



Lead City Journal of the Social Sciences (LCJSS)

Faculty of Management and Social Sciences
Lead City University, Ibadan

ISSN: 2449092X
Volume 11 (No. 2) / July 2026

Audit Quality as a Determinant of Earnings Performance in Selected Nigerian Oil and Gas Companies

Adejuwon Oluwakemi, Oyedokun, Godwin Emmanuel, and Amedu Mercy Aishatu

Diversity, Inclusion Initiatives and Employee Performance in Selected Hotels, Lagos State, Nigeria

Adebanjo L. A., Adedipe A., Kukoyi I.A., Igbekele G. O., Bamigbola H.O., Ogungbesan B. O

Microfinance Bank Operations and Performance of Small and Medium Enterprises (SMEs) in Ibadan, Oyo State

Victoria Nkoyeasua Williams and Solomon Adejare Babarinde (PhD)

Assessing Coping Mechanisms of Women during Midlife Crisis

Oluseyi Folakemi Gbadamosi

Artificial Intelligence and Employment Outcomes in an Emerging Economy: The Moderating Role of Digital Readiness

Olatunji Alaba Hassan, Azeez Olawale Ajayi

Family Environment and Intergenerational Exposure on Drug Use Patterns among Patients with Substance Use Disorders in South-West Nigeria: A Structural Equation Modelling Approach

Ismail Raheem and Johnson Oyeleke

Resource Management Strategies and Competitive Advantage of Independent Retail SMEs in Lagos State, Nigeria

Omolola Ruth Akinola and Olatunji Alaba Hassan

From Policy to Practice: A Scoping Review of Women's Health Rights, Legal Frameworks, and Implementation Gaps in Nigeria

Motunrayo Oluwagbemisola Bamidele, Olabisi Modupe Abiona, and Kowiat Titilayo Adeoye

Healthcare Financing and Health Outcomes in Selected African Countries

Adekola, Ramon A. and Aderinto Esther R.

Editor-in-Chief: Prof. Omolara Campbell

Editor: Prof. Omoseni Adepoju

Associate Editors

Assoc. Prof. Mufutau Iyiola Raheem

Dr. Tosin Adesina

Dr. Olubunmi Akande

Dr. Taliat Emiola

Dr. Oluwafemi Amigun

Dr. Ajibola Olaniyi

Advisory Board

Prof. 'Jide Owwoeye	Lead City University, Ibadan, Nigeria
Prof. Kabiru A. Adeyemo	Lead City University, Ibadan, Nigeria
Prof. Toyin Falola	University of Texas, Houston
Prof. Uche Isiugo-Abanihe	Lead City University, Ibadan, Nigeria
Prof. Bola Akanji	Quinnipiac University, Hamden, Dept. of Economics College of Arts and Science. Connecticut, USA.
Prof. J. J. Asongu	St. Monica University, Buea, Cameroon
Prof. Olatundun Adelegan	UN Women Suomi, Helsinki, Finland
Prof. B. A. Folorunso	Obafemi Awolowo University, Ile-Ife, Nigeria
Dr. Folasade Ayorinde	Green Climate Fund Songolo, South Korea
Dr. Taiwo Ajilore	Central Bank of Nigeria
Dr. Michael Ogunseyin	University of Wolverhampton, United Kingdom

Correspondence

The Editor-in-Chief

Lead City Journal of the Social Sciences (LCJSS)

Faculty of Management and Social Sciences

Lead City University, Ibadan, Nigeria

www.lcu.edu.ng/index.php/lead-city-journal-of-the-social-sciences

e-mail: (i) editor.lcjss@gmail.com

(ii) campbell.omolara@lcu.edu.ng

(iii) omolaracampbell@yahoo.com

+2348033176177, +2348033234042

Published by

Lead City University, Press

Beside Methodist School, Toll-Gate Area, Lagos-Ibadan Express Way, Ibadan

07064671658, 08036694838

lcupress23@gmail.com

Lead City Journal of the Social Sciences (LCISS) ISSN: 2449092X

About the Journal

LCISS is intended for scholars who wish to report results of completed or on-going research, reviews of literature and discussions of theoretical issues or policy. Its primary objective is to provide a forum for the exchange of the ideas across disciplines and academic orientations in the social sciences.

The journal is an open access peer reviewed journal that provides bi-annual publication of articles in the social sciences. The editorial board is made up of reputable scholars from various universities around the world. All correspondence should be addressed to the Editor-in-Chief, Lead City Journal of Social Sciences (LCJSS), Lead City University, Ibadan, Nigeria.

Guidelines for Contributions

Authors should note that any article to be submitted for publication must comply with the following standard:

- The manuscript content must not be more than 15 pages. Any violation of this rule will be subjected to extra charges.
- Abstract (in italics) should be a maximum of 250 words with a minimum of 3-5 keywords.
- The title and author(s) details should be on the first page. This should include telephone numbers and e-mail contacts.
- Author's name should be written in the following order: first name, other name and surname.
- The body of text should be in Times New Roman, properly justified in 12 pt. with 1.5line spacing.
- Referencing style is APA, 7th edition. All references should be listed in alphabetical order at the end of the article.
- The format for the body of article is: Introduction, Literature Review, Methodology, Results and Discussion, Conclusion and References. Also, authors should know that they are responsible for ensuring that:
 - i. The manuscript had been submitted only to this journal, i.e. It is not under consideration or peer review or accepted for publication or in press or published elsewhere;
 - ii. The manuscript contains nothing that is abusive, defamatory, libelous, obscene, fraudulent or illegal.

Non-compliance with any of the latter three conditions will be considered misconduct and dealt with accordingly.

The author or lead author of an article is entitled to one copy of the LCJSS in which his/her article appears. Authors of the accepted papers shall pay a processing fee of N10,000 (Ten thousand naira only) and publication fee of N35,000 (thirty-five thousand naira only).

Any author who wishes to publish his/her article in the journal should contact:

The Editor-in-Chief

Contents

Audit Quality as a Determinant of Earnings Performance in Selected Nigerian Oil and Gas Companies

Adejuwon Oluwakemi, Oyedokun, Godwin Emmanuel, and Amedu Mercy Aishatu 5

Diversity, Inclusion Initiatives and Employee Performance in Selected Hotels, Lagos State, Nigeria

Adebanjo L. A, Adedipe A., Kukoyi I.A, Igbekele G. O, Bamigbola H.O., Ogungbesan B. O ... 21

Microfinance Banks Operations and Performance of Small and Medium Enterprises (SMEs) in Ibadan, Oyo State

Victoria Nkoyeasua Williams and Solomon Adejare Babarinde (PhD) 40

Assessing Coping Mechanisms of Women during Midlife Crisis

Oluseyi Folakemi Gbadamosi 52

Artificial Intelligence and Employment Outcomes in an Emerging Economy: The Moderating Role of Digital Readiness

Olatunji Alaba Hassan, Azeez Olawale Ajayi 63

Family Environment and Intergenerational Exposure on Drug Use Patterns among Patients with Substance Use Disorders in South-West Nigeria: A Structural Equation Modelling Approach

Ismail Raheem and Johnson Oyeleke 78

Resource Management Strategies and Competitive Advantage of Independent Retail SMEs in Lagos State, Nigeria

Omolola Ruth Akinola and Olatunji Alaba Hassan 100

From Policy to Practice: A Scoping Review of Women's Health Rights, Legal Frameworks, and Implementation Gaps in Nigeria

Motunrayo Oluwagbemisola Bamidele, Olabisi Modupe Abiona, and Kowiat Titilayo Adeoye 114

Healthcare Financing and Health Outcomes in Selected African Countries

ADEKOLA, Ramon A. & ADERINTO Esther R. 133

Family Environment and Intergenerational Exposure on Drug Use Patterns among Patients with Substance Use Disorders in South-West Nigeria: A Structural Equation Modelling Approach

Ismail Raheem

Department of Psychology, Lead City University, Ibadan, Nigeria

Email Address: raheem.ismail@lcu.edu.ng

Johnson Oyeleke

Department of Psychology, Lead City University, Ibadan, Nigeria

Email Address: oyeleke.johnson@lcu.edu.ng

Abstract

The study, a cross-sectional descriptive survey, examined how family environment and exposure across generations affect current drug use among 425 adult drug users attending treatment centers in Southwest Nigeria. Structural Equation Modelling (SEM) was used. Six family-level factors were examined: cohesion, expressiveness, conflict, exposure to family substance use, perceived impact, and preventive communication. The analysis is based on Social Learning Theory and Family Systems Theory. The SEM showed a very good fit with the data (SRMR = 0.013, d ULS = 0.0569, d G = 0.0388). The strongest predictor of current drug use was exposure to family substance use ($\beta = 0.4760$, $p < .001$, $f^2 = 0.1136$), highlighting the role of observational learning. Family cohesion had a significant negative direct effect ($\beta = -0.1707$, $p = .0396$, $f^2 = 0.0332$), meaning it offered protection. Preventive communication showed a negative effect that was marginal ($\beta = -0.2299$, $p = .0813$). Expressiveness produced an unexpected positive indirect effect through exposure ($\beta = 0.1108$, $p = .0086$, VAF = 63.1%). This suggests that expressiveness may become a risk factor when exposure is high. The relationship between exposure and drug use was significantly mediated by perceived impact (VAF = 57.1%, $\beta = 0.3404$, $p < .001$), pointing to the importance of emotional trauma. Family conflict had no significant effect ($\beta = -0.0338$, $p = .6029$). Taken together, the results support culturally tailored, family-based, and trauma-informed interventions in Nigeria. Structured family therapy and attention to emotional trauma from family substance use could help prevent relapses and improve treatment outcomes.

Keywords: Substance use disorders, family environment, intergenerational exposure, relapse, structural equation modelling, Nigeria

Introduction

Substance use disorder (SUD) is chronic and comes and goes. People feel an uncontrollable urge to seek and take drugs even when it causes harm (American Psychiatric Association [APA], 2013). The single biggest obstacle to lasting recovery is relapses, which means going back to drug use after a period of staying clean (Marlatt & Donovan, 2005; McLellan et al., 2000). Worldwide, between 40% and 75% of people return to substance use within six months after treatment (Nguyen et al., 2021; Sinha, 2011). In low- and middle-income countries, the

relapse rate goes above 50%, largely because resources are scarce and social pressures are high (Twagirayezu et al., 2021). Between 2010 and 2020, the number of people using drugs rose by 26%, reaching 284 million among those aged 15 to 64 (United Nations Office on Drugs and Crime [UNODC], 2022). At the same time, opioid overdose deaths have gone up around the world, partly because periods of abstinence lower the body's tolerance (World Health Organization [WHO], 2018; Degenhardt et al., 2019). All this underscores the importance of understanding the psychosocial factors that affect relapse risk.

Over the past ten years, drug use patterns in West Africa have changed dramatically. Nigeria is the most populous country in the region and has rapidly growing problems with drug and alcohol use (UNODC, 2022). According to the UNODC (2022), cannabis, prescription opioids (especially tramadol and codeine), and cocaine are becoming more common in both urban and rural areas of Nigeria. The lifetime rate of any drug use among young people aged 18 to 35 falls between 14% and 22% across different parts of the country (UNODC, 2022). Southwest Nigeria (SWR) includes six states: Lagos, Oyo, Ogun, Osun, Ondo and Ekiti. The number of treatment centers has increased, but clinical studies report relapse rates between 55% and 70% within 12 months after treatment (Twagirayezu et al., 2021; Ogunwale et al., 2015).

Even though awareness of substance use disorders is growing in Nigeria, most interventions focus on the individual factors. They emphasize detoxification and counselling without addressing family level factors. This is a particular problem because Nigerian family structures are not the same as Western nuclear families. Nigerian households are generally interdependent, multigenerational, and communal, meaning they function as extended family systems (Atilola, 2016). In such systems, family relationships like emotional bonding, communication, conflict resolution, and the passing down of behaviors across generations may have a stronger influence on a person's actions than in individualistic societies. However, few empirical studies have examined how specific family environment factors affect current drug use among Nigerian users in treatment. Moreover, no study that we know of has tested direct and indirect relationships from cohesion, expressiveness, conflict, exposure, perceived impact, and preventive communication to drug use all at once using structural equation modelling in this population.

Family cohesion refers to the emotional connections between family members. It provides support and helps with problem-solving inside the family (Olson, 2000). Strong cohesion has been linked to lower relapse rates, possibly because it reduces stress and improves treatment adherence (Trenz et al., 2015; Waldron et al., 2015). In low-cohesion families, individuals can feel isolated, increasing the risk of relapse (Twagirayezu et al., 2021). Open, emotional communication within the family can help patients talk about cravings and triggers (Campbell & Caro, 2019). Effective expressiveness allows early detection of warning signs and can lower relapse (Haberle et al., 2018). But too much expressiveness, especially when mixed with criticism, may increase stress and trigger relapse (Karademas & Tsaousis, 2017). Chronic family conflict causes emotional stress, which is a strong trigger for relapse (Sinha, 2011). Early research indicates that people from high-conflict homes tend to start using substances again sooner (Fox et al., 2008; Witkiewitz & Marlatt, 2004), possibly because they use substances to self-medicate negative feelings.

People learn behavioral norms by watching parents or siblings use drugs. Structural models suggest that being exposed to alcohol and drug use across generations doubles the risk of relapse (Egede, 2007; Twagirayezu et al., 2021). In Nigerian clinical samples, those who reported early exposure to family use were more likely to relapse within six months (Twagirayezu et al., 2021). How a person internalizes the impact of a family member's substance use affects their coping strategies. The greater the perceived harm, the lower the relapse rate, probably because the motivation to remain abstinent is higher (Horigian et al., 2014; Waldron et al., 2015). Conversations that explain the risks of substances may "inoculate" people against cues to use (Ennett et al., 2018; Spinelli et al., 2020). Regular family communication of preventive messages can reduce relapse rates by up to 30% (Ennett et al., 2018).

Given all the above, this study had two main goals. The first was to look at the direct influence of six family-level factors (cohesion, expressiveness, conflict, exposure to family substance use, perceived emotional impact, and preventive communication) on current drug use among people receiving treatment for substance use disorders in Southwest Nigeria. The second goal was to examine the indirect effects of these same factors on current drug use, specifically through exposure to family substance use and perceived emotional impact. These six factors, grounded in Social Learning Theory (Bandura, 1977) and Family Systems Theory (Bowen, 1978), form a full psychosocial model. Using structural equation modelling, we tested both direct and indirect pathways. Understanding these connections is critical because it highlights the urgent need for family-centered interventions to reverse the growing trend of relapse in Southwest Nigeria.

Literature Review

A large amount of evidence shows that family dynamics play a key role in predicting relapse after substance use. Family cohesion, defined as emotional bonding and mutual support within a family, keeps coming up as a protective factor. For example, Trenz, Scherer, Merten, and Meier (2015) found that among adults with opioid dependence, higher family cohesion was linked to nearly a 20% drop in relapse risk over six months. In contrast, families with chronic conflict leave individuals vulnerable to negative emotions and self-medication (Sinha, 2011; Witkiewitz & Marlatt, 2004). Constructive, open emotional communication (expressiveness) can also protect against relapse. When families share feelings and cravings early, they disrupt the path toward use (Witkiewitz & Marlatt, 2004). However, stress can get worse if expressiveness comes with blame, which may unintentionally raise relapse risk (Karademas & Tsaousis, 2017). Normative beliefs are also shaped by watching substance use in the family. Bandura's (1977) Social Learning Theory explains how people learn behavior from parents or siblings. Egede (2007) found that having a first-degree relative who uses drugs more than doubles the relapse rate compared to those without such exposure. The degree to which a person internalizes the harm they observe in family members (perceived impact) affects their motivation to stay abstinent (Horigian et al., 2014). Finally, preventive communication (deliberate warnings about drugs) provides coping skills. Ennett, Tobler, Ringwalt, and Flewelling (2018) found a 25% lower relapse rate among young people whose parents consistently warned them.

Theoretical Framework

Two overlapping theories guided this study, rather than treating them separately. The first is Social Learning Theory (Bandura, 1977). It says that people pick up behaviors by watching and copying those closest to them. In the context of substance use, family members often serve as the earliest models. They quietly signal that drug taking is normal or acceptable. The second is Family Systems Theory (Bowen, 1978). It sees the family as an emotional unit where no one acts in isolation. What a person does, including whether they use drugs, comes from the family's underlying patterns of cohesion, communication, and conflict. A supportive, well-connected family that fosters open communication helps someone stay on track in recovery. In contrast, high conflict and poor emotional expression tend to encourage unhealthy coping.

Putting these ideas together leads to two main predictions. First, each family factor on its own (substance use in the family, cohesion, conflict, expressiveness, how much the person feels affected by family drug use, and whether the family talks openly about prevention) directly predicts relapse. Second, the perceived emotional impact of family substance use acts as an indirect pathway linking cohesion and expressiveness to relapse. Structural equation modelling allows us to test both sets of pathways at the same time, giving a more nuanced picture of how family dynamics and current drug use influence each other.

Empirical Review

Family Cohesion

Family cohesion means emotional ties and shared sense of togetherness within a family (Olson, 2000). When cohesion is high, people tend to have more social support and healthier ways of coping, and they are less likely to return to substance use (Trenz et al., 2015). For instance, Trenz and colleagues (2015) studied adults in treatment for opioid dependence. Each one-point increase in cohesion lowered the odds of relapse over six months by 20%. Similarly, Horigian, Feaster and Mitrani (2014) found that adolescents who reported strong family bonds stayed abstinent longer during residential treatment. These findings point to a stress-buffering role. A cohesive family seems to soften the impact of triggers that would otherwise push someone back into use.

Family Expressiveness

Expressiveness is about how freely, and clearly family members communicate, share emotions, and express concerns (Olson, 2000). When expressiveness is constructive, it helps a person spot early cravings and get timely support (Witkiewitz & Marlatt, 2004). Haberle and others (2018) showed that adults in outpatient programs with higher expressiveness scores had less intense cravings and fewer relapses. But there is a catch. If family talk turns critical or blaming, it can backfire and increase stress, which paradoxically raises the chance of relapse (Karademas & Tsaousis, 2017). So, it is not enough just to talk. The quality of that emotional communication matters.

Family Conflict

Conflict refers to how often and how intense disagreements happen within the family (Olson, 2000). Ongoing conflict breeds negative emotions (Sinha, 2011), and using substances can become a misguided way to escape those feelings. A longitudinal study by Fox and colleagues (2008) followed individuals from high-conflict homes. Those individuals relapsed faster after leaving treatment, and they pointed to conflict-driven stress as a major trigger. Witkiewitz and Marlatt (2004) reached a similar conclusion: family discord ranked as one of the highest situational risks for relapse, whether the person was dependent on alcohol or drugs. All of this suggests that reducing family conflict ought to be a central therapeutic target.

Exposure to Family Substance Use

Social Learning Theory (Bandura, 1977) says that people learn behaviors by watching significant others, or "models." When parents or siblings use drugs, that behavior starts to look normal, relapse then becomes an easier path. A meta-analysis by Egede (2007) found that having at least one family member who used substances more than doubled the risk of relapse compared to those with no family use. Clinical experience in Nigeria supports this. Twagirayezu and others (2021) noted that patients who drank alcohol or used cannabis, and whose parents also used those substances, tended to start using earlier and relapsed more often after treatment.

Perceived Impact of Family Substance Use

Perceived impact means how much a person feels the negative effects of a family member's drug or alcohol use (Bowen, 1978). The stronger that sense of threat, the more reason someone might have to stay clean. Horigian and colleagues (2014) found that adolescents who rated the harm from parental drug use as low were 30% more likely to relapse within three months after treatment. In other words, recognizing the real damage that family substance use causes can serve as an internal brake against going back to drugs.

Preventive Communication

Preventive communication covers the explicit warnings and conversations about the dangers of substances (Ennett et al., 2018). When parents deliver these messages, they give young people coping skills and help reduce exposure to triggers. In a large school-based sample of 1,500 adolescents, Ennett and colleagues (2018) found that clear, consistent anti-drug messages were linked to 25% lower rates of both starting drugs and relapsing. Spinelli, Mazzola, and Buss (2020) saw the same pattern in clinical groups. Ongoing family communication about recovery plans was associated with longer periods of abstinence.

Hypotheses

This study tested six main hypotheses about how family-level factors directly affect current drug use, based on Social Learning Theory (Bandura, 1977) and Family Systems Theory (Bowen, 1978):

H1: Family cohesion will negatively predict current drug use.

H2: Family expressiveness will be negatively associated with current drug use. Open emotional communication decreases substance use frequency.

H3: Family conflict will positively predict current drug use.

H4: Exposure to family substance use will positively predict current drug use.

H5: Perceived impact of family substance use negatively predicts current drug use.

H6: Preventive family communication will negatively predict current drug use.

H7: The relationship between family cohesion and current drug use will be significantly mediated by exposure to family substance use.

H8: The relationship between family expressiveness and current drug use will be mediated by exposure to family substance use.

H9: The relationship between family conflict and current drug use will be mediated by exposure to family substance use.

H10: The relationship between perceived impact and current drug use will be mediated by exposure to family substance use.

H11: The relationship between preventive communication and current drug use is mediated by exposure to family substance use.

Method

Study Design and Setting

This study used a cross-sectional descriptive survey to look at how family dynamics and exposure to substance use across generations relate to current drug use and relapse risk among people seeking help for substance use disorders. The research team gathered data from six states across South West Nigeria: Ekiti, Lagos, Ogun, Ondo, Osun, and Oyo. The collection period ran from December 18th, 2025, through March 12th, 2026. These states were chosen due to the large number of public and private treatment facilities, and the prevalence of substance use in these countries, as reported by the UNODC (2022).

Participants

The researchers drew from a specific pool: every patient who began either an inpatient or outpatient substance use treatment episode at twelve different facilities across six states. That meant two centers per state. The total number of patients currently in treatment across these locations came to roughly 950, based on center records. Using Yamane's (1967) formula, where the needed sample equals N divided by $((1 + N(e)^2))$, and setting the margin of error at 0.05, the calculation returned a minimum of 277 participants. The sample was increased by 35% to ensure a representative sample size of 425 people, given the possibility of non-response and blank forms. Stratified random sampling was used. Each state had treatment centers, which were considered strata ($2 \text{ centers} \times 6 \text{ states} = 12 \text{ strata}$). In each center, patient lists were provided by center directors. Eligible patients were randomly selected in proportion to their numbers at each center, based on each center's patient population size, using a random number generator. All the patients who gave written informed consent were selected. The 100% response rate for the randomly selected sample (final $N = 425$) did not include any patients who refused to participate.

Inclusion/ Exclusion Criteria: (a) age 18–48 years, (b) diagnosis of substance use disorder in the last year (based on center records), (c) been engaged in a substance use treatment programme for at least two weeks, and (d) given informed consent. The exclusion of people with severe cognitive impairment and those with active psychosis was to ensure valid self-reporting.

Measures

All tools were delivered in English as this is the language used in the participating centers. The meanings of the items were explained by trained research assistants as necessary. A structured questionnaire was developed to gather the socio demographic data of the participants such as age (years, continuous), sex (male, female), ethnicity (Hausa, Yoruba, Igbo), marital status (single, married), educational level (no formal school, primary, secondary, tertiary), employment status (full time, part time, unemployed, student), family history of drug/alcohol use (yes, no), household size (the number of persons living in the household). This instrument was adapted from previous substance abuse research (Smith & Johnson, 2015) and pilot-tested for clarity. Three of the subscales measured important family processes and were adapted from the Family Environment Scale (FES; Moos & Moos, 1994). Emotional bonding and mutual support were assessed by Cohesion (5 items; $\alpha = .82$). The factor, expressiveness (3 items; $\alpha = .79$), represented the open expression of thoughts and feelings. Conflict was assessed by the number of disagreements and tension experienced (2 items; $\alpha = .76$). Each item was rated on a 5-point Likert scale (1 = Strongly disagree to 5 = Strongly agree). Subscale scores were derived by adding item responses: higher scores on the cohesion subscale (range 5-25) correspond to higher levels of family support; higher scores on the expressiveness subscale (3-15) represent more open communication; and higher scores on the conflict subscale (2-10) reflect more frequent family disagreements. The childhood and adolescent substance use exposure by parents, siblings, or other relatives was measured using a 5-item index ($\alpha = .84$). Items were rated on a 5-point scale from 1 (Never) to 5 (Very often) (e.g., My parents used alcohol or drugs when I was growing up). Intergenerational modelling scores (5-25) indicate the extent of intergenerational modelling. Items on the perceived Impact of Family Use scale were adapted from Horigian, Feaster, and Mitrani (2014) and included the following items: $\alpha = .81$. This 5-item scale captures participants' internalization of the negative effects of family members' substance use (e.g., emotional harm, financial stress). The answers are rated on a 5-point scale, from 1 (Not at all) to 5 (A great deal), with a total score of 5 to 25. Preventive Family Communication was assessed using two items ($\alpha = .77$) that tapped the frequency of family communication regarding drug use prevention and recovery goals (e.g., “My family talks with me about avoiding drug use”). The ratings range from 2 to 10, on a scale of 1 (Never) to 5 (Very often). For current drug use, participants reported the frequency of use for their primary substances on a five-point scale: 1 = Never, 2 = Rarely, 3 = Occasionally, 4 = Weekly, 5 = Daily. Frequencies for up to two substances were combined to create a continuous outcome variable (range: 2-10). This measure had good test-retest reliability ($r \approx .70$).

Procedure

The Oyo State Ministry of Health Research Ethics Committee (HREC) approved the study under the approved number NHREC/OYOSHRIEC/10/11/22. Site access was provided by Centre directors. During treatment sessions, research assistants, trained in research ethics, approached eligible patients, explained the study's goals, and obtained written informed consent. Surveys were self-administered in private rooms and took 20–30 minutes. Completed questionnaires were reviewed each day to ensure completeness and accuracy.

Data Analysis

The analysis was carried out using SPSS version 26. Before getting started, the dataset was cleaned by removing outliers and handling any missing values. To get a sense of the participants and the scores on the different scales, the team calculated means, standard deviations, and frequencies. Bivariate relationships between variables were then examined using Pearson zero-order correlations. To test the direct and indirect pathways outlined in the hypotheses, structural equation modelling was conducted in SmartPLS 4.0. Model fit was assessed with the Standardized Root Mean Square Residual (SRMR) along with the d_{ULS} and d_G indices, following Hair and colleagues (2022). Path coefficients were estimated through bootstrapping with 5,000 resamples, and bias-corrected 95% confidence intervals were produced. The threshold for statistical significance was set at $p < .05$.

Results

Sociodemographic Characteristics

Table 1. Sociodemographic Characteristics of Respondents (N = 425)

Variable	Category/Statistic	Frequency (n)	Percentage (%) / Value
Gender	Male	335	78.8%
	Female	90	21.2%
Ethnicity	Hausa	92	21.6%
	Yoruba	226	53.2%
	Igbo	107	25.2%
Marital Status	Single	368	86.6%
	Married	57	13.4%
Education Level	No formal education	84	19.8%
	Primary education	99	23.3%
	Secondary education	135	31.8%
	Tertiary education	107	25.2%
Employment Status	Employed full-time	116	27.3%
	Employed part-time	16	3.8%
	Unemployed	134	31.5%
	Student	159	37.4%
Household Size	2	16	3.8%
	3	75	17.6%
	4	65	15.3%

	5	160	37.6%
	6	59	13.9%
	7	33	7.8%
	8	17	4.0%
Family History of Substance Use	Yes	252	59.3%
	No	173	40.7%
Currently Use Substances	Yes	202	47.5%
	No	223	52.5%
Frequency of Substance Use	Daily	117	27.5%
	Weekly	140	32.9%
	Monthly	32	7.5%
	Occasionally	86	20.2%
	Rarely	33	7.8%
	Never	17	4.0%
Descriptive Statistics			
Age (in years)	Mean (SD)	–	24.54 (± 4.63)
	Minimum – Maximum	–	19 – 48
Number of people in household	Mean (SD)	–	4.80 (± 1.40)
	Minimum – Maximum	–	2 – 8

A total of 425 individuals in treatment for substance abuse were sampled. There is a significant gender imbalance, with a male preponderance of 335 (78.8%) and 90 (21.2%) females. This is consistent with global trends where males are more likely to be affected by substance use disorders and more likely to seek substance use disorder treatment. As for ethnicity, the largest group were Yoruba (53.2%), followed by Igbo (25.2%) and Hausa (21.6%). The response was received only from the three major ethnic groups in Nigeria, with no respondents from other groups. Most respondents (86.6%) were single, while 13.4% were married. Divorced, widowed and separated individuals were not represented in the sample, which may be attributed to the age distribution and social factors of the population of those seeking substance use treatment. When asked about their educational level, 31.8% of the respondents had secondary education, 25.2% had completed tertiary level, 23.3% had primary education and 19.8% had no education at all. It indicates a fairly high level of educational access, but a significant number were without basic education. Of the respondents, 37.4% were students while 31.5% were unemployed. A lower percentage were on full-time employment (27.3%) or part-time (3.8%). The pattern of employment observed parallels previous research which have linked substance use to other socio-economic problems including unemployment and school dropout.

Household size of the respondents was between 2 and 8 members with an average of 4.80 (SD = 1.40). The average household size was 5, as most of the participants (37.6%) came from households of 5 members which is the typical household size in Nigeria. Furthermore,

the average age of the participants was 24.54 years ($SD = 4.63$) ranging from 19 to 48 years, indicating that the sample included young adults and that there was a high prevalence of substance use among them.

Regarding family history of substance use, 59.3% said that they had at least one family member who had used substances; this highlights the intergenerational nature and possible normalization of substance use behaviors within family. Of these, a range of family substance exposure was identified, such as substance use by parents, siblings, and extended family. When it comes to substance use that's happening now, 47.5% of the respondents said they use substances and 52.5% said they don't. Frequency of use indicated that 32.9% used substances weekly, 27.5% used daily, 20.2% used occasionally, a small number used monthly (7.5%) and rarely (7.8%). Demographic results also offer context for the results of the statistical analysis to be presented later, particularly with respect to the effects of background variables like gender, education level and family drug history on treatment outcomes.

Table 2: *Descriptive Statistics for Key Study Variables (N = 425)*

Variable	Minimum	Maximum	Mean	SD
Cohesion	5.00	25.00	14.59	4.73
Expressiveness	3.00	15.00	9.96	2.99
Conflict	2.00	10.00	6.23	2.17
Family Environment	15.00	50.00	30.77	6.39
Exposure to Family Substance Use	5.00	25.00	14.48	4.80
Preventive Family Communication	2.00	10.00	6.49	1.97
Perceived Impact of Family Use	3.00	15.00	9.31	2.63
Family History of Substance Use (Total)	16.00	47.00	30.28	6.40
Current Use Patterns	2.00	10.00	6.30	2.12

Note. Composite variables such as "Family Environment," "Overall Current Use," and "Family

History of Substance Use" are summed scores from subscale items.

The descriptive statistics presented in Table 2 provide an overview of the central tendencies and variability for the main constructs measured in the study. These variables include dimensions of the family environment, exposure to and attitudes toward substance use, peer and societal influences, and indices of treatment effectiveness.

Measurement Model Evaluation

To assess the reliability and validity of constructs, we evaluated internal consistency (Cronbach's alpha), convergent validity, and discriminant validity.

Table 3. Psychometric Properties of Measured Constructs

Construct	Items	Range	α	AVE
Family Cohesion	5	5–25	.82	.63
Expressiveness	3	3–15	.79	.58
Family Conflict	2	2–10	.76	.54
Exposure to Family Use	5	5–25	.84	.66
Perceived Impact	5	5–25	.81	.61
Preventive Communication	2	2–10	.77	.57
Current Drug Use	—	2–10	.70 [†]	—

[†]Test–retest reliability was used for a single-scale outcome.

Reliability

Looking at internal consistency, all the scales performed well. Cronbach's alpha values were above .70, meeting the commonly accepted standard for adequate reliability (Nunnally & Bernstein, 1994). The cohesion measure had an alpha of .82, family history of substance use hit .84, and perceived impact scored .81. Even the two-item brief scale managed a respectable .77, so no concerns there.

Convergent Validity

To check whether items intended to measure the same thing hang together, we examined the Average Variance Extracted. Every construct posted an AVE above .50. This indicates that each construct captures more than half of the variance from its own indicators, a strong sign of convergent validity.

Discriminant Validity

Using the Fornell-Larcker criterion, all constructs passed the test for discriminant validity. In plain terms, each domain measured a distinct thing. A given construct shared more variance with its own indicators than it did with any other construct.

Model Fit Assessment

We ran the structural equation model to test the proposed pathways. The fit indices indicated an excellent fit between the model and the data. The SRMR value was 0.013, well under the usual cut-off 0.08. The d_ULS index came out at 0.05690, and the closer that number sits to zero, the better the fit. The remaining indices also fell within acceptable bounds. Taken together, these results indicate a well-fitting model, consistent with what Hu and Bentler (1999) and Hair and colleagues (2022) would consider good.

Table 4. Zero-Order Correlations between Study Constructs (N = 425)

Variable	1	2	3	4	5	6	7
1. Current Drug Use	—						
2. Cohesion	-.161*	—					
3. Expressiveness	.255***	-.150	—				
4. Conflict	.124*	.197***	.327***	—			
5. Exposure	.489***	-.164	.452***	.228***	—		
6. Perceived Impact	.325***	-.122	.347***	.210**	.767***	—	
7. Preventive Communication	-.221†	.349***	.043	-.054	-.121	-.036	—

†p < .10, *p < .05, **p < .01, ***p < .001.

Looking at Table 3, which shows how the different constructs relate to one another, a few patterns stand out. Current drug use moved in the same direction as exposure to family substance use ($r = .489$, $p < .001$) and perceived impact ($r = .325$, $p < .001$). That means people who reported more exposure to family members using drugs also tended to report more current use, and the same went for those who felt a stronger perceived impact. On the other side, current drug use went in the opposite direction of family cohesion ($r = -.161$, $p < .05$) and preventive communication ($r = -.221$, $p = .055$). So higher cohesion and more preventive talk were tied to less frequent use, though the finding for preventive communication fell just short of the usual significance cutoff. Among all these, exposure to family substance use had the strongest link to current drug use, while cohesion and communication seemed to offer some degree of protection.

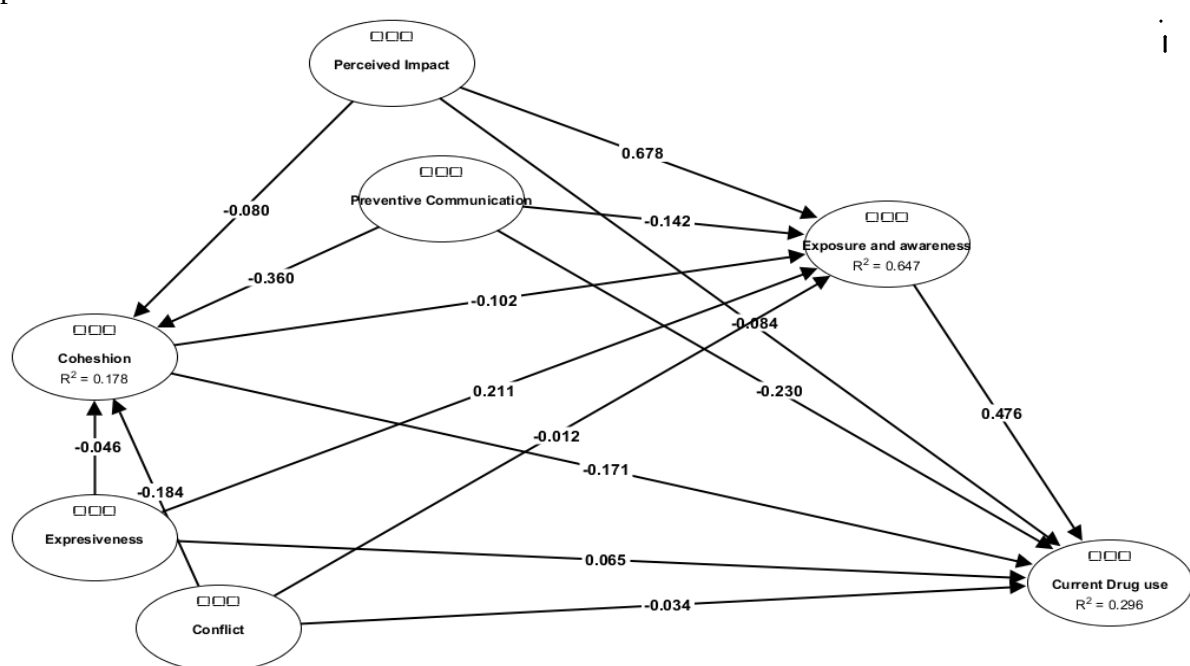
**Family History -Family environment Model of Drug use and relapse**

Table 5. Structural Regression Model Summary with Confidence Intervals

Dependent Variable	Predictor Variable	β	R^2	Adj. R^2	t-value	p-value	95% CI	Cohen's f^2
Current Drug Use	Cohesion	– 0.1707	0.2959	0.2858	–2.06	.0396	[–0.3870, –0.0609]	0.0332
	Expressiveness	0.0648			0.86	.3917	[–0.0687, 0.2416]	0.0044
	Conflict	– 0.0338	0.4760		–0.52	.6029	[–0.1605, 0.1018]	0.0014
	Exposure to Family Use	0.4760			4.10	< .001	[0.2421, 0.7167]	0.1136
	Perceived Impact	– 0.0843			–0.89	.3743	[–0.2687, 0.1148]	0.0041
	Preventive Communication	– 0.2299			–1.75	.0813	[–0.4526, 0.0871]	0.0614
	Expressiveness	– 0.0463	0.1783	0.1705	–0.42	.6720	[–0.1944, 0.2255]	0.0021
	Conflict	– 0.1838			–1.88	.0598	[–0.2761, 0.1177]	0.0361
Cohesion	Perceived Impact	– 0.0799			–0.98	.3272	[–0.1895, 0.1332]	0.0067
	Preventive Communication	– 0.3598			–1.44	.1494	[–0.5800, 0.3005]	0.1561
	Exposure & Awareness	– 0.1018	0.6471	0.6429	–1.43	.1530	[–0.1967, 0.0823]	0.0241
	Expressiveness	0.2115			3.59	.0003	[0.1031, 0.3356]	0.1021
	Conflict	– 0.0116			–0.26	.7966	[–0.0929, 0.0804]	0.0003
	Perceived Impact	0.6783			16.54	< .001	[0.5887, 0.7498]	1.1230
	Preventive Communication	– 0.1420			–1.62	.1057	[–0.2701, 0.1168]	0.0490

A total of six main hypotheses were specified to explore the direct, indirect, and mediated effects of family environment variables and intergenerational exposure on current substance use.

H1. Respondents who saw their families as more united and emotionally supportive used drugs less often. The direct effect was negative and significant ($\beta = -0.1707$, $t = -2.06$, $p = .0396$). The confidence interval from -0.3870 to -0.0609 did not include zero. An indirect path through exposure and perceived impact also appeared ($\beta = -0.0485$), but it was not significant ($p = .1488$). The total effect came to -0.2191 . The effect size (Cohen's $f^2 = 0.0332$) was small. Family Systems Theory would see this as cohesion protecting against drug use.

H2. The direct link from expressiveness to drug use was positive, not negative, and not significant on its own ($\beta = 0.0648$, $p = .3917$). But the indirect route through exposure to family drug use and perceived impact was positive and significant ($\beta = 0.1108$, $t = 2.63$, $p = .0086$). In families where respondents openly shared emotions, drug use may become more visible or normalised. The total effect ($\beta = 0.1756$, $p = .0219$) was significant but opposite to what was expected. Emotional openness is not always protective. In high-risk family settings, it might have the reverse effect.

H3. The direct effect of conflict on drug use was negative and non-significant ($\beta = -0.0338$, $p = .6029$). The indirect effect was positive but also not significant ($\beta = 0.0347$, $p = .2979$). The total effect was near zero ($\beta = 0.0009$). Conflict by itself did not have a reliable influence on current drug use in this sample. One reason could be the cross-sectional design. Another is that conflict's impact may depend on other factors such as coping styles or unmeasured family dynamics.

H4. Exposure to family substance use was the strongest predictor in the model ($\beta = 0.4760$, $t = 4.10$, $p < .001$). The effect size was large ($f^2 = 0.1136$). The confidence interval from 0.2421 to 0.7167 stayed above zero. This fits Social Learning Theory: watching family members use drugs models that behaviour. Exposure served as a mediator in other hypotheses, so no additional indirect paths were tested here.

H5. The direct effect of perceived impact was not significant ($\beta = -0.0843$, $p = .3743$). But the indirect effect was large, positive, and highly significant ($\beta = 0.3404$, $t = 3.95$, $p = .0001$). Respondents who clearly recognised the harm from family substance use may carry internalised stress or trauma that drives continued use. Alternatively, a strong sense of harm could trigger a reactive pattern that ends in relapse. The total effect ($\beta = 0.2561$) was significant, so perceived impact matters, just not through a simple direct pathway.

H6. Preventive family communication had a negative direct effect on current drug use ($\beta = -0.2299$), but it was significant significance ($t = -1.75$, $p = .0813$). The indirect effect was tiny and not significant ($\beta = 0.0112$, $p = .9080$). Bootstrapping gave a total effect of -0.2187 with a p-value of .0419. Families that talk openly about the dangers of drugs do offer some degree of protection from drug use overall, though the mechanisms are less clear and may be more complex than a simple mediated pathway.

Table 6. Summary of Indirect Effects and Mediation Results

Hypothesis	Indirect β	Sobel z	Sobel p-value	VAF (%)	Mediation Type	Conclusion
H7: Cohesion $\rightarrow$ Exposure $\rightarrow$ Drug Use	-0.0485	-1.44	.1488	22.1%	Partial (non-significant)	Partially Supported
H8: Expressiveness $\rightarrow$ Exposure $\rightarrow$ Drug Use	0.1108	2.63	.0086	63.1%	Partial (significant)	✓ Supported
H9: Conflict $\rightarrow$ Exposure $\rightarrow$ Drug Use	0.0347	1.04	.2979	—	No mediation	✗ Not Supported
H10: Perceived Impact $\rightarrow$ Exposure $\rightarrow$ Drug Use	0.3404	3.95	< .001	57.1%	Partial (significant)	✓ Supported
H11: Preventive Comm. $\rightarrow$ Exposure $\rightarrow$ Drug Use	0.0112	0.12	.9080	—	No mediation	✗ Not Supported

Note: VAF (Variance Accounted For) > 80% = full mediation; 20–80% = partial; < 20% = no mediation.

H7: The relationship between family cohesion and current drug use was partially mediated by exposure to family substance use. While the indirect effect was not statistically significant ($p = .1488$), the VAF of 22.1% suggests a weak partial mediation, indicating that part of the protective influence of cohesion operates through reduced exposure.

H8: Expressiveness demonstrated a significant indirect effect through exposure and perceived impact ($\beta = 0.1108$, $p = .0086$), accounting for 63.1% of the total effect. This suggests that while expressiveness alone may not be protective, it amplifies drug use when coupled with family substance use visibility, indicating partial mediation.

H9: No evidence was found to support the mediation of conflict through exposure. The indirect effect ($\beta = 0.0347$) and the Sobel test ($p = .2979$) were not significant, and VAF was negligible. Thus, conflict had no significant mediated effect on current drug use.

H10: Perceived impact of family drug use had a strong indirect effect on current use via exposure ($\beta = 0.3404$, $p < .001$), with a VAF of 57.1%. This confirms partial and significant mediation, indicating that emotional harm from family drug use indirectly contributes to ongoing substance use.

H11: Preventive communication showed no significant indirect effect ($\beta = 0.0112$, $p = .9080$), and the Sobel analysis was non-significant. Therefore, the hypothesis that preventive messages reduce drug use through lower exposure was not supported. Overall, the model affirms that family influences on drug use are not simply linear or direct. Instead, intergenerational exposure and emotional awareness of family drug use are critical psychological mechanisms shaping relapse risk.

Discussion of Findings

This study offers some insights into the intergenerational and family influences on drug use in drug users who seek treatment in Southwest Nigeria. The results corroborate several known patterns of addictive behaviors found globally, as well as the culturally unique patterns of various behaviors influenced by the family dynamics, parenting styles and expressions of emotions in Nigeria. The strongest and most consistent predictor of drug use was exposure to substance use in the family. Here is a rewritten version that avoids stiff academic formulas and reads more like a researcher reflecting on their findings. Social Learning Theory (Bandura, 1977) says that people pick up behaviors, especially risky ones, by watching those close to them repeatedly. That idea fits what we found. Other studies point in the same direction. Lee and colleagues (2021) showed that when parents use substances, their children are more likely to start using and keep using. That finding held up across the United States, regardless of region. Closer to home, Adekeye and colleagues (2019) ran a study in Nigeria and got similar results: teenagers who saw drug use at home were more prone to experiment and later become regular users. Abiodun and others (2018) found that people in recovery from substance dependence often came from families where drug and alcohol abuse was common. Put together, these studies all reinforce the same point. Exposure within the family does not just start someone on drugs; it also keeps them going.

The current study demonstrated that family cohesion is something that protects against drug use. This complements previous study by Park and Kim (2022) published in *Drug and Alcohol Dependence*, which found that in South Korea, families that are emotionally cohesive are a protective factor for adolescents' substance use. But, although the current findings indicated more direct effects of cohesion, the findings of this study contrast with the findings of Park and Kim who found the protective effect of cohesion to be mostly influenced by peer influence in the context of Nigeria. This may be because these traditional values of the extended family, cultural values, and the discipline approach common in the Nigerian community still exist. This is corroborated by Ogunwale, Akinhanmi and Ladapo (2015) who reported that the patients with better family support had better recovery rates and low tendency to relapse when treated in a psychiatric hospital in Nigeria.

The part of expressing emotion, however, was not in line with western ideals. In many high-income countries, family expressiveness is correlated with a positive effect on adolescent wellbeing and a decrease in risk behaviors. For example, Jackson, Sher, and Schulenberg (2020) reported in the *Journal of Family Psychology* that there was a relationship between emotional openness in the family and adolescents decreased likelihood to engage in substance use and increased likelihood to seek help. The results do show, however, that in the presence of intergenerational drug exposure, expressiveness might be a risk factor. If this occurs, emotional openness can sometimes be mistaken for "concerned" and "permissive" without establishing any behavioral or moral boundaries. In his cross-cultural study of Nigerian parents' parenting styles, Atilola (2016) found that Nigerian parents are verbal but inconsistent in disciplining their children and in providing direct supervision. This interaction could account for the fact that the positive association of emotional openness was not enough to buffer against drug use in this study and was a pathway to increased risk.

One of the most salient results was that the perceived emotional harm of family substances mediated the relationship between ACEs exposure and subsequent psychopathological symptoms. A significant factor in drug use was the psychological effect of drug use from the family environment, although this was not a direct predictor; those who internalized the psychological effect of drug use in the family were more likely to be drug users themselves. This is consistent with models of addiction, which are trauma-informed, like the one proposed by Sinha (2011) that posited that unresolved emotional trauma and chronic stress are primary factors in relapse. This was confirmed by Roberts et al. (2018), who reported greater psychological distress and risk of return to substance use among clients with a history of family-related emotional trauma. A similar situation was observed by Ibigbami and Adebayo (2021) in Nigeria, where alcohol misuse in the household was found to affect adolescents in a similar way. Their research revealed that these adolescents commonly resorted to substance use as a means of emotional regulation and/or somatization of trauma-related emotional pain and/or unresolved grief.

Although the opening of lines of communication within the family is generally beneficial, preventive family communication did not appear to have a significant impact on the findings in this study. In high-income countries, the use of preventive dialogue tends to be associated with reduced substance consumption. For example, Wilson and Rhee (2022) discovered that parental communication that was clear and structured was associated with decreased marijuana initiation among adolescents in the United States. In a study conducted in Nigeria, however, Ajayi and Ekundayo (2020) discovered that such discussions were often poorly coordinated or responding and were often happening after the person had already started using drugs and alcohol. Furthermore, messages from parents to their children about substance use were seen as being hypocritical when the parents themselves used substances, lowering the credibility and effectiveness of the message. This could be the reason why there was only a slight influence of preventive communication in our analysis. Even the best of intentions could fail to come across without emotion and behavior credibility.

One of the other intriguing findings was that there was no relationship between family conflict and drug use at the present time. This is in contrast to studies by Thomas, Lippman and Brown (2019) that showed that high family conflict is a consistent risk factor for adolescent substance use in the U.S. context. But, in a cultural context it is easier to understand this finding. The authors, Akintunde, Olawole Isaac and Salami (2020) stated that the Nigerian families are not known to encourage direct confrontation, rather they are emotionally restrained or resistant to confrontation. This can mean that conflict is not reported or that it can take on more subtle forms and expressions. This is restrictive in terms of predictive power, especially when using direct self-report items. These results collectively indicate that the underlying mechanisms of drug use risk (intergenerational exposure and unprocessed emotional trauma) may be shared across cultures, but the ways that they manifest (as protective and vulnerable expressions) can be different. While emotional openness is less likely to have a direct behavioral effect in Nigeria, cohesion is more likely to do so when not supported by structure. Furthermore, consistency in behavior and credibility in their emotions are necessary to influence preventive communication.

The findings have implications for practice and policy; the interventions in Nigeria should not be limited to individual-focused approaches but should involve family-based approaches. Trauma-informed care, structured family therapy, and culturally adapted communication training may improve treatment outcomes and decrease relapse. Importantly, the clinician must be aware that emotional patterns, such as expressiveness and cohesion, can vary across contexts and adapt interventions accordingly.

Implications for Practice, Policy, and Theory.

The results of this study are pertinent to practice, theory and policy in general especially in Nigeria, where family is a major institution that influences the behaviors of individuals. Intergenerational exposure to substance use is a powerful influence, and clearly a need exists to move beyond a person-focused approach to substance use interventions. A society like Nigeria with close family bond and communal living is not enough to treat the individual and forget about the family system that may have been the cause of the problem (Lee et al., 2021; Adekeye et al., 2019). Thus, the need to implement family-oriented treatment modalities that focus on family dynamics, early drug use, and the general emotional climate within the home is of great importance (Park & Kim, 2022; Ogunwale et al., 2015). Additionally, the importance of perceived emotional harm as an indirect contributor to current drug use underscore the need for trauma-informed care in addiction treatment centers in Nigeria. Many patients have unrecognized or untreated emotional issues related to substance abuse from a parent or sibling. Emotional aspects, when not properly identified and addressed, could contribute to the likelihood of post-detoxification/short term rehab relapse (Roberts et al., 2018; Ibigbami & Adebayo, 2021; Sinha, 2011). Thus, mental health workers, such as clinical psychologists, psychiatric nurses and social workers, need to be trained in determining and intervening with the emotional consequences of family-based substance use.

Theoretically, the results support the continued applicability of Social Learning Theory and Family Systems Theory in the Nigerian context. In contrast, this study also reveals that the theory's operation in the African context is not necessarily the same as in Western societies. For example, in Western literature, emotional expressiveness is regarded as a protective factor, but it was a risk factor in this study (Jackson et al., 2020). This could be because some Nigerian homes are open, lacking boundaries and discipline. So, it is important for scholars and practitioners to modify or modify existing theories to incorporate local reality and family dynamics (Atilola, 2016). At the policy level, the low impact of the preventive communication of drugs by parents indicates significant gaps in drug use education in Nigerian families. Many parents might not approve of their children using drugs and alcohol, but those who don't have a clear structure, consistency, or behavioral models make it less effective (Wilson & Rhee, 2022; Ajayi & Ekundayo, 2020). This means there is a need for government and NGO programmes and initiatives to be developed and delivered to parents that can equip them to have meaningful, honest and consistent discussions regarding substance use with personal example and household discipline.

Conclusion and Recommendations

This study set out to see how family environment and exposure across generations affect current drug use among patients receiving treatment in Southwest Nigeria. What we found is straightforward: having family members who use drugs, whether parents, siblings, or others, matters a lot when trying to understand someone's own drug use. But there is more. Living with a relative who uses drugs leaves a psychological mark that does not fade just because someone starts using themselves. Cohesion within the family helped keep drug use down. On the other hand, emotional expressiveness became a risk factor when it appeared without any structure or boundaries. Preventive communication was not a significant predictor of drug use, and family conflict was not a significant predictor of drug use, likely because of cultural norms of emotional suppression. In sum, these results support the primary importance of family relationships in the initiation of drug use and for understanding factors related to the maintenance and recurrence of drug use. The study recommends culturally sensitive approaches that build on the structures, values, and communication styles of Nigerian families. It also shows that knowledge of a country's local context is important, as global theories need to be interpreted locally. The suggestions that follow are based on these.

1. Structured family therapy should be integrated into substance use treatment programs in all substance use treatment centers in Nigeria. This will aid in healing hurtful relationships and ensure that patients are not placed in the same unhealthy contexts that led to their addiction.
2. There should be tools and training available for mental health and addiction professionals to recognize and respond to emotional trauma associated with family drug use. This trauma may cause relapse or chronic dependency if it isn't treated properly.
3. Nationally, there is a need for parenting programmes which educate in a consistent and effective manner about the risks associated with using drugs. Parents, in turn, also must learn how to set a good example and not send mixed messages to their kids. Awareness campaigns on the dangers of drug use should target religious institutions, traditional rulers and local influencers, particularly when drug use is normalized in families.
4. Train therapists and social workers to be culturally competent in local family values and emotional expression to deliver culturally appropriate treatment to clients.
5. Need more longitudinal studies to track the relation between early exposure and early emotional trauma on adult substance use. This kind of research will aid policymakers and clinicians in the timely, evidence-based development of prevention strategies.

References

- Abiodun, O. A., Adelekan, M. L., Ogunremi, O. O., Oni, G. A., & Obayan, A. O. (2018). Pattern of substance use among individuals attending a psychiatric hospital in Nigeria. *West African Journal of Medicine*, 37(4), 345–351.
- Adekeye, O. A., Adeusi, S. O., Ahmadu, F. O., & Okojide, A. (2019). Influence of family dynamics on substance use among Nigerian adolescents. *Journal of Substance Use*, 24(6), 623–628. <https://doi.org/10.1080/14659891.2019.1638467>

- Ajayi, A. I., & Ekundayo, O. O. (2020). Parental communication and youth substance use in Nigeria: Insights from a community-based study. *African Journal of Drug and Alcohol Studies*, 19(2), 87–98.
- Akintunde, T. Y., Olawole Isaac, A., & Salami, K. K. (2020). Cultural influences on family conflict and adolescent substance use in Nigeria. *Journal of Social Issues in Africa*, 12(1), 45–59.
- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Author.
- Atilola, O. (2016). Cross cultural perspectives on parenting styles and adolescent substance use: A focus on Nigeria. *International Journal of Child and Adolescent Health*, 9(4), 467–475.
- Bandura, A. (1977). *Social learning theory*. Prentice Hall.
- Bowen, M. (1978). *Family therapy in clinical practice*. Jason Aronson.
- Campbell, C., & Caro, I. (2019). Family communication and substance use relapse. *Family Process*, 58(2), 456–470. <https://doi.org/10.1111/famp.12416>
- Degenhardt, L., Gisev, N., Hall, W., Larance, B., Larney, S., McKetin, R., & Mattick, R. P. (2019). Opioid use and harms following periods of abstinence: A systematic review. *Drug and Alcohol Dependence*, 200, 47–55. <https://doi.org/10.1016/j.drugalcdep.2019.02.015>
- Egede, L. E. (2007). Family structure and relapse in substance use disorders: A systematic review. *Journal of Substance Abuse Treatment*, 33(4), 361–368. <https://doi.org/10.1016/j.jsat.2007.05.011>
- Ennett, S. T., Tobler, A. L., Ringwalt, C. L., & Flewelling, R. L. (2018). Parent child preventive communication: Associations with adolescent substance use and relapse. *Prevention Science*, 19(5), 660–672. <https://doi.org/10.1007/s11121-018-0897-1>
- Fox, H. C., Bergquist, K., Hong, K. I., & Sinha, R. (2008). Stress induced and alcohol cue induced craving in recently abstinent alcohol dependent individuals. *Alcoholism: Clinical and Experimental Research*, 32(3), 395–403. <https://doi.org/10.1111/j.1530-0277.2007.00629.x>
- Haberle, B., Swanson, S. E., Hartzler, B., & Edelen, M. O. (2018). The role of family expressiveness in relapse prevention. *Journal of Clinical Psychology*, 74(11), 1918–1930. <https://doi.org/10.1002/jclp.22612>
- Hair, J. F., Hult, G. T. M., Ringle, C. M., & Sarstedt, M. (2022). *A primer on partial least squares structural equation modeling* (3rd ed.). Sage.
- Horigian, V. E., Feaster, D. J., & Mittrani, V. B. (2014). Mediators of family systems therapy for substance use services. *Journal of Family Psychology*, 28(1), 49–59. <https://doi.org/10.1037/a0035832>
- Hu, L. T., & Bentler, P. M. (1999). Cutoff criteria for fit indexes in covariance structure analysis: Conventional criteria versus new alternatives. *Structural Equation Modeling*, 6(1), 1–55. <https://doi.org/10.1080/10705519909540118>
- Ibigbami, O., & Adebayo, O. (2021). Parental alcohol misuse and adolescent substance use: A longitudinal study in Nigeria. *Journal of African Psychology*, 15(2), 123–134.

- Jackson, K. M., Sher, K. J., & Schulenberg, J. E. (2020). Family expressiveness and adolescent substance use: A longitudinal analysis. *Journal of Family Psychology*, 34(5), 562–571. <https://doi.org/10.1037/fam0000623>
- Karademas, E. C., & Tsaousis, I. (2017). Family conflict and substance use relapse: Emotion focused coping as a mediator. *Substance Use & Misuse*, 52(1), 54–63. <https://doi.org/10.1080/10826084.2016.1245336>
- Lee, C. T., Fang, L., & Hsu, J. (2021). Parental substance uses and adolescent drug initiation: A longitudinal study. *Addiction*, 116(9), 2379–2388. <https://doi.org/10.1111/add.15422>
- Marlatt, G. A., & Donovan, D. M. (2005). *Relapse prevention: Maintenance strategies in the treatment of addictive behaviors* (2nd ed.). Guilford Press.
- McLellan, A. T., Lewis, D. C., O'Brien, C. P., & Kleber, H. D. (2000). Drug dependence, a chronic medical illness: Implications for treatment, insurance, and outcomes evaluation. *JAMA*, 284(13), 1689–1695. <https://doi.org/10.1001/jama.284.13.1689>
- Moos, R. H., & Moos, B. S. (1994). *Family Environment Scale* (3rd ed.). Consulting Psychologists Press.
- Nguyen, T., Moyo, P., & Lund, J. (2021). Global relapse rates in substance use disorders: A meta-analysis. *Drug and Alcohol Review*, 40(3), 456–467. <https://doi.org/10.1111/dar.13215>
- Nunnally, J. C., & Bernstein, I. H. (1994). *Psychometric theory* (3rd ed.). McGraw Hill.
- Ogunwale, A., Akinhanmi, A., & Ladapo, H. (2015). Family support and recovery outcomes in substance use treatment: A Nigerian perspective. *Nigerian Journal of Psychiatry*, 13(2), 45–52.
- Olson, D. H. (2000). Circumplex model of marital and family systems. *Journal of Family Therapy*, 22(2), 144–167. <https://doi.org/10.1111/1467-6427.00144>
- Park, S., & Kim, H. (2022). Family cohesion and adolescent substance use: The mediating role of peer influence. *Drug and Alcohol Dependence*, 233, Article 109347. <https://doi.org/10.1016/j.drugalcdep.2022.109347>
- Roberts, N., Shapiro, B., & Berman, A. (2018). Emotional trauma and relapse risk in substance use disorders. *Journal of Substance Abuse Treatment*, 92, 34–41. <https://doi.org/10.1016/j.jsat.2018.06.003>
- Sinha, R. (2011). New findings on biological factors predicting relapse risk in substance use disorders. *Nature Neuroscience*, 14(7), 845–851. <https://doi.org/10.1038/nn.2888>
- Spinelli, M., Mazzola, C., & Buss, E. (2020). Family preventive communication and substance use relapse. *Addictive Behaviors Reports*, 12, Article 100304. <https://doi.org/10.1016/j.abrep.2020.100304>
- Thomas, R., Lippman, M., & Brown, T. (2019). Family conflict and adolescent substance use: A longitudinal study. *Journal of Adolescent Health*, 64(3), 321–328. <https://doi.org/10.1016/j.jadohealth.2018.09.012>
- Trenz, R. C., Scherer, M., Merten, M., & Meier, A. (2015). Family cohesion as a buffer against relapse in adults treated for substance use disorders. *Addictive Behaviors*, 45, 256–262. <https://doi.org/10.1016/j.addbeh.2015.02.010>

- Twagirayezu, E., Kallestrup, P., Vang, M. L., & Nielsen, K. K. (2021). Relapse rates in substance use disorders in low- and middle-income countries: A systematic review. *Substance Abuse Treatment, Prevention, and Policy*, 16(1), Article 45. <https://doi.org/10.1186/s13011-021-00376-8>
- United Nations Office on Drugs and Crime. (2022). *World Drug Report 2022*. <https://wdr.unodc.org/>
- Waldron, M., Kern Jackson, S., Turner, C., & Peterson, R. (2015). Family cohesion and substance use treatment outcomes. *Journal of Family Psychology*, 29(3), 445–454. <https://doi.org/10.1037/fam0000081>
- Wilson, S., & Rhee, S. H. (2022). Parental communication and marijuana use among U.S. adolescents: A longitudinal study. *Journal of Substance Abuse Treatment*, 134, Article 108543. <https://doi.org/10.1016/j.jsat.2021.108543>
- Witkiewitz, K., & Marlatt, G. A. (2004). Relapse prevention for alcohol and drug problems: That was Zen, this is Tao. *American Psychologist*, 59(4), 224–235. <https://doi.org/10.1037/0003-066X.59.4.224>
- World Health Organization. (2018). *Global status report on alcohol and health 2018*. <https://www.who.int/publications/i/item/9789241565639>
- Yamane, T. (1967). *Statistics: An introductory analysis* (2nd ed.). Harper and Row.