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Religious Attitude Associated with General Health and Smoking in Iranian Students

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Background:

Abstract

Given the university students' model role in the society and the importance of period of university education in selecting behavioral methods and lifestyles in the future have made it necessary to study the smoking pattern and its associated factors and complications among students. The aim of this study was to compare religious attitude and mental health between smoking and non-smoking students.

Methods:

In this research, religious attitude and mental health was studied in 1065 smoking and non-smoking students of Kerman University of Medical Sciences. In this study, three questionnaires were used (Demographic Questionnaire, General Health Questionnaire and Religious Attitude Scale Questionnaire) which were completed by the students voluntarily. The data were analyzed by descriptive statistic methods, multivariate analysis of variance (MANOVA), t-test, Pearson correlation, and regression coefficient.

Findings:

The mean age of smokers was 20 years and most of the smokers were male (78.9%), single (86.5%) and in BS or BA degree (52.5%). Most of them smoked a cigarette or more in the past month. The average age of start of smoking was 18 years. There was no significant difference between religious attitude and mental health in smoking students in terms of gender but in non-smoking students there was a significant difference in this regard. Smoking students had lower mental health status and religious attitude in comparison with non-smoking students. Between religious attitude and general health in smoking and non-smoking students was also a direct association.

Conclusion:

Due to psychological and physiological consequences of cigarette smoking, promoting smoking prevention by religious missionaries and university professors, and helping the students to quit smoking by counselors, psychologists and psychiatrics are necessary.

Key words:

Religious attitude, Mental health, Cigarette smoker, Student.

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Introduction

Cigarette smoking is a significant factor in mortality and has a negative effect on mental and physical health.¹ Mental, physical and social performances are considered as causes and effects of cigarette smoking.² Studies showed that depression and anxiety are related to cigarette smoking.³⁻⁵ Study of Morissette et al indicated that smokers have higher anxiety in comparison with non-smokers.⁶ In another study that Mykeltun et al has done about smoking consequences, the results indicated a relationship between smoking in youths and depression-anxiety disorders.⁷ The study of Samimi and Valizadeh in this field showed that smokers had less general health and lower quality of life.⁸ The other factor that could be discussed in this field is the religion; religion is a subject with long-standing history.⁹ Religion had been discussed by psychologists like Freud and Jung. Thereafter, thinkers like Stanley Hall and Allport have spent their time in explanation and representation of religion. Moreover, Eric stated that deterministic religion leads to mental disorders but philanthropic and optimistic religion lead to health and growth of individual talent.¹⁰ Studies indicated that religious tendencies cause improvement in general health, quality of life, life expectancy and even social communications.¹¹⁻¹³ Trevino et al also stated that religious beliefs increase the self-esteem.¹³ Koenig, based on the studies has done in this field said that "religious beliefs do not always lead to mental health" because clinical psychologists are often faced with patients who feel guilty, ruminated, anxious and rejected which could be due to the contents of their religious beliefs.¹⁴ Unlike this finding, Bayani et al,⁹ Khodayarifard,¹⁵ Mir Zamani and Mohamadi¹⁶ in various studies showed that religious tendency is conversely related to individuals' depression and anxiety. The probability of cigarette smoking can be predicted by various factors such as religious attitudes and activities, anxiety and mood disorder.^{8,10,17} Religious commitment and belonging to a valid class which contains desirable social values have been considered as two protective factors from cigarette smoking.^{18,19} In another study, religious and spiritual beliefs led to increase in self-esteem, life satisfaction, social relations improvement, adaptive mechanism and decrease in anxiety; the effects of these outcomes reduced cigarette

consumption.¹⁷ Another study showed that the prevalence of heart diseases was much less common in people with stronger religious attitudes. This subject was related with people's healthy behaviors such as smoking and exercise.¹⁴ Religious beliefs and activities prohibit the individual from starting the cigarette smoking and continuing this habit.^{18,20} Whooley et al showed that the probability of smoking was less in youths that had deeper religious beliefs and were committed in participating in religious ceremonies.²¹ Nollen et al have come to realize that social supports and religious tendencies are effective in cigarette smoking.²² A research among Iranian university students showed that the prevalence of smoking has increased, and this period is a specific time point for many to start smoking.²³ Given the students' model role in the society and the importance of university education period in selecting behavioral methods and lifestyles in the future have made it necessary to study cigarette smoking pattern and its associated factors and complications among students.^{9,24-26} The general objective of the current study was to compare religious attitude and mental health between Iranian smoking and non-smoking students.

Methods

This research was approved by the Ethics Committee of Neuroscience Research Center of Kerman University of Medical Sciences by moral code number EC/KNRC/87-16. This study was a cross-sectional study on 1065 students of Neuroscience Research Center of Kerman University of Medical Sciences (821 females and 244 males) selected by convenience sampling method. Of these students, 976 were non-smokers and 89 were smokers. Three questionnaires were used in this study. The first questionnaire was for collecting data such as age, marital status, the age of first time started smoking, and the smoking pattern in the past month and past year. To assess religious attitude, we used Religious Attitude Scale Questionnaire. This questionnaire was made by Khodayarifard in 1999 at Tehran University and contained 40 questions based on 5-level Likert scale which was graded from completely agree to completely disagree. Religious attitude score was calculated between 40 and 200. Those who gained 40 to 84 had low religious attitude and a score of 166 to 200

indicated a high religious attitude. The content of questionnaire evaluated ethics, values, the effect of religion on personal and social life style and behavior, ideology and religion beliefs. The reliability of this questionnaire was assessed by open test method which was 83% indicating a high credibility of test.²⁷ The reliability of this questionnaire was calculated 89% by Cronbach's alpha coefficient. To assess the mental health, GHQ-28 questionnaire (general health questionnaire) was used. Goldberg and Hillier (1979) designed this questionnaire with 28 questions and four sub-scales: anxiety, physical performance, social function and depression. The grading was based on 4-level Likert scale (never, rarely, usual and more than usual for 0, 1, and 3 respectively). Different studies in Iran reported its reliability as 96% and 84%.²⁸ The reliability of the current questionnaire was calculated as 86% by Cronbach's alpha coefficient method.

The data of this research were analyzed by

descriptive statistic methods, multivariate analysis of variance (MANOVA), t-test, Pearson correlation, and regression coefficient.

Results

The scores obtained from this questionnaire were analyzed by utilizing SPSS₁₃ software. As results showed the mean age of the students was almost at the age of twenty and most of the cigarette consumers were male, single, in BS or BA degree and most of them smoked one cigarette or more in the past month. The average age of starting the smoking was at the age of 18 (Table 1). T-test results showed a significant difference between non-smoking males and females in terms of religious attitude and general health ($P = 0.001$ and $P = 0.001$, respectively). But, in terms of religious attitude and general health between the two genders in smoking students, no significant difference was observed (Tables 2 and 3).

Table 1. Descriptive results of smoking and non-smoking students

Variables		Smoking Number (%)	Non-smoking Number (%)
Gender	Male	75 (78.9)	169 (17.3)
	Female	14 (21.1)	807 (82.7)
Marital status	Single	77 (86.5)	845 (86.7)
	Married	12 (7.3)	130 (13.3)
Educational Degree	AA/AS associate	31 (34.8)	319 (32.7)
	BA/BS bachelor	47 (52.8)	575 (58.9)
	MA/MS master	5 (5.6)	26 (2.7)
	PhD	6 (6.7)	56 (5.7)
Age	20 years old	45 (50.6)	757 (77.56)
	25 years old	42 (42.7)	198 (20.28)
	30 years old	2 (2.2)	21 (2.15)

Table 2. The results of t-test of general health and religious attitude between non-smoking males and females

Variable	Group	Number	Mean	Standard deviation	t-test	Significant level
General health	Female	807	58.93	10.81	4.52	0.001
	Male	109	65.95	9.03		
Religious attitude	Female	807	158.60	15.22	4.46	0.001
	Male	109	152.43	20.74		

Table 3. The results of significant t-test of general health and religious attitude between smoking males and females

Variable	Groups	Number	Mean	Standard deviation	t-test	Significant level
General health	Female	14	45.92	16.94	0.89	0.41
	Male	75	50.01	9.03		
Religious attitude	Female	14	134.42	21.02	0.17	0.86
	Male	75	133.38	20.67		

Meanwhile, the results indicated that the correlation between religious attitude and general health variables and its subscales which influenced by factors such as the age of starting smoking, education degree and marital status would either decrease or increase. The results showed that the mean scores of general health and all its subscales (anxiety, depression, physical performance, and social functioning) were higher in smoking students than those in non-smoking students; i.e., depression and anxiety scores in smoking students were higher while social and physical performance scores were lower in comparison with non-smoking students (Table 4). MANOVA tests in association with variables of general health group (Wilks's Lambda = 0.751, $F = 14.32$, $P < 0.01$) were significant. In all subscales of general health, there was a significant difference between the two groups as follows: depression ($P = 0.01$), social performance ($P = 0.01$), physical performance ($P = 0.01$) and anxiety ($P = 0.01$); i.e., depression and anxiety levels were higher in smoking students and social and physical performance levels were lower in comparison with non-smoking students. The results showed that between the two groups there was a significant difference in terms of general health ($P = 0.01$); i.e., smoking students had much

less general health in comparison with non-smoking students. Also, between the two groups there was a significant difference in terms of religious attitude ($P = 0.01$); i.e., smoking students had less religious attitude in comparison with non-smoking students. The results of Pearson correlation test indicated a significant relationship between religious attitude and general health of smoking students ($P = 0.05$) and non-smoking students ($P = 0.01$) (Table 5). The results of simultaneous regression for both general health and religious attitude variables on smoking rate ($P = 0.02$) showed that religious attitude ($\beta = 0.11$) had stronger role in smoking than general health ($\beta = 0.06$). Moreover, by controlling religious attitude variable, general health correlation in cigarette smoking reduced from 0.09 to 0.06, while by controlling general health factor, religious attitude correlation in cigarette smoking reduced from 0.133 to 0.109. It seems that religious attitude, as a separate factor regardless of *general health*, had stronger effect on reduction of cigarette smoking. Simultaneous regression analysis of variables in smoking students ($P = 0.17$) indicated the following results: depression ($\beta = 0.13$), anxiety ($\beta = 0.06$), sleeping ($\beta = 0.042$), social performance ($\beta = 0.03$) and religious attitude ($\beta = 0.12$).

Table 4. Descriptive results of mental health subscales in both smoking and non-smoking groups

Variable	Groups	Number	Mean	Standard deviation
Depression	Smoking	89	18.05	3.94
	Non-smoking	976	17.26	4.62
Social performance	Smoking	89	13.42	2.69
	Non-smoking	976	12.73	3.13
Physical performance	Smoking	89	16.39	3.51
	Non-smoking	976	14.88	4.02
Anxiety	Smoking	89	16.21	3.29
	Non-smoking	976	14.74	4.27
General health (Total score)	Smoking	89	64.08	7.94
	Non-smoking	976	59.63	10.63

Table 5. The association of religious attitude and general health in smoking and non-smoking students

Groups	Variable	Number	Mean	Standard deviation	r	Significant level
Non-smoking	Mental health	976	59.63	10.67	0.22	0.001
	Religious attitude	976	157.53	16.46		
Smoking	Mental health	89	64.08	7.94	0.29	0.005
	Religious attitude	89	133.33	20.60		

Discussion

The current research has studied the religious attitude and general health in smoking and non-smoking students. In this study, smoking rate was higher in males than that in females which was in accordance with Divsalar et al¹⁸. However, it is noteworthy that despite cultural and traditional issues in Iran and Islamic nations for female smokers as an antisocial action,²⁹ the rate of smoking among females is increasing.³⁰ The average age of start of smoking was at the age of 18, which was in accordance with other studies.^{10,26, 31} This issue emphasizes the necessity of proper planning in order to prevent adolescents and youths from smoking. On the other hand, most of the smoking students were single; that was in accordance with Divsalar et al¹⁸, Divsalar and Nakhaee.²³ The more social responsibilities, the less possibility of smoking; so, being married -as one of the hardest responsibilities can be a remarkable and significant preventing factor of smoking.¹ In this research, there was a difference between non-smoking female and male students in terms of religious attitude; i.e., religious attitude was higher in females than in males, but the related results were not in accordance with the results of Bayani et al⁹, Cheraghi and Molavi.¹⁰ Besides, this study showed that non-smoking males had a higher general health than females which was in accordance with Samimi and Valizadeh⁸ and Bayani et al,⁹ but was not in accordance with Cheraghi and Molavi.¹⁰ In study of Samimi and Valizadeh, religious attitude and general health of smoking females were higher than those of smoking males, while in the current study there was no difference between these two groups.⁸ The results of this study indicated that the religious attitude rate in smoking students was lower than that in non-smoking students; the findings, therefore, are in accordance with Samimi and Valizadeh,⁸ Nollen et al,²² Nonnemaker et al,²⁰ and Divsalar et al.¹⁸ Religious attitude and beliefs can be considered as an obstacle for smoking tendency, and also participating in religious ceremonies leads to less cigarette smoking among smoking students.^{18,32} The results of the above-mentioned studies indicated the necessity of increasing the knowledge of students in order to promote religious beliefs which can be carried out in different ways such as parents, clergies, teachers, mass media and religious activity

groups of the university. From the other point of view, the results of this study showed that general health of smoking students is lower than that of non-smoking students and smoking students had higher anxiety, depression, and lower social performance and sleeping time. The obtained data were in accordance with Morissette et al,⁶ Mykletun et al,⁷ Samimi and Valizadeh,⁸ and Tavakolizadeh et al.³¹ Smoking leads to physical consequences such as pulmonary and heart diseases, and psychiatric disorders such as anxiety and depression. These changes can reduce individual's physical, mental and social life quality. Smoking people smoke cigarette to reduce negative emotions like anxiety, depression and etc. while smoking itself increases their stress.³¹ Between smoking and anxiety depression disorders, there is a mutual relationship; i.e., smoking leads to these disorders or by having these disorders the individual tends to smoke.²¹

The results of this study indicated a direct association between religious attitude and general health of non-smoking students. The findings of this study are in accordance with studies of Halling and Unell,¹¹ Smith et al,³³ Trevino et al,³ Cheraghi and Molavi,¹⁰ and Bayani et al.⁹ Giving hope to life, religion leads to increase in mental health, and the ability to face the stress. Religious attitude leads to self-reliance sense, lack of dependency to others, using people with high religious attitude as models of their life and consequently, accepting the difficulties of life. The religious attitude also leads to increase in social life, protection of peer group and learning the proper ways of decision making for solving the problems.³⁴ Moreover, the results indicated that smoking people with deep religious attitudes have also better general health. Religious beliefs and participating in the ceremonies can reduce the smoking tendency.²³ Religious activities which close the individual to God and help him/her get rid of frustrations and hopelessness may bring about decrease in depression and anxiety leading to reduction in smoking rate and consequently, improve the quality of life. University admission is a big change in individual's life and prepares him/her for the acceptance of future responsibilities of the society. Lack of adjustment and having improper stress can also be considered as a risk factor for students to smoke. Regarding the increase rate of university admission of students in our country and the

increase of vulnerability to smoking, paying specific attention to the youths (especially with regard to their model roles in the society) seems to be necessary in order to accomplish control and prevention interventions. Thus, it is necessary to inform the students by religious missionaries, university professors, consultants, psychologists and psychiatrists regarding the physical and mental consequences of smoking. The authorities and officials can have important roles in reducing smoking tendency of adolescents and youths by creating employment opportunities and proper recreations. The parents and professors also can

accomplish this very important job by guidance and creating friendly environments for students.

Conflict of interest: The Authors have no conflict of interest.

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References

1. Nori M, Adili F, Poorebrahim R, Ramin H, Fakhrazadeh H. The pattern of smoking and its relationship with other risk factors for cardiovascular disease in residents under the population research center, Tehran Medical Sciences University. *Journal of Diabetes and Lipid Disorders* 2003; 3(1): 99-107.
2. Morrell HE, Cohen LM, al'Absi M. Physiological and psychological symptoms and predictors in early nicotine withdrawal. *Pharmacol Biochem Behav* 2008; 89(3): 272-8.
3. Breslau N, Novak SP, Kessler RC. Psychiatric disorders and stages of smoking. *Biol Psychiatry* 2004; 55(1): 69-76.
4. Glassman AH, Covey LS, Stetner F, Rivelli S. Smoking cessation and the course of major depression: a follow-up study. *Lancet* 2001; 357(9272): 1929-32.
5. Glassman AH, Helzer JE, Covey LS, Cottler LB, Stetner F, Tipp JE, et al. Smoking, smoking cessation, and major depression. *JAMA* 1990; 264(12): 1546-9.
6. Morissette SB, Tull MT, Gulliver SB, Kamholz BW, Zimering RT. Anxiety, anxiety disorders, tobacco use, and nicotine: a critical review of interrelationships. *Psychol Bull* 2007; 133(2): 245-72.
7. Mykletun A, Overland S, Aaro LE, Liabo HM, Stewart R. Smoking in relation to anxiety and depression: evidence from a large population survey: the HUNT study. *Eur Psychiatry* 2008; 23(2): 77-84.
8. Samimi R, Valizadeh A. Relationship of smoking and general health of medical students 2006. *Hormozgan Medical Journal* 2007; 11(4): 303-8.
9. Bayani AA, Godarzi H, Bayani A, Kochehi AM. Relationship of religious orientation with anxiety and depression in students. *Journal of Mental Health Principles* 2008; 10(39): 209-14.
10. Cheraghi M, Molavi H. The relationship between different aspects of religious and public health at University of Isfahan. *Journal of Educational and Psychological Studies Faculty of Education and Psychology* 2006; 2(2): 1-22.
11. Halling A, Halling A, Unell L. General health and tobacco habits among middle-aged Swedes. *Eur J Public Health* 2007; 17(2): 151-4.
12. Jessor R. Risk behavior in adolescence: A psychosocial framework for understanding and action. In: Rogers DE, Ginzberg E, Editors. *Adolescents at risk: medical and social perspectives*. California: Westview Press; 1992. p. 19-34.
13. Trevino KM, Pargament KI, Cotton S, Leonard AC, Hahn J, Caprini-Faigin CA, et al. Religious coping and physiological, psychological, social, and spiritual outcomes in patients with HIV/AIDS: cross-sectional and longitudinal findings. *AIDS Behav* 2010; 14(2): 379-89.
14. Koenig HG. Spirituality, wellness and quality of life. *Sexuality Reproduction and Menopause* 2004; 2(2): 74-82.
15. Khodayari Fard M, GHobari Bonab B, Shokoohi Y. Range of psychological research in the field of religion. *Andishe Va Raftar Quarterly* 2001; 6(24): 45-53.
16. Mir Zamani M, Mohamadi MR. Research about the religious value in a group of mental patients based on test Lport study, Vernon and Lindsay. *Hakim Quarterly* 2001; 4(1): 51-8.
17. Jesse DE, Reed PG. Effects of spirituality and psychosocial well-being on health risk behaviors in Appalachian pregnant women. *J Obstet Gynecol Neonatal Nurs* 2004; 33(6): 739-47.
18. Divsalar K, Nakhaee N, Amini MR. The relationship between religious activities and cigarette smoking in one of the university students in Kerman. *Teb va Tazkie* 2007; 16(3-4): 63-9.
19. Ellison CG. Religious involvement and subjective well-being. *J Health Soc Behav* 1991; 32(1): 80-99.
20. Nonnemaker J, McNeely CA, Blum RW. Public and private domains of religiosity and adolescent

- smoking transitions. *Soc Sci Med* 2006; 62(12): 3084-95.
21. Whooley MA, Boyd AL, Gardin JM, Williams DR. Religious involvement and cigarette smoking in young adults: the CARDIA study (Coronary Artery Risk Development in Young Adults) study. *Arch Intern Med* 2002; 162(14): 1604-10.
22. Nollen NL, Catley D, Davies G, Hall M, Ahluwalia JS. Religiosity, social support, and smoking cessation among urban African American smokers. *Addict Behav* 2005; 30(6): 1225-9.
23. Divsalar K, Nakhaee N. Prevalence of smoking and its related factors in two university students in Kerman. *Journal of Babol University of Medical Sciences* 2008; 10(4): 78-83.
24. Basir Z. Factors affecting smoking in nursing students. [MSc Thesis]. Tehran: University of Medical Sciences of Iran; 1993.
25. Bahrami Ehsan H, Tashak A. Dimensions of the relationship between religious orientation and mental health assessment and religious orientation scale. *Journal of Psychology and Education* 2004; (69): 41-64.
26. Rigotti NA, Lee JE, Wechsler H. US college students' use of tobacco products: results of a national survey. *JAMA* 2000; 284(6): 699-705.
27. Khodayarifard M, Shokoohi Y, Ghobari Bonab B. Religious attitude scale preparation of students. *Journal of Psychology* 2000; 4(3): 268-85.
28. Ansari H, Bahrami L, Akbar Zadeh L, Bakhshani NM. Of public health at University of Medical Zahedan and some related factors. *Tabib Shargh* 2007; 9(4): 295-305.
29. Asfar T, Ward KD, Eissenberg T, Maziak W. Comparison of patterns of use, beliefs, and attitudes related to waterpipe between beginning and established smokers. *BMC Public Health* 2005; 5: 19-31.
30. Tyas SL, Pederson LL. Psychosocial factors related to adolescent smoking: a critical review of the literature. *Tob Control* 1998; 7(4): 409-20.
31. Tavakolizadeh JS, Ghahrami M, Hadizade F, Chamanzari H. Study of mental health in young non-smokers and smokers in Gnaba. *Ofogh Danesh* 2003; 9(1): 1-9.
32. Gillum RF. Frequency of attendance at religious services and cigarette smoking in American women and men: the Third National Health and Nutrition Examination Survey. *Prev Med* 2005; 41(2): 607-13.
33. Smith CR, Faris R, Denton ML. Mapping American adolescent subjective religiosity and attitudes of alienation toward religion: A research report. *Sociology of Religion* 2003; 64(1): 111-33.
34. Abedini S, kamalzadeh H, Sadegifar E, Shahraki vahed A. Assessing smoking in Bandar Abbas University of Medical Sciences. *Journal of Medical Sciences and Health Services Hormozgan* 2007; 11(4): 297-302.

ارتباط نگرش مذهبی با سلامت عمومی و مصرف سیگار در دانشجویان ایرانی

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چکیده

توجه به نقش الگویی دانشجویان در جامعه و حساسیت دوران دانشجویی در انتخاب شیوه‌های رفتاری و سبک زندگی آنان در آینده، ضرورت مطالعات در خصوص مصرف سیگار و عوامل و عوارض مرتبط با آن را در این قشر برجسته ساخته است. هدف این مطالعه، مقایسه نگرش مذهبی و سلامت روانی بین دانشجویان سیگاری و غیر سیگاری و رابطه نگرش مذهبی و سلامت روانی در این دو گروه بود.

در این پژوهش، سلامت روانی و نگرش مذهبی در ۱۰۶۵ نفر از دانشجویان سیگاری و غیر سیگاری دانشگاه علوم پزشکی کرمان مورد بررسی قرار گرفت. در این مطالعه از سه پرسش‌نامه دموگرافیک، سلامت روانی (GHQ) و نگرش سنج مذهبی استفاده گردید که به صورت خود ایفا توسط دانشجویان تکمیل شد. داده‌های این پژوهش، با روش‌های آمار توصیفی، تحلیل واریانس چند متغیری (MANOVA)، آزمون معنی‌داری t مستقل و ضریب همبستگی Pearson و رگرسیون مورد تحلیل و بررسی قرار گرفت.

میانگین سنی افراد سیگاری ۲۰ سالگی بود و بیشتر مصرف کنندگان سیگار، مرد (۷۸/۹ درصد)، مجرد (۸۶/۵ درصد) و در مقطع تحصیلی کارشناسی (۵۲/۵ درصد) بودند. داده‌ها نشان داد که میانگین سن شروع مصرف سیگار ۱۸ سالگی بوده است. بین نگرش مذهبی و سلامت روانی در دانشجویان سیگاری از لحاظ جنسیت تفاوت معنی‌داری وجود نداشت ولی در دانشجویان غیر سیگاری این تفاوت قابل ملاحظه بود. دانشجویان سیگاری در مقایسه با دانشجویان غیر سیگاری از سلامت روانی و نگرش مذهبی پایین‌تری برخوردار بودند. همچنین، بین نگرش مذهبی و سلامت عمومی در دانشجویان سیگاری و غیر سیگاری رابطه مستقیم وجود داشت.

با توجه به پیامدهای روانی و جسمی ناشی از مصرف سیگار، اطلاع‌رسانی از طریق مبلغین مذهبی و استادان دانشگاه‌ها جهت پیش‌گیری و درمان آن از طریق مشاوران، روان‌شناسان و روان‌پزشکان برای دانشجویان مصرف کننده سیگار ضروری است.

نگرش مذهبی، سلامت روانی، سیگاری، دانشجو.

مقدمه:

روش‌ها:

یافته‌ها:

نتیجه‌گیری:

واژگان کلیدی:

تعداد صفحات: ۸

تعداد جدول‌ها: ۵

تعداد نمودارها: -

تعداد منابع: ۳۴

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