Religious Beliefs, Treatment Seeking, and Treatment Completion among Persons with Substance Abuse Problems

Kesha Baptiste-Roberts¹, Niya Werts², Kimberly Coleman¹, Mian Hossain¹

Abstract

Background: Religious beliefs can assist with the success of treatment in persons with substance abuse problems by providing social support, confidence, and hope.

Methods: As such, a secondary analysis using 2013 National Survey on Drug Use and Health (NSDUH), of 20219 participants with self-identified illicit substance use problems was conducted. Survey was weighted bivariate and multivariate regression analysis was used to adjust for potential confounders.

Findings: Approximately, 15.0% of the study sample were between ages of 18-25 years and 71.5% were Non-Hispanic Black, 11.3% were Non-Hispanic White, and 12.1% were Hispanic. About 10.3% had less than a high school education, 28.0% graduated high school, 30.0% had some college education, and 32.0% were college graduates. Only 1.3% reported receiving substance abuse treatment in the past 12 months and 5.4% perceived a need for substance abuse treatment in the last 12 months. 65.0% reported that religious beliefs were an important part of their life and 62.5% reported that their religious beliefs influenced their decision making. After adjustment for sociodemographic factors, both the importance of religious beliefs and the influence of religious beliefs on decision making were associated with increased odds of having treatment [odds ratio (OR) = 1.56, 95% confidence interval (CI): 1.14-2.14 and OR = 1.51, 95% CI: 1.11-2.05, respectively]. However, there was no association between the importance of religious beliefs or the influence of religious beliefs on decision making and perceived need for substance abuse treatment.

Conclusion: These findings suggest that religious beliefs may be an important determinant in receiving treatment among substance abusers and also have implications for exploration of faith-based and faith-placed interventions.

Keywords: Religious; Substance-related disorders; Treatment

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Introduction

Several national surveys show that over half of Americans identify that religion is a very important part of their life and although the percentage of persons who believe in God has decreased over time, 80% of American still report believing in God and approximately 9% of those who do not believe in God, report belief in some higher power or spiritual force.1 Given the lack of consensus regarding the definition of the core constructs of religiousness and spirituality and the overlapping aspects, most studies either use the terms interchangeably or together. Moreover, several studies have shown a favorable influence on several health outcomes2-4 such as mortality, cardiovascular disease (CVD),5 cancer,6 and substance abuse.6 Several studies show that religiousness or religiosity may have a powerful role in the prevention of substance abuse and several theoretical arguments exist. There is consistent evidence that religiosity and spirituality are negatively related to alcohol, tobacco, and illicit substance use.7-11 The processes and mechanisms through which different aspects of religiosity and spirituality influence health are still under study and several have been proposed through psychological processes or the provision of social support.12,13

Moreover, inquiries into the role of religiosity and spirituality in facilitating successful addiction treatment have been fairly new. It is largely unknown if religiosity influences an addict’s decision making regarding seeking treatment, initiating treatment, and completing a treatment program. As such, the purpose of this study was to examine the relationship between religious beliefs and the influence of religious beliefs on decisions and perceived need for treatment and receiving treatment for substance abuse in the past 12 months among a self-identified sample of persons with illicit substance use problems.

Methods

A secondary analysis using the 2013 National Survey on Drug Use and Health (NSDUH), of 20219 participants with self-identified substance abuse problems defined as ever having used illicit drugs was conducted. NSDUH is a repeated cross-sectional national survey conducted by the Center for Behavioral Health Statistics and Quality (CBHSQ), Substance Abuse and Mental Health Services Administration (SAMHSA).14 The target population is a nationally representative noninstitutionalized sample of the United States (US), aged 12 years and older. Approximately, 67500 persons are surveyed annually via face-to-face interviews. The purpose of the survey is to obtain data on national prevalence and patterns of substance abuse and mental disorders. An independent multistage probability sampling design was used to sample household residents from 50 states in addition to the District of Columbia. Data were collected via in-person interviews in participants’ homes. Detailed information about the survey methods is published elsewhere.14

Measures: The outcome variables in this study were having received treatment for substance abuse problems in the past 12 months and perceived need of substance abuse treatment in the past 12 months. The main explanatory variables were the importance of religious beliefs and influence of religious beliefs in decision making, respectively. Participants were provided with these statements: “Your religious beliefs are a very important part of your life” and “Your religious beliefs influence how you make decisions in your life”. Participants were instructed to indicate their level of agreement ranging from “strongly disagree” to “strongly agree” on a 4-point Likert-type scale. Participants who selected either “agree” or “strongly agree” were categorized as persons for whom religious beliefs were important and as persons whose decisions were influenced by their religious beliefs, respectively. Covariates included gender, age, race, education, marital status, employment, poverty status, and total household income.

Descriptive and summary statistics to describe sample demographic characteristics were calculated using Stata software, Release 11 (Stata Corporation, College Station, TX, USA). Survey was weighted bivariate and multivariate regression analyses were conducted for each religious exposure variable and each treatment outcome variable. Multivariate models included age, race, gender, education, marital status, employment, poverty level, and total family income. Additional multivariate models were constructed eliminating total family income, but there was no difference in the results.

Results

Table 1 shows the descriptive statistics for the sociodemographic, religious, and treatment variables.
As shown, 53.5% of the respondents were men and 71.5% were Non-Hispanic White. Almost half of the sample were currently married and employed full time. 68% were 200% or more at poverty level and approximately 37% reported total family income of $75000 or more. 65% reported that religious beliefs were important, while 62.5% stated that religious beliefs influenced their decisions. 5.0% of the participants reported needing treatment in the past 12 months, while only 1.3% reported receiving treatment in the past 12 months.

In the bivariate analysis, there were statistically significant differences in age, education, marital status, employment, and poverty level by receipt of treatment in the past 12 months as shown in table 2.

In the multivariate model examining the association between the importance of religious beliefs and reporting receiving treatment in the last 12 months, after adjustment for race, gender, age, education, marital status, employment, poverty level, and family income, persons who stated that religious beliefs were important had 1.56 times the odds of reporting receiving treatment in the past year compared to persons who indicated that religious beliefs were not important [odds ratio (OR) = 1.56, 95% confidence interval (CI): 1.14-2.14] (Table 3). The OR for each age category increased for the first two age categories of 22-25 and 26-34 years and then decreased for the age categories of 35-49 and 50 years and above. Compared to those aged 18-24 years, respondents aged 26-34 years had 2.78 times the odds of reporting receiving treatment in the past 12 months. Non-Hispanic Blacks were 50.0% less likely to report receiving treatment compared to Non-Hispanic Whites. Compared to men, women were 31.0% less likely to report receiving treatment. Compared to college graduates, persons who did not complete high school, high school graduates, and those who completed some college education had increased odds of reporting receiving treatment, with the strength of association decreasing with each increment in education (OR = 2.24, 95% CI: 1.19-4.20). In addition, compared to respondents that were currently married, those who were widowed, divorced, separated, or single or never married had higher odds of reporting receiving treatment in the past 12 months (OR = 2.27-6.76 and OR = 4.50, 95% CI: 2.72-7.44).
Table 2. Bi-variate relationship between socio-demographic and economic characteristics with receiving illicit drug treatment among adults aged 18 or older who ever used illicit drug, National Survey on Drug Use and Health (NSDUH), 2013

| Variables                                      | Illicit drug treatment received in past year | Chi-square | P     |
|------------------------------------------------|---------------------------------------------|------------|-------|
|                                                | No (19807) | Yes (412) |       |
| Religious beliefs are important                | n (%)      | n (%)    | 2.1%  |
| Yes                                            | 12262 98.5 | 253 1.5  | 3.10  0.078 |
| No                                             | 7545 98.9 | 159 1.1  | 3.10  0.078 |
| Religious beliefs influence decisions           | n (%)      | n (%)    | 2.1%  |
| Yes                                            | 11342 98.6 | 227 1.4  | 1.38  0.241 |
| No                                             | 8465 98.8 | 185 1.2  |       |
| Race                                           | n (%)      | n (%)    | 2.1%  |
| Whites                                         | 12910 98.7 | 288 1.3  | 0.15 |
| Blacks                                         | 2473 98.6 | 43 1.4   | 0.926 |
| Hispanics                                      | 2757 98.5 | 48 1.5  |       |
| Other                                          | 1667 98.8 | 33 1.2  |       |
| Gender                                         | n (%)      | n (%)    | 2.1%  |
| Female                                         | 10038 98.8 | 177 1.2  | 1.93  0.165 |
| Male                                           | 9769 98.5 | 235 1.5  |       |
| Age (year)                                     | n (%)      | n (%)    | 2.1%  |
| 18-21                                          | 4301 97.8 | 107 2.2  | 14.78  < 0.001 |
| 22-25                                          | 5330 97.8 | 143 2.2  |       |
| 26-34                                          | 3270 97.7 | 80 2.3  |       |
| 35-49                                          | 4232 98.8 | 56 1.2  |       |
| 50 and above                                   | 2674 99.4 | 26 0.6  |       |
| Education                                      | n (%)      | n (%)    | 2.1%  |
| Incomplete high school                         | 2783 96.9 | 114 3.1  | 18.72  < 0.001 |
| High school                                    | 5993 98.4 | 147 1.6  |       |
| Some college                                   | 6279 98.6 | 130 1.4  |       |
| College graduate and above                     | 4752 99.6 | 21 0.4  |       |
| Marital status                                 | n (%)      | n (%)    | 2.1%  |
| Currently married                              | 6349 99.7 | 46 0.3  | 48.05  < 0.001 |
| Widowed/divorced/separated                     | 2318 98.3 | 57 1.7  |       |
| Single or never married                        | 11140 97.4 | 309 2.6  |       |
| Employment                                     | n (%)      | n (%)    | 2.1%  |
| Employed full time                             | 10457 99.4 | 135 0.6  | 19.16  < 0.001 |
| Employed part time                             | 3852 98.1 | 89 1.9  |       |
| Unemployed                                     | 1739 94.9 | 83 5.1  |       |
| Other                                          | 3759 98.0 | 105 2.0  |       |
| Poverty level (% of federal poverty threshold) | n (%)      | n (%)    | 2.1%  |
| 100% at the poverty level                      | 4285 96.7 | 154 3.3  | 22.30  < 0.001 |
| 100%-199% at the poverty level                 | 4322 97.9 | 114 2.1  |       |
| 200% or more at the poverty level              | 11200 99.3 | 144 0.7  |       |
| Total family income                            | n (%)      | n (%)    | 2.1%  |
| Less than $20000                               | 4889 96.8 | 173 3.2  | 20.12  < 0.001 |
| $20000-$49999                                  | 6447 98.5 | 133 1.5  |       |
| $50000-$74999                                  | 3106 98.9 | 54 1.1  |       |
| $75000 and more                                | 5365 99.5 | 52 0.5  |       |

Similarly, in the investigation of the relationship between the influence of religious beliefs on decisions and receipt of treatment after adjustment for potential confounders persons who reported that religious beliefs influenced their decisions had 1.51 times the odds of reporting receiving treatment in the past 12 months compared to their counterparts. In this multivariate model Non-Hispanic Blacks were 49% less likely to report receiving treatment compared to their Non-Hispanic White counterparts. Similar statistically significant associations between age education marital status and employment were observed as shown in table 4.
Table 3. Odds ratios (OR) and confidence intervals (CI) for the logistic regression estimates for the relationship between religious beliefs as important and receiving illicit drug use related treatment among adults aged 18 or older who ever used illicit drug, National Survey on Drug Use and Health (NSDUH), 2013

| Covariates                                | Illicit drug treatment received in past year | Unadjusted models | Adjusted model |
|-------------------------------------------|---------------------------------------------|-------------------|----------------|
|                                           | OR   | 95% CI          | OR   | 95% CI          |
| Religious beliefs are important           |      |                  |      |                  |
| Yes vs. No                                | 1.32 | 0.97-1.80        | 1.56** | 1.14-2.14       |
| Race                                      |      |                  |      |                  |
| Whites                                    | 1.00 | -                | 1.00 | -                |
| Blacks                                    | 1.11 | 0.70-1.77        | 0.50** | 0.30-0.84       |
| Hispanics                                 | 1.17 | 0.68-2.02        | 0.70 | 0.39-1.24       |
| Other                                     | 0.95 | 0.43-2.05        | 0.64 | 0.29-1.37       |
| Gender                                    |      |                  |      |                  |
| Female vs. Male                           | 0.80 | 0.58-1.10        | 0.69* | 0.49-0.97       |
| Age (year)                                |      |                  |      |                  |
| 18-21                                     | 1.00 | -                | 1.00 | -                |
| 22-25                                     | 1.04 | 0.73-1.47        | 1.79** | 1.24-2.58       |
| 26-34                                     | 1.07 | 0.73-1.57        | 2.78*** | 1.81-4.28      |
| 35-49                                     | 0.56** | 0.36-0.87    | 1.87* | 1.14-3.06       |
| 50 and above                              | 0.25*** | 0.14-0.44   | 0.70 | 0.36-1.36       |
| Education                                 |      |                  |      |                  |
| Incomplete high school                    | 7.98*** | 4.16-15.32     | 3.20*** | 1.58-6.45      |
| High school                               | 4.11*** | 2.23-7.59     | 2.49*** | 1.31-4.73      |
| Some college                              | 3.56*** | 1.90-6.68     | 2.24* | 1.19-4.20       |
| College graduate and above                | 1.00 | -                | 1.00 | -                |
| Marital status                            |      |                  |      |                  |
| Currently married                         | 1.00 | -                | 1.00 | -                |
| Widowed/divorced/separated                | 5.11*** | 2.95-8.85    | 3.92*** | 2.27-6.76      |
| Single or never married                   | 7.70*** | 5.06-11.71    | 4.50*** | 2.72-7.44      |
| Employment                                |      |                  |      |                  |
| Employed full time                        | 1.00 | -                | 1.00 | -                |
| Employed part time                        | 3.32*** | 2.24-4.92     | 2.96*** | 1.92-4.55      |
| Unemployed                                | 9.34*** | 5.85-14.92    | 5.23*** | 3.11-8.80      |
| Other                                     | 3.52*** | 2.37-5.23     | 3.70*** | 2.42-5.68      |
| Poverty level (% of federal poverty threshold) |      |                  |      |                  |
| 100% at the poverty level                 | 4.54*** | 3.16-6.52     | 1.25 | 0.64-2.43       |
| 100%-199% at the poverty level            | 2.82*** | 1.88-4.21     | 1.18 | 0.68-2.05       |
| 200% or more at the poverty level         | 1.00 | -                | 1.00 | -                |
| Total family income                       |      |                  |      |                  |
| Less than $200000                         | 7.03*** | 4.37-11.32    | 1.43 | 0.66-3.10       |
| $20000-$49999                             | 3.32*** | 2.01-5.48     | 1.21 | 0.69-2.14       |
| $50000-$74999                             | 2.27** | 1.31-3.95     | 1.50 | 0.86-2.63       |
| $75000 and more                           | 1.00 | -                | 1.00 | -                |

*P < 0.050, **P < 0.010, ***P < 0.001

OR: Odds ratio; CI: Confidence intervals

There was no statistically significant association observed between the importance of religious beliefs and perceived need for treatment (OR = 1.01 95% CI: 0.84-1.19). Similarly, there was no statistically significant association observed between the influence of religious beliefs on decisions and perceived need for treatment (OR = 1.09 95% CI: 0.92-1.29).

Discussion

In this sample of persons with self-identified substance abuse problems, both the importance of religious beliefs and the influence of religious beliefs on decisions were statistically significantly associated with receipt of substance abuse treatment in the past 12 months.
The ORs were almost identical. Our findings align with the model of Longshore et al.\textsuperscript{15} that demonstrated the importance of religious beliefs on drug treatment research. Our study additionally suggests that one’s religious beliefs may also influence the decision to initiate treatment and treatment-seeking behaviors. However, in our study, we were unable to determine if one’s religious beliefs influences the acceptability of a specific treatment program to a person with substance abuse problems.

The current study highlights the potential importance of addressing religious beliefs and behaviors in substance abuse counseling. The integration of religious beliefs into substance abuse counseling presents several considerations for care...
providers and substance use disorder (SUD) intervention planners. One of the cornerstones of behavioral intervention is evidence-based theory. Because definitions of religiosity and spirituality vary widely and beliefs about the connection to substance abuse behavior, even more so, there has traditionally been difficulty grounding religious interventions within the framework of a health behavior model. To address this gap, Neff and MacMaster\textsuperscript{16} proposed a spiritual behavior change model which comprised of concepts from the Theory of Reasoned Action (TRA), the Health Belief Model (HBM), and Social Learning Theory. Notably, the Neff and MacMaster’s model differs from the Transtheoretical Model (TTM)\textsuperscript{17} (one of the most often-cited health behavior theories for addictions), noting that while TTM provides perspective on the behavior change process, it does not comprehensively address the mechanisms underlying those processes.\textsuperscript{17} Understanding the process of spiritual development in the path of substance abuse treatment and recovery may be a critical step in effective treatment planning.

Another key consideration for providers is how different spiritual and religious frameworks do and do not align with the disease model of addiction (DMA) and medication-assisted treatment (MAT) strategies. The DMA is not without criticism.\textsuperscript{18} Nonetheless, the model has many champions, and MAT strategies align well with the DMA. A qualitative study by van der Meer and Nappo\textsuperscript{19} of three different religious groups’ substance abuse programs noted that some religious sects exclusively promoted prayer as an intervention and eschewed the use of MAT. Other religions in the study either supported or were open to a combination of prayer and MAT.\textsuperscript{19} Chu and Sung\textsuperscript{20} study of substance abuse treatment counselors’ philosophies indicated that counselors in faith-based programs were less likely to ascribe to the disease paradigm of addiction. Providers should be very aware of the potential friction between religious beliefs, DMA, and MAT, particularly if program participants have either been prescribed MAT by other health care providers or seek the option to explore medication therapies as part of their treatment plans.

Finally, another important issue for providers and patients is the assessment of religious beliefs as salient individual protective factors. Persons who place greater value on their religious beliefs may benefit more than others from integrating religion into their treatment plans. The 10-item Treatment Spirituality/Religiosity Scale (TSRS) developed by Lillis et al.\textsuperscript{21} shows promise as the basis of a practical measurement tool. The TSRS was developed with a specific focus on SUD treatment environments and administered as a subscale of the Community-Oriented Programs Environment Scale (COPES).\textsuperscript{21} The authors suggest that the easily scored scale could assist providers in determining patient preferences for spirituality/religiosity (S/R) content in treatment programs. While the TSRS has notable limitations (e.g., lack of differentiation between spirituality and religiosity and specific references to Judeo-Christianity), an adapted religiously-inclusive version could have great utility in helping to improve participant-program fit.\textsuperscript{21}

**Conclusion**

Considering the current study’s findings and the above considerations, care providers may want to develop some sensitivity to patients’ religious beliefs and consider the opportunities and challenges of incorporating these beliefs in treatment programming. As patients seek meaning, purpose, and forgiveness to chart the course toward sobriety, religious beliefs may emerge as the guiding principle on their journeys.

**Limitations:** One limitation of this study is that the group reporting ever use of illicit drugs may consist of current users, recreational users, and past users. As such, the substance abuse-related problems may be chronic problems resulting from past substance use among persons who are no longer using illicit drugs. Persons who may not be currently using illicit drugs may be more likely to have completed treatment and as such, may have a unique perspective on the long-lasting effects of their past illicit drug use. Another limitation is the inability to explore the influence of engagement of religious practices or involvement across the life course. It may be important to look at the change in religious beliefs over time rather than at one point in time.

**Conflict of Interests**

The Authors have no conflict of interest.

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Authors’ Contribution
Conceptualized the research, wrote, reviewed and edited the manuscript: KBR; contributed to writing, reviewing, and editing of the manuscript: NW; contributed to the conceptualization of the research, reviewing, and editing of the manuscript: KC; conducted the data analysis and reviewed the manuscript: MH.

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مقدمه: اعتقادات مذهبی می تواند با ایجاد حمایت اجتماعی، اعتماد و امید، به موقعیت درمان در افرادی که دارای مشکلات سوء مصرف مواد هستند، کمک کند.

روش‌ها: به همین منظور، یک آنالیز تالوج با استفاده از بررسی ملی در مورد مصرف مواد و بهداشت ۲۰۱۹ انجام گرفت. این بررسی شامل ۳ شرکت کننده با مشکلات خودشناسیایی شده مصرف مواد غیر قانونی انجام شد. بررسی دو متغیر وزن‌دهی درمان و تحلیل رگرسیون جدید متغیرهای متغیرها مداخله‌گر بالقوه استفاده شد.

یافته‌ها: حدود ۱۵ درصد از نمونه‌های مطالعه در سنین ۱۸ تا ۲۵ سال بودند و ۷۱ درصد از افراد سیبیوسه غیر لاتین بودند. حدود ۳۲ درصد تحصیلات ادامه‌مادی تکمیل نشده داشتند و ۲۲ درصد فارغ‌التحصیل دانشگاه بودند. فقط ۱/۲ درصد گزارش کردند که در سه ماه گذشته مصرف مواد دریافت کرده‌اند. حدود ۵۴ درصد نیز در ۱۲ ماه گذشته با دیگر درمان سوء مصرف مواد مواد داشته‌اند. ۶۵۰۰۰ نمونه تشویقی در مورد سوء مصرف مواد بهداشت عمومی در ایران حاضر بودند. فقط ۱/۲ درصد افراد سیبیوسه غیر لاتین، بودند. ترکیب گیری: اعتقادات مذهبی بهترین مدلی می‌تواند برای تعیین کننده‌های می‌تواند در دانشکده‌های مجامعی در افراد سیبیوسه غیر لاتین باشد.

توصیه‌گری: اعتقادات مذهبی می تواند تبعین کننده می‌تواند در دانشکده‌های مجامعی بوده و همچنین، رهبردهایی برای بررسی درمان‌های مبتلای به ایمان دارد.

واژگان کلیدی: مذهبی؛ اعتقادات مربوط به مواد؛ درمان؛ سیبیوسه غیر لاتین

ارجاع: بیتیست رایترز کشا، نیا ورنتز، کریمی، کولمن، میان حسین.

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