas religious struggle predicts low levels of spiritual well-being. Many studies have examined the relationship between the broad concept of religion and spirituality and addiction to drug use, and have introduced religion/ spirituality as a protective agent against addiction (Faigin, 2008). The review of 265 articles and books published in the area of spirituality and addiction, it was found that 85 percent of the studies on addiction fell within the category of substance abuse and religion/ spirituality (Cook, 2004). In a review article, Booth & Martin (1998) found that religion (e.g. religious preferences and practices) has a negative correlation with substance abuse in teenagers and students. High levels of religious involvement such as attending church was predictor of a drug-free life in the interval of one to fifteen following years. In Iran, several studies have been conducted to investigate this issue. Hajjarian & Ghanbari (2013) concluded that there was a significant negative relationship between tendency to religious points and the level of drug consumption and there was a significant positive relationship between interaction with addicts and tendency to drug use. Moreover, Makarem & Zanjani (2013) showed that religious beliefs and belief in the consequences of drug use play an effective role in reducing drug use. Asghari, Kord Mirza & Ahmadi (2013) showed that religious orientation has an important role in tendency to substance abuse among students. However, relatively few studies have attempted to determine the mechanisms through which religion/ spirituality can impact substance use (Johnson et al., 2008; cited in Drerup et al., 2011). Studies have shown that the relationship between spirituality/ religion and drug use can be mediated by people's attitudes towards and opinions about drug use (Chawla, Neighbors &

Lewis, 2007). Johnson et al (2008) found that religion/ spirituality predicts negative opinions about alcohol consumption; in other words, individuals' negative attitudes about alcohol use have a negative association with its real consumption. These attitudes include ideas such as "alcohol consumption is a sin", "alcohol consumption is contrary to my personal beliefs and values". Social modeling is another mediator variable. Religious affiliation affects drug use in different ways through social modeling, which include observed norms, dealing with drug use patterns, and some suggestions for drug use (Chawla et al., 2007). Social learning theory and cognitive theory constitute the theoretical foundation of the model presented in the present study. Two well-known theories pertaining to peers are differential association theory (Sutherland & Cressey, 1978) and social learning theory (Bandura, 1986). Theory of differential learning is an interactive approach with an emphasis on the learning process people are involved that makes them show deviant behaviors. This theory assumes that adolescents learn norms, attitudes, techniques, rational excuses (rationalization), and incentives for delinquency through interaction with close friends.

Social learning theory emphasizes the social mechanisms in the learning process of deviant behaviors and assumes that adolescents learn maladaptive behavior through observation, modeling or mimicking the behavior of close associates and also learn the consequences of social strengthening of that learned behavior. These theories express the initial mechanism of the spread of deviant behavior among the network of friends, peers and family. Najaflavi & Navabinejad (2014) found a significant difference between drug-dependent individuals and normal people in profile of the family environment, especially such components as cohesion, conflict, religious orientation, control, achievement orientation, intellectual – cultural orientation, and organization. These results indicate the impact of family and close friends on the acquisition of deviant behavior. Cognitive theories also reiterate the role of beliefs and opinions of individuals about the negative effects of drug use in the onset of drug use. These theories regard individuals' expectations and attitudes about drugs as the most important factor associated with substance use and believe that other factors, such as personality traits and communication with others exert their effects through the understanding and assessment of the individuals on drugs. Beck believes that certain beliefs under certain circumstances are activated in substance abusers which increase the likelihood of substance abuse. These are completely personal and unconventional beliefs that include predictive beliefs (specific expectations from drugs, such as I become strong if I take drugs), relief-seeking beliefs (sedative properties of drugs, such as if I do not use drugs, propensity to consume now continues.), facilitative beliefs and leniency (substance use is acceptable despite its unacceptable results, such as this is my right to take drugs because I take pains day and night; therefore, it is worth its consequences). Drug-related belief is activated as a result of inner and outer

circumstances. This belief leads to automatic thoughts and ultimately the need and the desire to use drugs (Beck, Wright, Newman & Liese, 1993).

Although numerous studies have explored the relationships of these variables with each other separately, all the variables have not been studied in a model so far. Therefore, this study aims to provide a structural model to show the relationship between substance use (cigarette and hookah), religious involvement and religious struggle, and mediators of the relationship between these two variables, including attitudes to drugs, social modelling, and spiritual well-being.

Method

Population, sample, and sampling method

All the bachelor students of Kharazmi University, Azad University of Karaj, and Agricultural Paradise of Karaj in the first academic semester 2012-2013 constituted the statistical population of this study. The sample of the study consisted of 504 students, including 255 female and 249 male students in different majors of engineering, agricultural, humanities and applied sciences.

Since the possibility of making a list of the population members was not possible, multistage random cluster sampling was used. In this way, four faculties were randomly selected from each university in the first phase; then, from two to four departments were selected from each faculty; at the end, from two to four bachelor classrooms, except the freshmen of the academic year 2012, were selected out of each department. Indeed, the total of 520 participants completed the questionnaires, out of whom 16 participants did not deliver complete questionnaires and, thereby, were excluded from the sample. Therefore, a 504-participant sample in the 19-to-25-year-old age group constituted the final sample of the study.

Instrument

1- Youth Risk Behaviors Scale (YRBS): This scale was used to measure the degree of cigarette smoking and hookah use. It is noteworthy that this scale has been extracted from the high-risk behavior scale of America's Control Disease Center (CDC). A set of behavior in contrast with physical health that raise the risk of diseases and social problems and, to a great extent, cause the death of teenagers and adults constitute the theoretical foundations of this scale (Brenner, Kaan & Mcmanus, 2002). Based on this questionnaire, high-risk behaviors in domains of driving, violence, smoking, alcohol use, narcotics and psychotropic drugs, nutrition and physical activity, and bad friends are evaluated in terms of frequency, intensity, and tendency to drug use in monthly periods, annual periods, and lifetime within 72 items (Bakhshani, Lashkaripour & Bakhshani, 2007). In this study, the smoking section of the scale was used and the

Cronbach's alpha coefficient for it was obtained .88. This section contains 8 items wherein 4 items are scored via the Likert scale (never to above 40 times) with 0 to 6 points; 2 items are scored with the response range of never up to 17 years old and above with 0 to 8 points; and 2 items are scores based on the Likert scale (never to very much) with 0 to 6 points. High score on this scale is equivalent to more consumption or greater desire for consumption. Brener et al. (2002) calculated the reliability of this scale via test-retest method in a two-week interval and obtained kappa coefficient for all items between .23 and .90. In Iran, Bakhshani et al. (2007) obtained the test-retest reliability coefficient and calculated the kappa coefficient for all the items roughly equal to .85.

2. Social modeling Scale: This scale was used to measure social effects (Reed, Wood, Kahler, Maddock & Palfai, 2003). According to the theoretical basis of this questionnaire, people follow their friends, families, and associates' examples in various fields such as smoking. Accordingly, this questionnaire evaluates tobacco use status of friends, families and acquaintances, friends' opinion about cigarette smoking and hookah, the pressure of the person for consumption from friends, and the dominant ideas about the consumption of one's peers.

This questionnaire encompasses 9 four-point Likert items wherein the choices include such alternatives as strongly disagree to strongly agree, never to so much, never to once a week or more, and never to five times a week. High score mean that the respondent follow his/her friends and acquaintances' example in high degrees. Cronbach's alpha coefficient of .87 has been reported for this scale. Diagnostic validity for this scale has been reported to be equal to .72. Similarly, the concurrent validity of this test was evaluated with social norm scale, family ties, perceived accessibility, self-control, and assertiveness scales and the resultant coefficients were obtained .62, .49, .45, -.52, and -.65, respectively (Read et al., 2003). The reliability of the questionnaire in this study was obtained .82 via Cronbach's alpha mode and also .79 via test-retest method in a 10-day interval on 60 male and female participants.

3- Spiritual well-being questionnaire: This questionnaire was constructed by Palotzin and Elison in 1982 and consists of 20 items and two subscales. The odd-numbered items of the scale belong to religious well-being subscale which is to assess one's relationship with God. On the other hand, the even-numbered items belong to existential well-being subscale which is dealt with a self-assessment of one's sense of life purpose and life satisfaction. The responses to the items are given based on six-point Likert scale from "strongly agree" to "strongly disagree". It should be noted that reverse scoring is dominant in some items. A high score indicates a high spiritual well-being. Palotzin & Elison (1982) reported the Cronbach's alpha coefficients of religious well-being, existential well-being, and total scale equal to .91, .91, .93, respectively. This scale has been applied for research purposes in various communities such as students, nurses, ordinary people, the mentally ill individuals, and people with physical illnesses.

Several studies have proven that this scale enjoys desired internal consistency and construct validity (Hammermeister, Flint, Alayli, Ridnour, & Peterson, 2005). In addition, the results of confirmatory factor analysis showed that the two-factor model of religious and existential well-being has a high goodness-of-fit among students, which is indicative of the construct validity of this scale. Dehshiri, Sohrabi, Jafari & Najafi (2008) reported the existence of a significant positive correlation between spiritual well-being scale scores and scores of happiness, religiosity; and found a significant negative correlation between the scores of this subscale and the scores of mental disorder. These findings prove the existence of convergent validity and divergent validity of spiritual well-being among the community of students. Bartlett's sphericity test results indicated a significant correlation between questions. The Cronbach's alpha coefficients of this questionnaire on male and female students were obtained equal to .9, .82, and .87 for the total scale, religious well-being subscale, and existential well-being subscale, respectively. In the same way, the reliability coefficients of the total scale, religious, and existential well-being subscales were respectively obtained .85, .78, and .81 via test-retest method. In this study, Cronbach's alpha for the total scale was obtained .92 and this value was obtained equal to .86 and .88 for religious and existential well-being subscales, respectively.

3- Negative beliefs about drug use: This scale includes negative beliefs and negative religious attitudes that people have towards substance use and was constructed by Johnson, Carlisle, Sheets & Kristeller (2008). The beliefs that cause one to regard drug use against his/her values and religion and feel guilty while taking drugs. This scale consists of four items, including "I feel guilty when smoking hookah and cigarette", "Drug use is inconsistent with my personal values and beliefs," "My religion does not approve of smoking hookah and cigarette". This questionnaire was scored based on a four-point Likert scale (it does not matter at all to it is too important). High scores indicate negative religious beliefs and opposition to substance. Cronbach's alpha for this scale was obtained .89 in this study. Moreover, the test-retest reliability coefficient of the questionnaire in this study was obtained .81 by the administration of the questionnaire on 60 participants within a 10-day interval.

3- Inventory of religious involvement: In this study, religion/ spirituality included two dimensions, namely religious involvement and religious struggle. Religious involvement measures general religiosity and is a combination of 9 scales: internal religiosity, brief daily spiritual experiences, Pargament's positive religious coping, positive religious support, organizational religiosity, frequency of saying prayers, personal devotions, subjective religion / spirituality, and objective personal beneficial experiences. In this study, a combination of these scales, including 29 items, was used to measure religious involvement (Johnson et al, 2008). Items 1 and 2 are scored based on a 4-point Likert scale with such alternatives as never, low, medium and high with 0 to 3 points assigned to each alternative respectively. However, items 3 to 14 are scored based on the same

Likert scale but with the following alternatives: strongly disagree, disagree, agree, and strongly agree with 0 to 3 points. Last but not least, items 15 and 29 are scored with such alternatives as never, sometimes, often, and every day. High score on this questionnaire is tantamount to high degrees of religious involvement. Cronbach's alpha for the total scale was obtained .87 (Drerup et al., 2011). In the present study, the reliability of the questionnaire was measured through Cronbach's alpha that was equal to .95. Similarly, the questionnaire was administered twice on 60 participants within an interval of ten days and the test-retest reliability coefficient of the scale was obtained .83.

4. Religious struggle scale: Brief Religious Coping Scale (Pargament et al., 1998) is a 14-item instrument that evaluates religious coping strategies and is scored based on a 4-point Likert scale from 1 (never) to 4 (always). This scale is the short form of Pargament et al.'s religious coping scale (1998). The scale includes 21 subscales and each subscale consists of 5 items which amounts to the total of 105 items and, thereby, is not suitable for research purposes. Therefore, its short form with two factors has been constructed. Positive religious coping with 7 items, including questions 7, 8, 9, 10, 11, 12, 13, and 14 and negative religious coping with 7 items, including questions 1, 2, 3, 4, 5, 6, and 7 are the two factors of this short form (Yeu, 2010). Negative religious coping is indeed a struggle that one has in the face of difficulties and hardships of life about his/her religious beliefs. This struggle can be reflected in such beliefs as doubting the power of God, abandoning hope in God, becoming angry with God, doubting the existence of God, expiating his/her sins, and being punished by God. High scores on this scale indicate high religious struggle in a person. In this study, negative religious coping scale was used to measure religious struggle. This scale enjoys high internal consistency and construct validity. Cronbach's alpha for negative religious coping scale has been reported to be placed in the range .69 to .81. (Pargament et al., 2000). In this study, Cronbach's alpha for negative religious coping scale was obtained .70. In addition, the test-retest reliability of the questionnaire was obtained .76 by administering the questionnaire to 60 male and female participants twice within a 10-day interval.

Procedure

After sampling and random selection of faculties, departments and classrooms, it was planned with the instructor of every classroom to allow the students to fill in the questionnaire during 20 to 25 minutes at the beginning of the class in a relaxed atmosphere. At first, some short explanation was provided about the theme of questionnaires and the response procedure. They were explained that the questionnaire should be filled in an anonymous format, it has research purposes only, and contains various issues that must be answered individually and with precision, accuracy and completeness. They were also asked to raise their

possible questions about each of the items. All questionnaires were completed at the beginning of classes before noon in collaboration with university professors in order to raise the precision and concentration of the participants. In all classes, the average number 20 to 30 participants was randomly selected to answer the questionnaires. Overall, the administration of questionnaires took six weeks.

Results

From among the 504 participants of the sample, the number of 255 students (49.4%) was female and the number of 249 participants (50.6%) was male. Demographic data of the sample are provided in the table below. As shown in the table, the number of 266 ones (52.8%) was selected from Kharazmi University, 162 ones (32.1%) from Azad University of Karaj, and 76 ones (15.1%) from Agricultural Paradise. In terms of academic majors, it is noteworthy that the number of 184 students (36.5%), 76 students (15.1%), 93 students (18.5%), and 134 students (26.6%) was studying Engineering, agriculture, basic sciences, and humanities, respectively. However, a total of 17 participants had not specified their fields of study. Finally, the number of 226 participants (44.8%) lived on campus while the number of 278 ones (55.2%) did not. Descriptive statistics of the variables under study are presented in the table below.

Table 1: Descriptive statistics of the variables under study

<i>Variable</i>	<i>Mean</i>	<i>SD</i>	<i>Min.</i>	<i>Max.</i>
Social modeling	18.15	5.79	9	33
Negative beliefs about cigarette and hookah	9.92	4.05	4	16
Religious struggle	11.37	3.27	7	25
Religious involvement	78.29	16.70	29	114
Cigarette smoking in the past month	1.54	1.40	1	6
Tendency to smoke cigarette	4.83	1.66	1	6
Hookah use in the last twelve months	2.12	1.72	1	6
Hookah use in the past month	1.59	1.25	1	6
Tendency to use hookah	4.28	1.84	1	6
Total score of spiritual well-being	65.78	9.03	20	120
Existential well-being	33.94	5.15	10	60
Religious well-being	31.88	5.05	10	60

Correlation matrix of the variables under study is presented in the table 2.

The main objective of this research is to achieve a clear understanding of how religious involvement and religious struggle affect hookah and cigarette smoking through social modeling, negative beliefs about smoking, and spiritual well-being. The test model designed for this purpose will show whether the main hypothesis of this study is confirmed by fitting the model with data obtained from the study population.

Table 2: Correlation matrix of the variables under study

<i>Variable</i>	<i>1</i>	<i>2</i>	<i>3</i>	<i>4</i>	<i>5</i>	<i>6</i>	<i>7</i>
Social modeling	1	-	-	-	-	-	-
Negative beliefs about consumption	-0/53**	1	-	-	-	-	-
Religious struggle	0/02	0/02	1	-	-	-	-
Religious involvement	-0/44**	0/66**	-0/08	1	-	-	-
Spiritual well-being	0/06	0/002	-0/1*	0/002	1	-	-
Cigarette smoking	0/52**	-0/45**	-0/05	0/38**	0/04	1	-
Hookah use	0/66**	-0/57**	0/38**	0/31**	0/09	0/57**	1

*P< 0/05, **P< 0/01

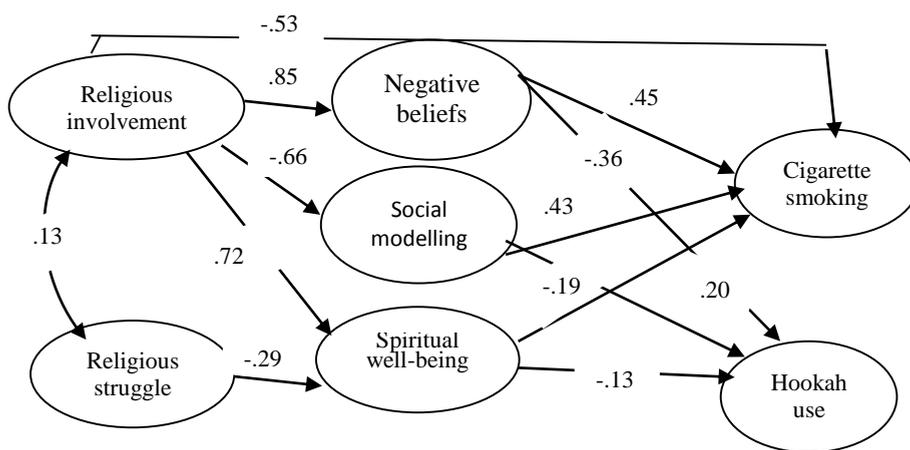


Figure 1: The proposed structural model of drug use among students

The results of the test model show its acceptability via fitness indicators. These indicators and the corresponding values are presented in the table below.

Table 3: Fitting indexes of the model

<i>SRMR</i>	<i>IFI</i>	<i>NFI</i>	<i>RFI</i>	<i>RMSEA</i>	<i>CFI</i>	<i>GFI</i>	<i>Df</i>	<i>2/dfχ</i>	<i>2χ</i>
.05	1	.96	.95	.06	1	.93	755	3.38	2552.35

The results indicate the GFI obtained in this study is equivalent to .93. Since the values equal to or greater than .9 are acceptable for this indicator, it can be concluded that the model has a desired goodness of fit according to this index. The value of NFI in this model is .96. This value within the range of .9 to .95 is considered acceptable and this value above the range is excellently acceptable. Therefore, the index represents a good fit of the data with the model. In addition, the CFI value for the model is equal to 1 and it is conventionally agreed that this value should be higher than .90. Thus, this value represents the high fitness of the model. Since the obtained Root Mean Square Error of Approximation, that is, .06 is lower than the criterion value of .1, the model enjoys a good fit. The index of 2/dfχ is assigned importance for the fit of models which is desired to

range from 2 to 5. This value for the present model is 3.38. In general, it can be concluded from the above indexes that the model enjoys an average and higher fit. The results of squared multiple correlation for endogenous variables are as follows: .78 cigarette smoking, .80 hookah use, .63 incremental incentives, .97 social incentives, .84 coping incentives, .72 negative beliefs about consumption, .43 social modeling, and .51 spiritual well-being.

Discussion and Conclusion

According to results of this study, the effects of religious involvement on cigarette and hookah smoking was mediated by social modelling, spiritual well-being, and negative beliefs about drugs and effect of religious struggle on cigarette and hookah smoking was mediated by spiritual well-being. These results are consistent with the findings of the studies conducted by Johnson et al. (2008) and Drerup et al. (2011). Furthermore, the results showed that the relationship between religious involvement and cigarette smoking is mediated by negative attitudes and beliefs on drugs. These results are consistent with findings of the studies carried out by Chawla et al. (2007) and Johnson et al (2008). To explain these relations, it seems that religion can specify some norms with the establishment of internal and external rules and regulations and direct one to hold the beliefs and attitudes that creates immunity against the drugs. The effects one's spiritual and religious beliefs have on how s/he interprets the events facilitate the adaptation and acceptance process of events (Cotton, Larkin, Hoopes, Cromer & Rosenthal, 2005). According to the perspective of social development, commitment and attachment to social institutions such as family, school, and religion create healthy beliefs and clear standards that lead to healthy behaviors, as well. (Hawkins & Weis, 1985). Thus, the opinions and attitudes that religion create towards cigarette and hookah smoking and the sense of commitment and value that one has towards these beliefs cause immunity against cigarette and hookah smoking.

In another part of the model, the results showed that religious struggle affect cigarette and hookah smoking that was mediated by spiritual well-being. This finding is consistent with that of the study undertaken by Johnson et al (2008). To explain these results, Fagin believes that people who feel they are separate from religious services, receive little spiritual support from the close people in their lives. The individual who has some conflicts, questions and tensions, such as anger toward God, in the relationship with God might come down with pervasive effects on his/her physical health and spiritual well-being. Anger towards God is triggered by lower mental health and weaker coping strategies due to the sense of abandonment from God and is likely to convert the positive and constructive effect of spirituality into negative and destructive effects. This puts one's mental system in need of alternative coping strategies. These strategies can include cigarette and hookah smoking and might be used as an

easy and available solution to relieve the mental suffering and pain. On the other hand, spiritual well-being reinforces psychological functions and compatibility; and makes people hate drugs and deal with problems through such strategies as self-awareness, communication and bonding with family, social support from others, confidence, meaningfulness, becoming goal-oriented in life, and effective coping and compatibility with problems. People with interpersonal and intrapersonal religious questions and doubts may feel deficiency in purpose, meaning, or organization; therefore, they cannot make sense of their lives and find answers to these questions. They may feel spiritual void and be looking for a new form of meaning, including the destruction of these habits fill this vacuum. In line with this approach, Gorsuch & Butler (1976) suggest that some people use drugs as a way to escape from their mental suffering. On the contrary, those people with strong and stable religious beliefs may have an eternal source of meaning at the core of their lives. For such people, a high sacred power becomes an organized force that directs the individual to useful routes in life and brings about a life free from high-risk behaviors such as cigarette and hookah smoking.

Overall, the results suggest that religious involvement and religious struggle predicts cigarette and hookah smoking through mediator variables such as social modeling, negative beliefs about smoking, and spiritual well-being. Social modeling is directly associated with cigarette and hookah smoking. Religion influences one's attitudes with the establishment of internal and external rules, religious beliefs provide one with higher strength and power to cope with personal, educational, and psychological stressors; therefore, s/he will be inclined, to a lesser extent, to such friends or groups wherein there is a high possibility of drug abuse in order to avoid such stress. On the other hand, positive religious copings are sources social and affective support. Thus, the individuals who take advantage of these copings in their daily lives suffer from lower degrees of depression and anxiety, do not seek for short-term relief, do not need to be accepted by their addicted friends, and, thereby, are less directed to cigarette and hookah smoking.

Since the proposed model of the study was conducted on student population with a limited sample, one of the major limitations this study suffers from is that the generalization of this model to other populations must be done with care and caution. Indeed, it needs further research on adolescents, adults and the samples with more participants. In this study, the consumption of other drugs and alcohol was not examined; therefore, the generalization of the findings to other drugs and alcohol need more extensive research and cooperation of the authorities. Since students constituted the sample of this study, it was not known whether or not they use or abuse other drugs and alcohol. Therefore, it further research is recommended to be done with control of these factors. Finally, with regard to Iran's religious atmosphere and the existence of some rules, response to the religious struggle questionnaire has been possibly followed by some limitation. In fact, the topic of religious struggle and concepts such as casting doubt on the

power of God, thinking about the non-existence of God, and casting doubt on the love of God towards humans are taboo subjects in Iran's society. Therefore, answering questions in this respect may be associated with bias and dishonesty.

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