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Original Article

Alcohol Use Disorders and its Association with Family Factors among Undergraduates of Obafemi Awolowo University, Ile-Ife, Nigeria

Akinsulore A[1,2], Ologunleko AF[1], Oladimeji BY[1,2]

[1]Department of Mental Health, Faculty of Clinical Sciences, Obafemi Awolowo University, [2]Department of Mental Health, Obafemi Awolowo University Teaching Hospitals Complex, Ile-Ife, Osun State, Nigeria

ABSTRACT

Background: Alcohol is a socially acceptable substance that plays a key traditional role in the African setting. Family factors such as dysfunctional family background may increase the risk of alcohol use disorder (AUD) among university students.
Objective: This study assessed the prevalence of AUD and its association with family factors among undergraduates of a Nigerian university.
Methods: This descriptive cross-sectional survey involved 360 consenting undergraduates recruited from Obafemi Awolowo University, Ile-Ife. Demographic variables were obtained with a questionnaire, whereas AUD was measured with AUD Identification Test. Family factors assessed were family structure, family socioeconomic status, family functioning, parenting styles and perceived social support (PSS).
Results: The mean age of respondents was 21.12 years (standard deviation = 2.37) and 223 (61.9%) were males. The prevalence of AUD was 16.7%. Factors significantly associated with AUD were demographic variables – being male ($P < 0.001$) and traditional religion ($P = 0.024$) and family factors – low socioeconomic class ($P = 0.023$), dysfunctional family ($P < 0.001$) and father use of alcohol ($P = 0.001$). Respondents with AUD reported significantly lower mean score on all the PSS subscales: family ($P = 0.001$), friend ($P < 0.001$) and significant other ($P < 0.001$) and authoritative parenting style of father ($P < 0.001$) and mother ($P < 0.001$). Predictors of AUD were male sex, father use of alcohol, father authoritative parenting style and high PSS from friends.
Conclusion: AUD is prevalent among Nigerian undergraduates with male sex and some family factors associated with it. The results of this study have significant implications for both primary and secondary prevention efforts.

Key words: Alcohol, alcohol use disorder, family factors, undergraduate, university

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INTRODUCTION

Globally, alcohol is a licit and socially acceptable substance and the most used psychoactive substance.[1] Apart from the economic and social roles, alcoholic beverages play key traditional roles such as festivals and celebrations in the African setting.[1,2] Alcoholic beverage contains a psychoactive substance called ethanol, a depressant which in low doses causes euphoria and reduces anxiety and sociability and in higher doses causes intoxication, stupor and unconsciousness.[3,4] Alcohol use occurs across all age groups, but the use among adolescents and young people aged 18–24 years was reported to be highest.[5] This age bracket includes the majority of enrolled university students in Nigeria.

University life is a 'transitional' period during which undergraduates move away from their parents and from a restricted secondary school life to a more independent life with limited parental supervision and a liberal campus environment.[1,6] These and many other factors such as academic stress, peer pressure, easy accessibility, family factors such as unhealthy family background and conflict with parents increase their risk of alcohol use and abuse among university students. [1,6-8]

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Address for correspondence: Dr. Akinsulore A, Department of Mental Health, Faculty of Clinical Sciences, Obafemi Awolowo University, Ile-Ife, Osun State, Nigeria.
E-Mail: sanmilore@oauife.edu.ng

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The family is the most vital social contexts that influence adolescents and young people to use and abuse alcohol.[9,10] Family has the most significant influence on young adults because the family is the first intimate social group many individuals belong to.[11]

Although a number of family factors have been identified in literature to be associated with alcohol use disorders (AUDs) among young people,[12-14] this study examined six family factors. These include family structure, family functioning, family's socioeconomic status, parenting style, parent use of alcohol and social support. The family structure includes the people who are considered part of the family and may have an effect on the children's behaviour. Adolescents who live in single-parent families, stepfamilies and foster care are more likely to be involved in severe risky behaviours such as alcohol and other drug use than those who live with both biological parents.[15,16]

Family functioning is a complex concept that assesses family interaction and relationships, problem-solving, communication and level of care for one another in the family.[14] Dysfunctional family characterised by high family stress and conflict has been reported to be associated with AUDs among adequate yearly progress.[17,18]

Another factor that is related to alcohol use among youths is familial socioeconomic status.[19] Previous studies have documented contrasting results. Some studies revealed a greater likelihood of substance use among youths from families with higher socioeconomic status,[6,20,21] whereas some studies have identified a higher risk of excessive alcohol intake among youths from lower socioeconomic groups.[22]

Parenting styles are child-rearing strategies that parents use in dealing with their children.[23] Previous studies have reported that authoritative parenting style is the most protective against alcohol and drug use.[24] However, authoritarian, permissive and neglectful parenting were reported to be risk factors for alcohol and other drug use.[25]

Alcohol use in parents is also a strong predictor of child drinking behaviour.[26,27] Several studies have examined the effects of parent's behaviour on the onset of heavy and problematic drinking of their children.[28,29] Young people are more likely to drink frequently and excessively if they are exposed to family members, especially a parent who drinks, gets drunk or is a problematic drinker.[30]

Social support has been found to be protective against alcohol use.[31] Adolescents who reported high levels of support from parents and family members were less frequent to use alcohol.[32] In another study, less supportive families were related to earlier onset of alcohol use.[33]

This study assessed the prevalence of AUDs and its association with family factors among undergraduates of Obafemi Awolowo University (OAU), Ile-Ife, Nigeria. To the best of our knowledge, this is the first study to examine family factors as they relate to AUDs among university students in Nigeria. To address this gap, this study examines the influence of six family factors on AUDs among a sample of undergraduates in a Nigerian university.

METHODS

Ethical consideration

Ethical approval was obtained from the Health Research Ethics Committee of the Institute of Public Health, OAU, Ile-Ife, with protocol number IPHOAU/12/862. Informed consent was obtained from the participants after the objectives of the study have been explained. Respondents were assured that the information given would be held in strict confidence.

Research design

This study employed a descriptive cross-sectional design to examine the influence of family factors in AUDs among undergraduates of OAU, Ile-Ife.

Study area

OAU is a federal government-owned and operated Nigerian university situated within the ancient city of Ile-Ife, Osun state, Nigeria. The university has two colleges (College of Health Sciences and Postgraduate College) and 13 faculties (Administration, Agriculture, Arts, Education, Environmental Design and Management, Technology, Social Sciences, Law, Sciences, Pharmacy, Basic Medical Sciences, Clinical Sciences and Dentistry). The last three faculties are in the College of Health Sciences of the institution. It has nine halls of residence.

Study population

The study was carried out among undergraduate students of OAU, Ile-Ife. There are more than 20,000 undergraduate and 6000 postgraduate students in the university as of December 2019.

a. Inclusion criteria: Undergraduate students of the OAU, Ile-Ife, aged 18 years and above
b. Exclusion criteria: Undergraduate students <18 years, postgraduate students and others students undergoing diploma courses.

Sample size

Using the formula for calculating sample size for estimating population proportions $n = Z^2 P(1 - P)/E$ where n = sample size, Z = the standard normal deviation at 95% confidence level (1.96), P = prevalence of alcohol-related disorder was 14.9% among undergraduates in a Nigerian university,[5] E = Specified error which was 4% and 1.96 is the critical value for a confidence level of 95%. Therefore, $N = 1.96^2 \times 0.72 \times 0.28/0.0025 = 305$ respondents. This figure was increased to 360 to make up for possible incomplete data.

Sampling procedure

Multistage sampling technique was employed to select the students from the study population. The first stage involved selection of four undergraduate halls of residence (two male

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halls and two female halls) using a simple random sampling technique. In each hall of residence, 90 students were selected making a total of 360 students. The second stage involved selection of blocks from each of the selected male and female halls using simple random sampling. For each of the block, 45 students were selected. In the third stage, 15 students were selected per floor. Furthermore, five rooms were randomly selected on each floor of the selected blocks and three students were randomly selected from each room using balloting.

Research instruments

Demographic factors

A questionnaire was used to obtain information on respondents' demographic variables. Such information includes age, gender, religion and faculty. The faculties were categorised into four groups. Group 1 includes faculty of basic medical science, clinical science and pharmacy; Group 2 includes faculty of science, agriculture and technology; Group 3 includes faculty of social science, administration and environmental design; Group 4 includes faculty of law, art and education.

Alcohol use disorder

This was measured with the Alcohol Use Disorder Identification Test (AUDIT). The AUDIT was developed by the World Health Organization screening tool for detecting alcohol-related problems such as harmful alcohol use, and a validation study has been done against DSM-IV criteria. Moreover, a study conducted in the United Kingdom reported that the AUDIT was useful for AUD screening according to the Diagnostic and Statistical Manual of Mental Disorders (DSM)-5 criteria.[34] The AUDIT is a self-rated 10-item questionnaire with each item scored 0–4, giving a total score of 40. In a validation study among undergraduates in Nigeria, the recommended a cut-off of 5, 7 and 9 corresponds with hazardous alcohol use, harmful use and alcohol dependence, respectively.[35] To evaluate AUD in this study, a cut-off of 7 and above (harmful use) was used. The AUDIT has been shown to be an excellent tool for discriminating between DSM-5 AUD and no AUD at this level.[36]

Family factors

Six family variables were assessed, and it includes family structure, family socioeconomic status, perceived family functioning, parenting styles and perceived social support (PSS).

Family structure was classified as nuclear family (children living with both parents), single-parent family, step-parent family (parents living with children of previous marriage) and extended family (comprises parents, children and grandparents or other extended family member).

Family socioeconomic status was derived from parents' occupation and parents' education using the Oyedeji socioeconomic classification.[37]

Perceived family function was assessed using the Family APGAR questionnaire which consists of five parameters of family functioning: Adaptability, Partnership, Growth, Affection and Resolve. The response options were designed to describe the frequency of feeling satisfied with each parameter on a 3-point scale ranging from 0 (hardly ever) to 2 (almost always). It is scored by summing the values for the five items for a total score that ranges from 0 to 10. The scale is graded as 0–6 (dysfunctional family) and 7–10 (highly functional family). The scale has been used in Nigeria.[38]

Parenting style was assessed with the Parental Authority Questionnaire (PAQ).[39] It is a self-report questionnaire which was designed to measure parental disciplinary style from the viewpoint of the child (of any age). The questionnaire contains a total of 30 items and the response pattern is the Likert format ranging from 1 (strongly disagree) to 5 (strongly agree). The PAQ has three subscales: permissive (items 1, 6, 10, 13, 14, 17, 19, 21, 24 and 28), authoritarian (items 2, 3, 7, 9, 12, 16, 18, 25, 26 and 29) and authoritative (items 4, 5, 8, 11, 15, 20, 22, 23, 27 and 30). There is a separate form for mother and a form for father, but the questions are the same and in the same order. To score the PAQ, the individual items for each parenting style are summed. The scores on each subscale are from a minimum of 10 and a maximum of 50.

PSS was assessed with the Multidimensional Scale of Perceived Social Support (MSPSS).[40] The 12-item questionnaire provides an assessment of three sources of support: family, friends and significant others. Items 3, 4, 8 and 11 measure family supports; items 6, 7, 9 and 12 measure friend support, whereas items 1, 2, 5 and 10 measure significant other support. The questionnaire is a 7-point rating scale ranging from very strongly disagree (1) to very strongly agree (7), with the overall score ranging from 12 to 84, whereas the subscale score ranges from 4 to 28 and a higher score indicates greater received social support.

Data analysis

The IBM-SPSS version 21 (Armonk, NY, USA) was used for statistical analysis. The data collected were sorted properly and organised. Results were calculated as frequencies, percentages, means and standard deviations (SDs). Frequency tables were generated, and relevant cross tabulations were made. Proportions were compared using the Chi-square test, whereas means were compared using independent *t*-test. Multiple logistic regression analysis with stepwise method was used to explore the predictors (demographics and family factors) of alcohol-related disorders among respondents. The model contained significant independent variables such as demographic factors (sex and religion) and family factors (father use of alcohol, socioeconomic class, family functioning, father and mother authoritative parenting style, PSS from family, friend and significant others). The dependent variable is AUD (AUDIT score ≥7). Odds ratio (OR) and 95% confidence intervals were calculated. The percentage of explained variance of models was assessed by both Cox and Snell R^2 and Nagelkerke R^2 indices. All tests were two-tailed, and the level of significance was computed at $P < 0.05$.

RESULTS

Three hundred and sixty questionnaires were analysed giving a response rate of 100%. The prevalence of

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AUD (AUDIT score ≥7) was 16.7% [Figure 1]. One hundred and ninety-seven respondents (54.7%) were 21 years and above, with a mean age of 21.12 years (SD = 2.37), and the age range was 18–32 years. There were 223 (61.9%) males, 299 (83.0) were Christians and 226 (62.8%) constitute Groups 2 and 3 of the faculties. AUDs were associated with being male (χ^2 = 30.09; P < 0.001) and traditional religion (χ^2 = 7.46; P = 0.024) [Table I]. Three hundred and four respondents (84.4%) lived with both biological parents, whereas only six (1.7%) lived in stepfamily. One hundred and ninety-seven respondents (54.7%) were classified into Class 2 socioeconomic status, whereas only 2 (0.6) were in Class 5. Two hundred and eighty-three respondents (78.6%) were from highly functional family, Ninety respondents (25%) fathers use alcohol and 23 respondents (6.4%) mother use alcohol. The mean scores (SD) of family, friend and significant other subscales of MSPSS were 5.54 (1.74), 4.66 (1.44) and 5.12 (1.52), respectively. The total mean score (SD) of MSPSS was 5.11 (1.21). The mean scores (SD) of father authoritative, authoritarian and permissive subscales of PAQ were 32.5 (8.19), 31.4 (7.74) and 27.3 (7.10), respectively. The mean scores (SD) of mother authoritative, authoritarian and permissive subscales of PAQ were 33.5 (8.01), 31.2 (7.84) and 27.9 (7.42), respectively. AUDs were associated with socioeconomic Class 5 (χ^2 = 13.04; P = 0.011), dysfunctional family (χ^2 = 17.61; P < 0.001) and father use of alcohol (χ^2 = 10.67; P = 0.001). Respondents with AUDs reported a significantly lower mean score on family (t = 3.36; P = 0.001), friend (t = 3.89; P < 0.001) and significant other (t = 4.48; P < 0.001) subscales of MSPSS. Furthermore, respondents with AUDs reported a significantly lower mean score on father authoritative (t = 5.27; P < 0.001) and mother authoritative (t = 4.57; P < 0.001) PAQ subscales [Table II].

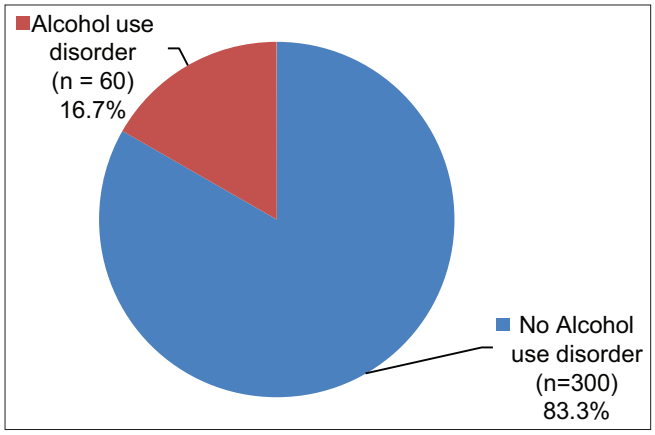

Figure 1: Prevalence of alcohol use disorder among respondents

Multiple logistic regression analysis was performed to assess the impact of a number of factors on the likelihood that respondents would report AUDs. The full model containing all predictors was statistically significant, χ^2 (14, N = 360) = 95.02, P <.001, indicating that the model was able to distinguish between respondents with and without AUDs. The model as a whole explained between 23.2% (Cox and Snell R^2) and 39.1% (Nagelkerke R^2) of the variance in alcohol use status and correctly classified 86.4% of cases. As shown in Table III, only four of the independent variables made a unique statistically significant contribution to the model (male sex, father use of alcohol, father authoritative and PSS from friends). The strongest predictor of reporting AUDs was male sex, recording an OR of 10.96. This indicated that male respondents were about 11 times more likely to report AUDs than female respondents, controlling for all other factors in the model. This was followed by father use of alcohol, recording an odd ratio of 6.10. This indicated that respondents whose father uses alcohol were over six times more likely to report AUDs than those whose parents did not use alcohol, controlling for all other factors in the model.

Table I: Association between demographic variables and alcohol-related problems among respondents

Variable	No alcohol use disorder (n=300; 83.3%), n (%)	Alcohol use disorder (n=60; 16.7%), n (%)	Total (n=360; 100%), n (%)	Statistics χ^2/P
Age group (years)				
<21	139 (85.3)	24 (14.7)	163 (45.3)	0.809/0.368
≥21	161 (81.7)	36 (18.3)	197 (54.7)	
Sex				
Male	167 (74.9)	56 (25.1)	223 (61.9)	30.09/<0.001
Female	133 (97.1)	4 (2.9)	237 (38.1)	
Religion				
Christianity	249 (83.3)	50 (16.7)	299 (83.0)	7.46/0.024
Islam	49 (87.5)	7 (12.5)	56 (15.6)	
Traditional	2 (40.0)	3 (60.0)	5 (1.4)	
Faculty				
Group 1	26 (92.9)	2 (7.1)	28 (7.8)	2.88/0.410
Group 2	91 (82.7)	19 (17.3)	110 (30.6)	
Group 3	93 (80.2)	23 (19.8)	116 (32.2)	
Group 4	90 (84.9)	16 (15.1)	104 (29.4)	

Group 1: Includes Faculty of Basic Medical Science, Clinical Science and Pharmacy, Group 2: Includes Faculty of Science, Agriculture and Technology, Group 3: Includes Faculty of Social Science, Administration and Environmental Design, Group 4: Includes Faculty of Law, Art and Education

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Table II: Association between family factors and alcohol-related problems among respondents

Variable	No alcohol use disorder (*n*=300; 83.3%), *n* (%)	Alcohol use disorder (*n*=60; 16.7%), *n* (%)	Total (*n*=360; 100%), *n* (%)	Statistics χ^2/*P*
Family structure				
Both biological parents	259 (85.2)	45 (14.8)	304 (84.4)	5.39/0.145
Single parent	26 (72.2)	10 (27.8)	36 (10.0)	
Extended family	11 (78.6)	3 (21.4)	14 (3.9)	
Stepfamily	4 (66.7)	2 (33.3)	6 (1.7)	
SEC				
Class 1	63 (81.8)	14 (18.2)	77 (21.4)	11.35/0.023*
Class 2	169 (85.8)	28 (14.2)	197 (54.7)	
Class 3	46 (76.7)	14 (23.3)	60 (16.7)	
Class 4	22 (91.7)	2 (8.3)	24 (6.7)	
Class 5	0 (0.0)	2 (100.0)	2 (0.6)	
Family functioning				
Functional family	248 (87.6)	35 (12.4)	283 (78.6)	17.13/<0.001
Dysfunctional family	52 (67.5)	25 (32.5)	77 (21.4)	
Father use of alcohol				
Yes	65 (72.2)	25 (27.8)	90 (25.0)	10.67/0.001
No	235 (87.0)	35 (13.0)	270 (75.0)	
Mother use of alcohol				
Yes	16 (69.6)	7 (30.4)	23 (6.4)	3.35/0.067
No	284 (84.3)	53 (15.7)	337 (93.6)	
Variable	**No alcohol use disorder, mean±SD**	**Alcohol use disorder, mean±SD**	**Total, mean±SD**	***t*-test/*P***
Perceived social support				
Family	5.68 (1.58)	4.86 (2.30)	5.54 (1.74)	3.36/0.001
Friend	4.79 (1.33)	4.03 (1.59)	4.66 (1.40)	3.89/<0.001
Significant other	5.298 (1.46)	4.34 (1.56)	5.12 (1.52)	4.48/<0.001
Total	5.25 (1.10)	4.41 (1.47)	5.11 (1.21)	5.07/<0.001
Father parenting style				
Authoritative	33.52 (7.87)	27.63 (7.90)	32.5 (8.19)	5.27/<0.001
Authoritarian	31.56 (7.49)	30.40 (8.88)	31.4 (7.74)	1.06/0.290
Permissive	27.31 (6.97)	27.33 (7.78)	27.3 (7.10)	−0.20/0.984
Mother parenting style				
Authoritative	34.37 (7.51)	29.33 (9.12)	33.5 (8.01)	4.57/<0.001
Authoritarian	31.47 (7.67)	29.90 (8.62)	31.2 (7.84)	1.42/0.157
Permissive	27.85 (7.25)	27.85 (8.30)	27.9 (7.42)	0.003/0.997

*Likelihood ratio. SEC: Socioeconomic class, SD: Standard deviation

DISCUSSION

This study provides useful information about the prevalence of AUDs among a sample of Nigerian undergraduates and its association with six family factors. The prevalence rate of 16.7% for AUDs (AUDIT score ≥7) reported in this study is within the range reported in Nigeria and other countries.[5,41] However, our reported prevalence of AUDs is over four times that earlier reported by Adewuya *et al*. in the same university.[6] This could be as a result of the difference in the instruments used, or it could be an indication of increase in alcohol consumption among undergraduates in the university over time. Moreover, it was higher than 12.5% reported among freshmen in the University of Ibadan, Nigerian,[20] and 0.8% reported among freshmen in Hong Kong University.[42] Moreover, it is lower 35.5% reported among the University of Malawi students[43] and 68% reported among undergraduates in New Zealand.[44] Therefore, there is a wide range of prevalence of AUDs among undergraduates within Nigeria and other countries. Some of the apparent differences may stem from methodological differences, social and cultural factors, accessibility and price of alcohol and university policies concerning alcohol.[5,6]

A higher proportion of respondents aged 21 years and above had AUDs when compared to those below 21 years. However, this study did not find a significant association between age group and AUDs, whereas a Nigerian study[5] reported a significant association between older age group and alcohol-related disorders.

In this study, AUDs were significantly associated with male sex. Male students were more likely to have AUDs than female

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Table III: Multiple logistic regression analysis predicting alcohol-related problems among respondents (*n*=360)

	B	SE	Wald	Significant	Exp(*B*)	95% CI for Exp(*B*)	
						Lower	Upper
Male (female=reference)	2.39	0.568	17.79	<0.001	10.96	3.60	33.36
Islam (reference)			2.22	0.330			
Christianity	0.47	0.507	0.85	0.357	1.60	0.59	4.31
Traditional	1.81	1.281	1.99	0.158	6.10	0.49	75.13
Father alcohol use (no=reference)	1.13	0.372	9.23	0.002	3.09	1.49	6.41
SEC_Class 1			5.75	0.219			
SEC_Class 2	−0.65	0.430	2.28	0.131	0.52	0.22	1.21
SEC_Class 3	0.004	0.511	0.00	0.994	1.00	0.37	2.73
SEC_Class 4	−1.61	0.883	3.33	0.068	0.20	0.04	1.13
SEC_Class 5	19.21	28,023.340	0.00	0.999	221,083,627.29	0.00	.
Dysfunctional family	0.65	0.371	3.10	0.078	1.92	0.93	3.98
Father_authoritative	−0.07	0.034	4.26	0.039	0.93	0.87	0.99
Mother_authoritative	0.00	0.033	0.00	0.998	1.00	0.94	1.07
PSS_family	−0.02	0.115	0.02	0.896	0.99	0.79	1.23
PSS_friend	−0.31	0.138	5.14	0.023	0.73	0.56	0.96
PSS_SO	−0.11	0.133	0.69	0.408	0.90	0.69	1.16
Constant	0.09	1.125	0.007	0.934	1.097		

SEC: Socioeconomic class, PSS: Perceived social support, SO: Significant other, CI: Confidence interval, SE: Standard deviation

counterparts. This is consistent with reports of earlier studies among undergraduates in Nigeria.[5,6,20] A possible explanation for this observation; males are more adventurous than their female counterparts and they are more likely to experiment during their adolescence. Furthermore, cultural factors may also explain why more males had AUD than females. In African settings, alcohol use is more permissible for males, whereas female alcohol users are viewed in a negative perspective.[45]

Traditional religion was found to be significantly associated with AUDs in this study. This may be attributed to the fact that some traditional religion practices involve the use of alcohol which may introduce them to the use of alcohol earlier. This is in contrast with findings of a previous Nigerian study that reported excessive use of alcohol among Christians.[46] Students who live with stepfamily and single parents had a higher proportion with AUDs; however, this was not statistically significant. Previous studies have reported a significant association between living with step and single parents with AUDs. [47,48] Socioeconomic status may play a role in AUDs. However, there are conflicting reports on the role of socioeconomic status in alcohol-related disorders. In this study, there was a significant association between AUDs and lower socioeconomic status, and this is consistent with findings in a previous among university students in Nigeria.[49] However, other Nigerian studies reported increased AUDs among young people of higher socioeconomic status.[6,20]

The family is a multifaceted system that consists of three subsystems, namely the parental subsystem, parent–child subsystems and the sibling subsystems.[17] All the family subsystems function together and are knitted in such a way that altering one will lead to a change in the other subsystems. In this study, dysfunctional family was associated with AUDs among the undergraduates. Similar findings were reported by a previous study.[50] Studies have shown that parental substance use is a factor in substance use among their offspring.[27] AUDs were found among respondents whose fathers use alcohol. This is consistent with the findings of previous studies.[1,6,51] This is probably due to the fact that parents being the first persons that children have frequent interactions with exerting enormous influence on them by acting as a role model. Hence, when parents abuse alcohol, they become drinking models to their children. In addition, children whose parents abuse alcohol may learn to view such behaviour (excessive substance use) as a norm. Therefore, they are more inclined to use this substance because they view it as normal behaviour. Furthermore, parents' alcohol use can influence children directly through a genetic predisposition. An individual who has a parent with AUDs may also have the same problem because they might have inherited genes that make them to be susceptible to alcohol abuse.[52,53] In this study, father authoritative parenting style was a protective factor, and this is similar to the report of a previous study.[24] Similarly, PSS from friends was a protective factor in this study, and this is consistent with the findings of a previous study.[31]

This study had some limitations. First, the study was conducted in only one tertiary institution and may not be generalizable to the entire undergraduate population of Nigeria. Second, the respondents were required to report substance use that had occurred in the past, and this may raise the possibility of recall bias. Third, this is a cross-sectional descriptive study and may not be able to establish the direction of causality in the relationship between AUD and family factors. However, this is the first study to look at the relationship between specific substance (alcohol) and family factors. Moreover, the use of standardised instruments to assess AUD and family factors is

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the strength of this study as it makes our findings to be easily comparable with studies conducted in other parts of the world.

CONCLUSION

This study draws attention to the dearth of scientific data on family factors associated with AUD among undergraduates in Nigeria. It shows that alcohol AUD is prevalent in among Nigerian undergraduates. Apart from male sex, family factors associated with AUD were father use of alcohol, father authoritative parenting style and PSS from friends. The results of this study have significant implications for both primary and secondary prevention efforts. It will be necessary to conduct studies assessing the rates of AUD among adolescents and young people in the general population setting and also relate it with the family factors. There is a need to conduct longitudinal studies examining family factors and alcohol use among young people.

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Conflicts of interest

There are no conflicts of interest.

REFERENCES

1. Olashore AA, Ogunwobi O, Totego E, Opondo PR. Psychoactive substance use among first-year students in a Botswana University: Pattern and demographic correlates. BMC Psychiatry 2018;18:270.
2. Lasebikan VO, Ola BA. Prevalence and correlates of alcohol use among a sample of Nigerian semirural community dwellers in Nigeria. J Addict 2016; 2016:6.
3. Cvetković D, Živković V, Lukić V, Nikolić S. Unnatural and violent death in cases with high blood alcohol concentration- autopsy study. J Forensic Sci 2017;62:1506-11.
4. Fairbairn CE, Sayette MA. A social-attributional analysis of alcohol response. Psychol Bull 2014;140:1361-82.
5. Abayomi O, Onifade PO, Adelufosi AO, Akinhanmi AO. Psychosocial correlates of hazardous alcohol use among undergraduates in Southwestern Nigeria. Gen Hosp Psychiatry 2013;35:320-4.
6. Adewuya A, Ola B, Aloba O, Mapayi B, Ibigbami O, Adewumi T. Alcohol use disorders among Nigerian university students: Prevalence and sociodemographic correlates. Niger J Psychiatry 2007;5:5-9.
7. Makanjuola AB, Daramola TO, Obembe AO. Psychoactive substance use among medical students in a Nigerian university. World Psychiatry 2007;6:112-4.
8. Onongha G. The influence of some factors on alcohol use and abuse among education students of Osun state university, Nigeria. Int J Hum Soc Sci 2012;2:276-83.
9. Chen AC, Gance-Cleveland B, Kopak A, Haas S, Gillmore M. Engaging families to prevent substance use among Latino youth. J Spec Pediatr Nurs 2010;15:324-8.
10. Latendresse SJ, Rose RJ, Viken RJ, Pulkkinen L, Kaprio J, Dick DM. Parenting mechanisms in links between parents' and adolescents' alcohol use behaviors. Alcohol Clin Exp Res 2008;32:322-30.
11. Bahr SJ, Hoffmann JP, Yang X. Parental and peer influences on the risk of adolescent drug use. J Prim Prev 2005;26:529-51.
12. Kask K, Markina A, Podana Z. The effect of family factors on intense alcohol use among European adolescents: A multilevel analysis. Psychiatry J 2013;2013:250215.
13. Kopak AM, Chen AC, Haas SA, Gillmore MR. The importance of family factors to protect against substance use related problems among Mexican heritage and White youth. Drug Alcohol Depend 2012;124:34-41.
14. Scully C, McLaughlin J, Fitzgerald A. The relationship between adverse childhood experiences, family functioning, and mental health problems among children and adolescents: A systematic review. J Fam Ther 2020;42:291-316.
15. Barrett AE, Turner RJ. Family structure and substance use problems in adolescence and early adulthood: Examining explanations for the relationship. Addiction 2006;101:109-20.
16. Hoffmann JP. Family structure and adolescent substance use: An international perspective. Subst Use Misuse 2017;52:1667-83.
17. Khandelwal A, Khandelwal S, Desousa A. Unraveling the dynamic interplay between family functioning and substance use among adolescents: An Indian perspective. Int J Med Sci Public Health 2017;6:822-8.
18. Schäfer G, Lecturer S. Family functioning in families with alcohol and other drug addiction. Soc Policy J N Zealand 2011;37:1-17.
19. Huckle T, You RQ, Casswell S. Socio-economic status predicts drinking patterns but not alcohol-related consequences independently. Addiction 2010;105:1192-202.
20. Olley BO. Child sexual abuse, harmful alcohol use and age as determinants of sexual risk behaviours among freshmen in a Nigerian university. Afr J Reprod Health 2008;12:75-88.
21. Schoenborn C, Adams P. Health behaviors of adults: United States, 2005–2007. Vital Health Stat 2010;245:132.
22. Lemstra M, Bennett NR, Neudorf C, Kunst A, Nannapaneni U, Warren LM, *et al*. A meta-analysis of marijuana and alcohol use by socio-economic status in adolescents aged 10-15 years. Can J Public Health 2008;99:172-7.
23. Changalwa CN, Ndurumo MM, Barasa PL, Poipoi MW. The relationship between parenting styles and alcohol abuse among college students in Kenya. Greener J Educ Res 2012;2:13-20.
24. Martínez-Loredo V, Fernández-Artamendi S, Weidberg S, Pericot I, López-Núñez C, Fernández-Hermida JR, *et al*. Parenting styles and alcohol use among adolescents: A longitudinal study. Eur J Investig Health Psychol Educ 2016;6:27-36.
25. García F, Gracia E. Is always authoritative the optimum parenting style? Evidence from Spanish families. Adolescence 2009;44:101-31.
26. Bremner P, Burnett J, Nunney F, Ravat M, Mistral W. Influences: A study of young people and their relationship with alcohol. New York: Joseph Rowntree Foundation; 2011.
27. Chassin L, Pitts SC, DeLucia C, Todd M. A longitudinal study of children of alcoholics: Predicting young adult substance use disorders, anxiety, and depression. J Abnorm Psychol 1999;108:106-19.
28. Brook JS, Balka EB, Crossman AM, Dermatis H, Galanter M, Brook DW. The Relationship between parental alcohol use, early and late adolescent alcohol use, and young adult psychological symptoms: A longitudinal study. Am J Addict 2010;19:534-42.
29. van Der Vorst H, Engels RC, Meeus W, Deković M, van Leeuwe J. The role of alcohol-specific socialization in adolescents' drinking behaviour. Addiction 2005;100:1464-76.
30. Monsurat I, Moshood I, Okunola A. Family factors and adolescents' substance abuse: A study of adolescent substance abusers in Ilorin, Kwara State. Kaduna J Sociol 2015;3:148-64.
31. Mason WA, Windle M. Family, religious, school and peer influences on adolescent alcohol use: A longitudinal study. J Stud Alcohol 2001;62:44-53.
32. de Haan L, Boljevac T, Schaefer K. Rural community characteristics, economic hardship, and peer and parental influences in early adolescent alcohol use. J Early Adolesc 2009;30:629-50.
33. Hellandsjø Bu ET, Watten RG, Foxcroft DR, Ingebrigtsen JE, Relling G. Teenage alcohol and intoxication debut: The impact of family socialization factors, living area and participation in organized sports. Alcohol Alcohol 2002;37:74-80.
34. Foxcroft DR, Smith LA, Thomas H, Howcutt S. Accuracy of alcohol use disorders identification test for detecting problem drinking in 18-35 year-olds in England: Method comparison study.

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Alcohol Alcohol 2015;50:244-50.
35. Adewuya AO. Validation of the alcohol use disorders identification test (audit) as a screening tool for alcohol-related problems among Nigerian university students. Alcohol Alcohol 2005;40:575-7.
36. Källmén H, Elgán TH, Wennberg P, Berman AH. Concurrent validity of the Alcohol Use Disorders Identification Test (AUDIT) in relation to Alcohol Use Disorder (AUD) severity levels according to the brief DSM-5 AUD diagnostic assessment screener. Nord J Psychiatry 2019;73:397-400.
37. Oyedeji G. Socio-economic and cultural background of hospitalized children in Ilesa. Niger J Paediatr 1985;12:111-7.
38. Shittu RO, Issa BA, Olanrewaju GT, Mahmoud AO, Aderibigbe SA, Odeigah LO. A comparison of clinical features of depressed and non-depressed people living with HIV/AIDS, in Nigeria, West Africa. Open J Med Psychol 2014;3:60-9.
39. Buri JR. Parental authority questionnaire. J Pers Assess 1991;57:110-9.
40. Zimet GD, Dahlem NW, Zimet SG, Farley GK. The multidimensional scale of perceived social support. J Pers Assess 1988;52:30-41.
41. Slutske WS. Alcohol use disorders among US college students and their non-college-attending peers. Arch Gen Psychiatry 2005;62:321-7.
42. Griffiths S, Lau JT, Chow JK, Lee SS, Kan PY, Lee S. Alcohol use among entrants to a Hong Kong University. Alcohol Alcohol 2006;41:560-5.
43. Zverev Y. Problem drinking among university students in Malawi. Coll Antropol 2008;32:27-31.
44. Kypri K, Paschall MJ, Langley J, Baxter J, Cashell-Smith M, Bourdeau B. Drinking and alcohol-related harm among New Zealand university students: Findings from a National Web-Based Survey. Alcoholism Clin Exp Res 2009;33:307-14.
45. Abikoye GE, Sholarin M, Adekoya JA. Parenting styles and peer-pressure as predictors of substance abuse among university students. Psychol Behav Sci 2014;3:55-9.
46. Adeyemo Florence O, Beatrice O, Okpala PU, Oghale O. Prevalence of drug abuse amongst university students in Benin City, Nigeria. Public Health Res 2016;6:31-7.
47. Blum RW, Beuhring T, Shew ML, Bearinger LH, Sieving RE, Resnick MD. The effects of race/ethnicity, income, and family structure on adolescent risk behaviors. Am J Public Health 2000;90:1879-84.
48. Oman RF, Vesely SK, Tolma E, Aspy CB, Rodine S, Marshall L. Does family structure matter in the relationships between youth assets and youth alcohol, drug and tobacco use? J Res Adolesc 2007;17:743-66.
49. Ihezue UH. Alcohol and drug taking among medical students at a Nigerian university campus: Part 2. Sociodemographic factors of etiologic significance. J Natl Med Assoc 1988;80:191-5.
50. Gitatui M, Kimani S, Muniu S, Okube O. Determinants of harmful use of alcohol among urban slum dwelling adults in Kenya. Afr Health Sci 2019;19:2906-25.
51. Kilpatrick DG, Acierno R, Saunders B, Resnick HS, Best CL, Schnurr PP. Risk factors for adolescent substance abuse and dependence: Data from a national sample. J Consult Clin Psychol 2000;68:19-30.
52. Richmond-Rakerd LS, Slutske WS, Lynskey MT, Agrawal A, Madden PA, Bucholz KK, *et al*. Age at first use and later substance use disorder: Shared genetic and environmental pathways for nicotine, alcohol, and cannabis. J Abnorm Psychol 2016;125:946-59.
53. Sharmin S, Kypri K, Wadolowski M, Bruno R, Khanam M, Aiken A, *et al*. Parent hazardous drinking and their children's alcohol use in early and mid-adolescence: Prospective cohort study. Eur J Public Health 2019;29:736-40.