THE INFLUENCE OF LONELINESS AND PARENTAL BONDING ON SUBSTANCE ABUSE AMONG UNDERGRADUATES IN EKITI STATE UNIVERSITIES.

BY

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CERTIFICATION

I certify that this study was carried out by **ODUESO TAIWO JONATHAN** (PSY\14\2039) of the Department of Psychology, Faculty of Social Sciences, Federal University, Oye Ekiti.

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DEDICATION

This project work is dedicated to God Almighty, my Creator and Redeemer. In Him I have my total being. Without Him, I am nothing. I also dedicate this research work to my wonderful and darling parents, Mr. & Mrs. Odueso for their unending and unflinching love towards me.

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May the Almighty God bless and reward each one of you abundantly.

TABLE OF CONTENTS

LIST OF TABLE

ABSTRACT

This study investigated the influence of loneliness and parental bonding on substance use and abuse among undergraduates in Ekiti state universities. The study adopted an ex-post facto research design Three hundred and forty six (346) undergraduates were randomly sampled from among the departments and faculties of the three institutions of study. These participants were administered with UCLA loneliness scale, Parental bonding inventory, and Drug and substance test (DAST) together with demographic information. Four hypotheses were tested using independent t-test and multiple regressions. The result of the tested hypothesis showed that loneliness did not significantly influence substance abuse (t = 1.77; df = 344, p >.05). Parental bonding did not significantly influence substance abuse (t = -.349; df = 344, p >.05). Age and level of study jointly predict substance abuse [F (2, 331) = 7.36; p<.01]. Gender did not significantly influence substance abuse (t = -.001; df = 344, p >.05). Based on the findings, it was concluded that loneliness, parental bonding and gender did not have any significant influence on substance abuse; while age and level of study jointly predict substance abuse. Recommendations were to parents to ensure effective supervision of their children.

Keywords: Loneliness, parental bonding, substance abuse, age, level of study, undergraduates, Ekiti State.

Word Count: 210

CHAPTER ONE

INTRODUCTION

1.1 BACKGROUND TO THE STUDY

Substance abuse is one of the most important health problems in the world, especially in Africa (Bakhshani & Hosseinbor, 2013), and many factors are related to onset and maintenance of this common disorder. Since the ancient times, philosophers and scientists have known loneliness as one of the most complex psychological phenomena. At that time loneliness was a positive concept (Rosedale, 2007), which meant withdrawal from daily routine events to achieve more important goals in life (thinking, meditation, and spiritual connection), but nowadays it is not considered as a positive experience in psychological literature and refers to social withdrawal and poor social interaction. There are a number of social and environmental factors that have been strongly related to substance use and substance use disorders. These are in keeping with the findings of twin studies, which show that while there is a strong genetic component to vulnerability to drug dependence, there is also a substantial environmental component (Kendler& Gardner, 1998; Kendler, Karkowski, & Prescott, 1999; Kendler& Prescott, 1998).

There is much evidence to suggest that people with antisocial behaviour are more likely to have or develop substance use problems. Adolescents with conduct disorders are significantly more likely to develop substance use disorders than those without such conduct problems (Cicchetti&Rogosch, 1999; Gittelman, Mannuzza, Shenker, &Bonagura, 1985). In general, it appears that the earlier, more varied and more serious a child's antisocial behaviour, the more likely will it be continued into adulthood, with substance misuse considered as one of these antisocial behaviours (Costello, Erkanli, Federman, &Angold, 1999; Robins, 1978).

Furthermore, children or young people with anxiety or depressive symptoms are more likely to begin substance use at an earlier age, and to develop substance use problems (Cicchetti&Rogosch, 1999; Costello et al., 1999; Henry et al., 1993; Loeber, Southamer-Lober, & White, 1999). The peer environment also has a large influence on the drug-taking behaviour of individuals. Drug use usually begins with peers, and peer attitudes to drug use have been shown to be highly predictive of adolescent drug use (Fergusson &Horwood, 1997; Hoefler et al., 1999; Newcomb, Maddahian, &Bentler, 1986) perhaps because those who use drugs are more likely to choose to spend time with peers who also use drugs. There is, however, no evidence concerning the influence of peers on the development or maintenance of drug dependence (Institute of Medicine, 1996).

Feeling of loneliness is a psychologically destructive and terrifying experience (Bekhet and Zauszniewski, 2012) that makes severe psychological and physical problems (Ditommaso, Brannen and Best, 2004; Stickley, Koyanagi, Roberts, Richardson, Abbott and Tumanov, 2013). In social interaction, satisfaction is very important and critical for health. Sense of loneliness could make problems in social interaction and decrease the self-protective behaviour potentials as a social threatening factor (Heinrich and Gullone, 2006). It is believed that loneliness is a pervasive and dysphoric experience, which is the outcome of the expectation of individual and his or her current status. Feeling of loneliness has a direct relationship with the emotional domain and individual cognitive function and causes lack of adaptation in cognition, experience, and social expectations (van Baarsen, 2002). Studies are in favour of high prevalence of the sense of loneliness. Dykstra (2009), and Ditommaso et al. (2004) reported the prevalence rate about 8% to 10% and the other studies showed that 15% to 30% of people experience loneliness continuously. Heinrich and Gullone (2006) believed that one out of four people suffer from

chronic loneliness. A recent review by Hawkley and Cacioppo (2010) revealed that about 80% of people aged lower 18 and 40% of the over 65 years reported feeling of loneliness at least sometimes.

Baumeister&Laery (1995) argued about the basic needs and the feeling of belonging as essential motivations in individual`s emotion, thinking, and behaviour, which need at least a minimum of positive stable interpersonal relationship; therefore, an individual who develops problems in making and maintaining satisfactory relationship with the others will develop problems in satisfaction of the feeling of belonging, and this kind of deprivation leads to morbidity (Baumeister&Laery, 1995; Cacioppo, Ernst, Burleson, McClintock, Malarkey, &Hawkley, 2000; Brown, Ten Have, Henriques, Xie, Hollander, & Beck, 2005; Hawkley, Burleson, Berntson, &Cacioppo, 2003). Generally, drug abuse is a multi-factorial disorder in which every factor has its specific and common effects on the development and maintenance of addiction (Hosseinbor, Bakhshani, &Shakiba, 2012). Thus, any intervention concerning the prevention and treatment of addicted individuals should consider these factors or variables (Bakhshani, &Hosseinbor, 2013).

Parental support is the largest influence on creating preferable and favourable behaviour in adolescents. A parent is a model and a symbol of focus to good personality towards their children. Research on modelling has shown that when parents are held in high esteem and are the main sources for reinforcement, their child is more likely to model them (Conger, Conger, Simons, &Whitbeck, 1991). If a parent acts in a negative way, the child is more likely to follow their parent's negative attitude. They are also more likely to generalize this attitude to the rest of the society. Thus, parents have much influence over their child's behaviour. From birth, a parent will mould and shape behaviours suitable to the norms of a society through childrearing and socialization processes.

A deficient style of parental bonding during childhood and adolescence has been frequently reported in the scope of subjects with addiction (Ashby Wills, Vaccaro& McNamara, 1992; Kearns & Rosenthal, 2001; Kostelecky, 2005). A high level of insecure attachment and low levels of secure attachment and self-differentiation (Thorberg&Lyvers, 2006) have been reported among these patients. In particular, patients with alcohol abuse showed impaired parental bonding and were incapable of developing secure interpersonal relationships; they had problems with affect regulation (De Rick, Vanheule&Verhaeghe, 2009). Furthermore, these patients showed insecure attachment, and this was associated with significantly more severe trait-anxiety and a higher level of cognitive avoidance in coping with anxiety (Wedekind, Bandelow, Heitmann, Havemann-Reinecke, Engel &Huether, 2013). However, the question of which pattern of parental bonding is related to alcoholism and drug addiction remains unclear, although several studies have deepened the knowledge of this topic. A recent review has tried to shed some light onto this controversial framework (Becoña, Fernández, Calafat&Fernández-Hermida, 2014). Over the last 30 years the most influential studies (ranging from Bowlby's general categories to Bartholomew's (Bartholomew & Horowitz, 1991) and Parker's classifications) have not uniformly utilized the concept of parental bonding, so leading to a generalizable but not yet conclusive consideration that insecure attachment has a negative impact on addictive and dependence disorders.

1.2 STATEMENT OF PROBLEM

Students and other people who abuse substances often experience an array of problems including academic difficulties, family and social issues, health related problems (which include mental health), and poor peer relationship among several other problems. Additionally, there are consequences for family members, the community, and the entire society at large.

Understanding what constitutes problems of substance use and abuse is the first step toward defining which acts violate conventional social norms and behaviours to self and others in the society. The construction of social norms, which vary from society to society, illustrates that substance abuse is a social phenomenon. Only norm violations found most unacceptable to society are codified into laws and acted upon by criminal justice agencies. Policies created to prevent and reduce substance use and abuse is closely based on what a society believes causes individuals to engage in such negative acts.

Heinrich &Gullone (2006) indicated that feeling of loneliness is a cognitive variable related to worse physical and mental health and has direct relationship with depression and alcohol abuse (Cacioppo, Hawkley, Crawford, Ernst, Burleson, Kowalewski, 2002; Swami, Chamorro-Premuzic, Sinniah, Maniam, Kannan, &Stanistreet, 2007), low self-esteem, low self-confidence, assertiveness, shyness (Heinrich &Gullone, 2006; Ladd, Kochenderfer, & Coleman, 1996), disinhibited, high risk behaviours, anxiety, and tension (Page & Cole, 1991). Denga (1987) articulated and categorized the causes of misbehavior, deviancy, criminal tendencies and substance use and abuse in accordance with certain appertaining conditions. Previous studies are however of the opinion that home conditions such as defective parent-child relationships, poverty, lack of affection, over-strict disciplines and fighting by parents contributes a whole lot to increase prevalence of susceptibility to problems of substance use and abuse among adolescents and emerging adults.

1.3 RESEARCH QUESTION

This research tends to answer the following questions:

i. Will loneliness have a significant influence on substance use and abuse among undergraduates in Ekiti State Universities?

ii. Are there parental bonding styles differences on substance use and abuse among undergraduates in Ekiti State Universities?

iii. Will age, religious affiliations and family type jointly predict substance use and abuse among undergraduates in Ekiti State Universities?

iv. Will there be a gender difference on substance use and abuse among undergraduates in Ekiti State Universities?

1.4 OBJECTIVES OF THE STUDY

1. To examine the influence of loneliness on substance use and abuse among undergraduates in Ekiti State Universities.
2. To examine parental bonding styles differences on substance use and abuse among undergraduates in Ekiti State Universities.
3. To examine whether age, religious affiliations and family type will jointly predict substance use and abuse among undergraduates in Ekiti State Universities.
4. To examine the gender differences on substance use and abuse among undergraduates in Ekiti State Universities.

1.5 SIGNIFICANCE OF THE STUDY

In its broadest way, this study is set at improving on the existing body of knowledge in the literature of loneliness and parental bonding on substance use and abuse among undergraduates. It usefulness to counselling units or centres of schools and institutions of higher learning will aid guidance counsellors, educational psychologists and counselling psychologists in understanding the deficiency in parental upbringing of children and also in assessing adequate and essential measures to adopt in preventing maladaptive behaviours and shaping proper behaviours among children before the onset of adolescents. It will also help therapists in eradicating substance use

and abuse, maladaptive behaviours, drugs and alcoholism in clinical assessment. This will however aid therapists in determining how and why a person is behaving the way they do, showing abnormal behaviour and how that person may be helped using various therapeutic techniques.

It will also help parents in understanding the best and most adequate child rearing practices and parental bonding styles to adopt in training their children in socially acceptable behaviours and inculcating sound moral and valued principles in shaping the behaviours of their young ones to make them socially, morally and psychologically competent in adolescence and in adulthood.

CHAPTER TWO

LITERATURE REVIEW

2.1. THEORETICAL FRAMEWORK

The following theories or models were used in describing and explaining the study variables. It also serves as a guide for the variables under investigation.

Theories of Loneliness

2.1.1. Causal Attributions Theory

This theory was developed by Weiner in 1974 to explain how individuals explain events. Weiner's work (1974) has demonstrated that people give a variety of different causal explanations for success and failure. These include four primary reasons (ability, effort, task difficulty and luck), plus several less common ones (e.g. mood, fatigue or illness). Specific causal explanations can be classified on two underlying dimensions: locus of causality (internal versus external vis-a-vis the actor) and stability (stable versus variable over time). Weiner's model suggests that causal attributions for loneliness should have implications for the person's expectations, emotions and behaviour. The stability dimension of attributions is especially important for the person's expectations. If one perceives the precipitating factors in loneliness as being stable or unchanging, then the person will probably anticipate being lonely in the future. Some studies (Mazo& Perlman, 1977) suggest that people who attribute their behaviour to internal causes cope more persistently and effectively. Perhaps people think and act as follows: "If I caused my situation, I can also change it." The one difficulty with this line of' reasoning is that we previously linked internal, stable attributions to depression and despair. Such despair should inhibit coping.

This theory enumerates individual attributions to the feeling of loneliness.

Theories of Parental Bonding

2.1.2. Attachment Theory

Attachment during Infancy, Childhood, and Adolescence

Bowlby (1958) departed from the prevailing psychoanalytic tradition of his day when he postulated that attachment, driven by evolutionary forces, was at the heart of an individual's social and personality development. "Human infants, like infants of other species, are preprogrammed to develop in a socially cooperative way; whether they do so or not turns in high degree on how they are treated" (Bowlby, 1988). An ethological widely researched and widely accepted psychological constructs ever proposed even now (Cassidy & Shaver, 2008). According to His theory, attachment is an emotional bond between caregiver and care receiver that functions to ensure the survival of the helpless infant and, as an extension, the species as a whole. Crying, cooing, laughter, and other forms of early communication, he asserted, are used by the infant to maintain proximity and elicit care giving behaviors from the primary supporter; typically the mother (Bowlby, 1958). With heron-going provision of nutrition, warmth, interest, and proximity, the infant gains reassurance that caregivers will consistently and accurately meet its needs and that the world is a safe place in which to live and explore (Bowlby, 1958). Over time, mental and emotional representations of this dynamic develop (Bowlby, 1958). Termed internal working models (IWMs), they include the infant's preferred attachment patterns (styles), a sense of the extent to which the infant can rely upon others to meet their needs, and, as a result, a belief about the extent to which they themselves are worthy of such care (Bowlby, 1969/1982, 1979). For better or worse, IWMs allow the individual to imagine how future encounters will likely unfold based on previous experiences.

Bowlby (1969/1982) asserted that children develop one of three attachment styles in reaction to their mothers' predominant interpersonal approach: secure, anxious/ambivalent, or avoidant/dismissive. The first of these, secure attachment, develops when the infant's needs are consistently and accurately met, thus facilitating healthy emotion regulation and social ease. The second, anxious/ambivalent attachment,

Attachment theory suggests that people's intimate relationships are related to their relationships with their attachment figure. This attachment figure is a primary caregiver. People have an attachment behaviour system that helps to control how close or distant they are from others. The way people develop this system is dependent on their perception of their attachment figure. When they feel secure that the attachment figure is present and responsive, people's attachment behaviour system relaxes. When they wonder whether the attachment figure is present and responsive, people's attachment behaviour system becomes activated. They become upset and strive to restore closeness to their attachment figure. Over time, people develop internal working models of attachment. These models include expectations regarding the degree to which their attachment figure will be responsive to their needs. These internal working models of attachment have been divided into three different types: (1) secure, in which the attachment figure is seen as reliable and expected to be responsive to the infant's needs, (2) avoidant, in which the attachment figure is seen as unavailable, and the infant defensively avoids close contact with others, (3) anxious/ambivalent, in which the attachment figure is not consistently available or responsive, and the infant becomes preoccupied with checking on the attachment figure's availability.

Attachment theory suggests that people apply these internal working models of attachment to their romantic relationships. Another line of attachment theory has focused on the

underlying structure of people's attachment models. This theory has proposed two dimensions that can each range from negative to positive: (1) views of the self, and (2) views of others. People with positive views of self and other are classified as secure. People with positive views of the self and negative views of others are classified as dismissing of intimacy. People with negative views of the self and positive views of others are classified as preoccupied with relationships. People with negative views of the self and of others are classified as fearful of intimacy.

2.1.3. Baumrind's Parenting Typology

Baumrind (1971) is a researcher who focused on the classification of parenting styles. Baumrind's research is known as "Baumrind's Parenting Typology". In her research, she found what she considered to be the four basic elements that could help shape successful parenting: responsiveness vs. unresponsiveness and demanding vs. undemanding. Through her studies Baumrind identified three parenting styles: Authoritative parenting, authoritarian parenting and permissive parenting. Maccoby and Martin expanded upon Baumrind's four original parenting styles by placing parenting styles into two distinct categories: demanding and undemanding. With these distinctions, four parenting styles were defined.

Authoritative parental bonding

Authoritative parenting is characterized by a child-cantered approach that holds high expectations of maturity. Authoritative parents can understand how their children are feeling and teach them how to regulate their feelings. Even with high expectations of maturity, authoritative parents are usually forgiving of any possible shortcomings. They often help their children to find appropriate outlets to solve problems. Authoritative parents encourage Children to be independent but still place limits on their actions. Extensive verbal give-and-take is not refused,

and parents try to be warm and nurturing toward the child. Authoritative parents will set clear standards for their children, monitor the limits that they set, and also allow children to develop autonomy. They also expect mature, independent, and age-appropriate behaviour of children. Punishments for misbehaviour are measured and consistent, not arbitrary or violent. Often behaviours are not punished but the natural consequences of the child's actions are explored and discussed allowing the child to see that the behaviour is inappropriate and not to be repeated, rather than not repeated to merely avoid adverse consequences. Authoritative parents set limits and demand maturity. They also tend to give more positive encouragement at the right places. However, when punishing a child, the parent will explain his or her motive for their punishment. Children are more likely to respond to authoritative parenting punishment because it is reasonable and fair. A child knows why they are being punished because an authoritative parent makes the reasons known. As a result, children of authoritative parents are more likely to be successful, well-liked by those around them, generous and capable of self-determination.

Authoritarian parental bonding

Authoritarian parenting is a restrictive, punishment-heavy parenting style in which parents makes their children follow their directions with little to no explanation or feedback and focus on the children and family's perception and status. Corporal punishment and shouting are forms of discipline frequently preferred by authoritarian parents. The goal of this style, at least when well-intentioned, is to teach the child to behave, survive, and thrive as an adult in a harsh and unforgiving society by preparing the child for negative responses such as anger and aggression that the child will face if his/her behaviour is inappropriate. In addition, advocates of this style often believe that the shock of aggression from someone from the outside world will be less for a child accustomed to enduring both acute and chronic stress imposed by his/her parents.

Children raised using this type of parenting may have less social competence because the parent generally tells the child what to do instead of allowing the child to choose by him or herself, making the child appear to excel in the short term but limiting development in ways that are increasingly revealed as supervision and opportunities for direct parental control decline.Children raised by authoritarian parents tend to be conformist, highly obedient, quiet, and not very happy. These children often suffer from depression and self-blame.For some children raised by authoritarian parents, these behaviours continue into adulthood.Children who are resentful of or angry about being raised in an authoritarian environment but have managed to develop high behavioural self-confidence often rebel in adolescence and/or young adulthood.

Permissive parental bonding

Permissive parents try to be "friends" with their child, and do not play a parental role. The expectations of the child are very low, and there is little discipline. Permissive parents also allow children to make their own decisions, giving them advice as a friend would. This type of parenting is very lax, with few punishments or rules. Permissive parents also tend to give their children whatever they want and hope that they are appreciated for their accommodating style. Other permissive parents compensate for what they missed as children, and as a result give their children both the freedom and materials that they lacked in their childhood. Baumrind researched on pre-school children with permissive parents and she came up with a result that children were immature, absence in impulsive control and they were irresponsible because of permissive parenting style. Children of permissive parents may tend to be more impulsive and as adolescents may engage more in misconduct such as drug use.

Neglectful parental bonding

Neglectful parents demonstrate minimal warmth and minimal control over the child. The

parent is often rejecting of the child and gives the child minimal if any attention or nurturance. These kinds of parents are neglectful in their parental responsibilities. Basically, the parent provides some or most of the physical necessities for the child, but has little if any relationship with their child. The motto "Children should be seen but not heard" may apply here. Parents are consumed with their own life and have little time or concern for their children. The child is left fending for themselves with little if any structure in the household. Most of the time, the child is basically rejected and ignored by the parent.

Theories of Substance Abuse

2.1.4. Psychoanalytic Theories of Substance Abuse

Psychoanalytic theory which was developed from the writings of Sigmund Freud (1856-1939), posits that all humans have natural drives, instincts and urges that are repressed in the unconscious and isdeveloped early in life and is composed of three distinct parts: the id, the ego, and the superego (Siegel, Senna& Welsh, 2006). The id represents the instinctual drives, the ego represents understood social norms that harness or suppress the id pleasurable desires, and the superego is learned moral reasoning (Siegel et al.).Substance abusers behaviours are shaped by deviancy as a result of imbalance between these three parts of our personality structure and is thought to be a symbolic way of meeting our unconscious needs (Siegel et al.). The internal conflicts that lead to negative behaviour patterns, usually resulting from a conflict between the id and societal norms understood by the ego, are very painful to the individual, so that the individual pushes them into the unconscious (Shoe-maker, 2005). Then, the individual develops coping strategies called defense mechanisms to cope with the conflicts, and these defense mechanisms can lead to problematic personality traits and problematic behaviors, such as deviancy. In essence, deviant behavior is seen as the external manifestation of an internal

disease.

Erik Erikson expanded on the psychoanalytic theory, explaining deviant behaviour patterns as an ''identity crisis'' created by inner turmoil or problems (Siegel et al., 2006). As has been noted by many critics of psychoanalytic theory, this identity crisis created by inner turmoil is difficult to test or validate empirically. The utility of psychoanalytic theory to explain complex, negative, substance abuse related behaviour and deviant behavior is limited by the lack of evidence to support it (Shoemaker, 2005; Siegel et al.) and by the ''circular nature'' of psychoanalytic thought (Pfohl, 1994). That is the unconscious manifestations of pathology are ''inferred from behavior'' and that behavior is interpreted as a symptom of the pathology (Pfohl, 1994).

Additionally, all humans have criminal tendencies or potentials. These tendencies are curbed, however, through the process of socialisation. A child that is improperly socialised, then, could develop a personality disturbance that causes him or her to direct antisocial impulses either inward or outward. Those who direct them inward become neurotic while those who direct they outward become criminals and eventually drug or substance abusers.

2.1.5. Socio-Cognitive Theory of Substance Abuse

The major postulator of the social cognitive theory was Albert Bandura (1977), which was formerly referred to as social learning theory (SLT). The theory defines human behaviour as a triadic, dynamic, and reciprocal interaction of personal factors, behaviour, and the environment (Bandura, 1977). According to this theory, an individual's behaviour is uniquely determined by each of these three factors. While the SCT upholds the behaviourist notion that response consequences mediate behaviour, it contends that behaviour is largely regulated antecedent through cognitive processes. Therefore, response consequences of behaviour are used to form

expectations of behavioural outcomes. It is the ability to form these expectations that give humans the capability to predict the outcomes of their behaviour, before the behaviour is performed. In addition, the SCT posits that most behaviour is learned vicariously.

The SCT's strong emphasis on one's cognitions suggests that the mind is an active force that constructs one's reality, selectively encodes information, performs behaviour on the basis of values and expectations, and imposes structure on its own actions.

Through feedback and reciprocity, a person's own reality is formed by the interaction of the environment and one's cognitions. In addition, cognitions change over time as a function of maturation and experience (i.e. attention span, memory, ability to form symbols, reasoning skills). Individual's cognition changes to behaviours as a result of environmental or societal modeled behaviour or through learning of imminent maladaptive behaviours from others in the society. However, the SCT posits the interaction of (1) observation, symbolic representations and self-generated stimuli and self-imposed consequences, (2) environmental conditions and (3) behaviors in determining behaviour. This thereby influences adolescentsproness to drugs and substance use in their developmental strides.

2.1.6. Kohlberg Moral Reasoning Theory

Kohlberg (1984) expanded on the earlier work of cognitive theorist Jean Piaget to explain the moral development of children. Kohlberg believed that moral development, like cognitive development, follows a series of stages. He used the idea of moral dilemmas- stories that present conflicting ideas about two moral values to teach 10 to 16 year-old boys about morality and values. The best known moral dilemma created by Kohlberg is the "Heinz" dilemma, which discusses the idea of obeying the law versus saving a life. Kohlberg emphasized that it is the way an individual reasons about a dilemma that determines positive moral development.

After presenting people with various moral dilemmas, Kohlberg reviewed people's responses and placed them in different stages of moral reasoning. According to Kohlberg, an individual progresses from the capacity for pre-conventional morality (before age 9), and to the capacity for conventional morality (early adolescence), and finally toward attaining post-conventional morality (once Piaget's idea of formal operational thought is attained), which only a few fully achieve. Each level of morality contains two stages, which provide the basis for moral development in various contexts.

Level 1: Pre-conventional

Throughout the pre-conventional, a child's sense of morality is externally controlled. Children accept and believe the rules of authority figures, such as parents and teachers. A child with pre-conventional morality has not yet adopted or internalised society's conventions regarding what is right or wrong, but instead focuses largely on external consequences that certain actions may bring.

Stage 1: Obedience and Punishment Orientation

Stage 1 focuses on the child's desire to obey rules and avoid being punished. For example, an action is perceived as morally wrong because the perpetrator is punished; the worse the punishment for the act is, the more "bad" the act is perceived to be.

Stage 2: Instrumental Orientation

Stage 2 expresses the "what's in it for me?" position, in which right behaviour is defined by whatever the individual believes to be in their best interest. Stage 2 reasoning shows a limited interest in the needs of others, only to the point where it might further the individual's own interests. As a result, concern for others is not based on loyalty or intrinsic respect, but rather a 'you scratch my back, and I'll scratch yours" mentality. An example would be when a child is

asked by his parents to do a chore. The child asks "what's in it for me?" and the parents offer the child an incentive by giving him an allowance.

Level 2: Conventional

Throughout the conventional level, a child's sense of morality is tied to personal and societal relationships. Children continue to accept the rules of authority figures, but this is now due to their belief that this is necessary to ensure positive relationships and societal order. Adherence to rules and conventions is somewhat rigid during these stages, and a rule's appropriateness or fairness is seldom questioned.

Stage 3: Good Boy, Nice Girl Orientation

In stage 3, children want the approval of others and act in ways to avoid disapproval. Emphasis is placed on good behaviour and people being "nice" to others.

Stage 4: Law and Order Orientation

In stage 4, the child blindly accepts rules and convention because of their importance in maintaining a functioning society. Rules are seen as being the same for everyone, and obeying rules by doing what one is "supposed" to do is seen as valuable and important. Moral reasoning in stage four is beyond the need for individual approval exhibited in stage three. If one person violates a law, perhaps everyone would, thus there is an obligation and a duty to uphold laws and rules. Most active members of society remains at stage four, where morality is still predominantly dictated by an outside force.

Level 3: Post-conventional

Throughout the post-conventional level, a person's sense of morality is defined in terms of more abstract principles and values. People now believe that some laws are unjust and should be changed or eliminated. This level is marked by a growing realisation that individuals are

separate entities from society and that individuals may disobey rules inconsistent with their own principles. Post-conventional moralists live by their own ethical principles- principles that typically include such basic human rights as life, liberty, and justice, and view rules as useful but changeable mechanisms, rather than absolute dictates that must be obeyed without question. Because post-conventional individuals elevate their own moral evaluation of a situation over social conventions; their behaviour, especially at stage six, can sometimes be confused with that of those at the pre-conventional level. Some theorists have speculated that many people may never reach this level of abstract moral reasoning.

Stage 5: Social Contract Orientation

In stage 5, the world is viewed as holding different opinions, rights and values. Such perspectives should be mutually respected as unique to each person or community. Laws are regarded as social contracts rather than rigid edicts. Those that do not promote the general welfare should be changed when necessary to meet the greatest number of people. This is achieved through majorly decision and inevitable compromise. Democratic government is theoretically based on stage five reasoning.

Stage 6: Universal Ethical Principle

In stage 6, moral reasoning is based on abstract reasoning is based on abstract reasoning using universal ethical principles. Generally, the chosen principles are abstract rather than concrete and focus on ideas such as equality, dignity, or respect. Laws are valid only insofar as they are grounded in justice, and a commitment to justice carries with it an obligation to disobey unjust laws. People choose the ethical principles they want to follow, and if they violate those principles, they feel guilty. In this way, the individual acts because it is morally right to do so (and not because he or she wants to avoid punishment), it is in their best interest, it is expected, it

is legal, or it is previously agreed upon. Although Kohlberg insisted that stage six exists, he found it difficult to identify individuals who consistently operated at that level.

The moral reasoning theory emphasises that moral judgements of situations need to be inculcated into the lives of children by their parents from an early stage of development before the onset or emergence of adolescence. Adolescents trained with high moral standards grow to become acceptable of societal norms and rules and therefore restricts themselves from any illegal or immoral behaviour and activities such as crime, deviant behaviour and substance use and abuse.

2.1.6. Theory of Planned Behaviour

The Theory of Planned Behaviour (TPB) developed by Ajzen (1985) is one of the most widely cited and applied behavioural theories in the study of psychology also one of a closely interrelated family of theories which utilise a cognitive approach to explaining behaviour which centres on individuals' attitudes and beliefs and coined from the Theory of Reasoned Action (TRA). The Theory of Reasoned Action posited an "intention to act" as the best predictor of behaviour and emphasizes to predict an individual's intention to engage in a behaviour at a specific time and space. In addition to attitudes and subjective norms (which make the theory of reasoned action), TPB adds the concept of perceived behavioural control, which originates from self-efficacy theory (SET), as proposed by Bandura (1977) which came from social cognitive theory. The major premise of the TPB is that individuals make rational decisions to engage in specific behaviours based on their own beliefs about the behaviours and their expectation of a positive outcome after having engaged in the behaviours. TPB hypothesize that substance use and abuse occurs because of the opportunity, as well as the intention to use the drugs (For instance, a student may

have a favourable attitude towards drug use and may have friends who also engage in abusing of drugs and substance, but the societal restriction and imposition of penalties on drug use make its use scarce, very difficult or impossible to accomplish).

According to Ajzen (2002), an intention to perform a behaviour is determined by three components: (1) attitude toward a behaviour (beliefs about a specific behaviour and its consequences); (2) subjective norm (normative expectations of other-people who are important to the actor regarding the behaviour), and (3) perceived behavioural control (the perceived difficulty or ease of performing the behaviour). The theory of planned behaviour model is thus a very powerful and predictive model for explaining human behaviour. As it is often said "The drug addict makes the mistake, while the drug dealer commits the crime"

The TPB states that behavioural achievement depends on both motivation (intention) and ability (behavioural control). It distinguishes between three types of beliefs which are behavioural, normative and control. The TPB however is composed of six constructs that collectively represent a person's actual control over the behaviour.

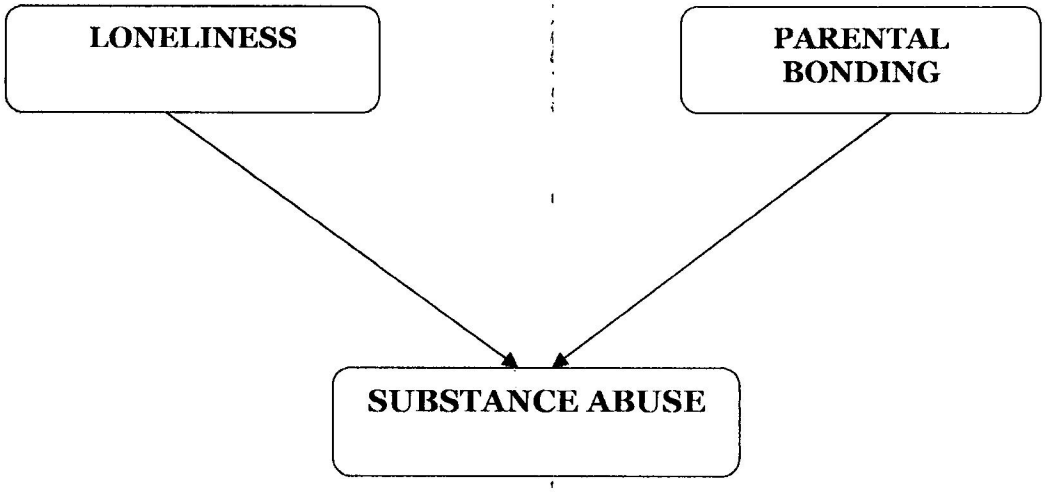
1) **Attitudes** – The degree to which a person has a favourable or unfavourable evaluation of the behaviour of interest. Also, entails a consideration of the outcomes of performing the behaviour.
2) **Behavioural Intention** – The motivational factors that influence a given behaviour where the stronger the intention to perform the behaviour, the more likely the behaviour will be performed.
3) **Subjective Norms** – The belief about whether most people approve or disapprove of the behaviour. Also, relates to a person's beliefs about whether peers and people of importance to the person think he or she should engage in the behaviour.

4) **Social Norms** – The customary codes of behaviour in a group or people or larger cultural context. Social norms are considered normative, or standard, in a group of people.

5) **Perceived Power** – The perceived presence of factors that may facilitate or impede performance of behaviour. Perceived power contributes to a person's perceived behavioural control over each of those factors.

6) **Perceived Behavioural Control** – A person's perception of the ease or difficulty of performing the behaviour of interest. Perceived behavioural control varies across situations and actions, which results in a person having varying perceptions of behavioural control depending on the situation. This construct of the theory was added later, and created the shift from the Theory of Reasoned Action to the Theory of Planned Behaviour.

2.2. THEORETICAL CONCEPTUALISATION



The diagram above describes and explains that loneliness and parental bonding influences

substance use and abuse.

2.3. RELATED EMPIRICAL STUDIES

Over the past years, various empirical and related works has been carried out in relation to how loneliness and parental bonding influences substance use and abuse. This review serves as a guiding light in the conduct of the present study.

These related empirical studies are therefore explained below:

MokuoluBoladeOlubunmi, AjayiOlubukola, Dada OlugbengaDavid(2015) researched on sociability and shyness as factors for proneness to substance use and abuse among undergraduates in Ekiti state university, Nigeria. They view substance use and abuse as a common issue among youths. Their study centred on the relationship which exists between substance abuse, sociability and shyness being issues that are common among youths in their study. An expo-facto design was adopted in the study, 200 undergraduates participated in the study consisting of 103 males and 97 females with an average age of 22 years. The results of their study found a significant main effect of sex and shyness on substance use and abuse but no significant main effect of sociability. There was also no significant interaction effect of the three study independent variables on substance use and abuse.

Previous researchers of the study by MokuoluBoladeOlubunmi, AjayiOlubukola, Dada OlugbengaDavid(2015) as reported by Page 12 & 13 revealed that high shy/ high social individuals were at an increased risk for substance use because this will help individuals cope with an approach avoidance conflict that they experience during and /or in anticipation of social interaction. However, Schmidt, L.A., & Fox, N.A. (1995) reported that shyness and sociability are distinguishable on measures of central and autonomic psychophysiology.

Research findings on the feeling of loneliness reports that it is a psychologically destructive and terrifying experience (Bekhet&Zauszniewski, 2012), that makes severe psychological and physical problems (Ditommaso, Brannen& Best, 2004; Stickley, Koyanagi, Roberts, Richardson, Abbott &Tumanov, 2013). In a review of the construct of loneliness and several measures developed to assess it. Oshagen and Allen (1992) noted that the prevalence of loneliness in the general population has been estimated to range from 15% to 28%.

Research on loneliness and substance abuse has been able to identify the major correlates and causes of substance abuse among youths. Studies have found a link between loneliness and alcohol and substance use, including the use of cocaine and analgesics (Akerlind&Hornquist, 1992; Hawkley&Cacciopo, 2010; Jylha, 1994; McWhirter, 1990; Rokach, 2002). In another study, loneliness was associated with poorer substance abuse treatment outcomes (Rychtarik, Foy, Scott, Lokey, &Prue, 1987). Studies by Baumeister&Laery (1995) argued about the basic needs and the feeling of belonging as essential motivations in individual's emotion, thinking, and behaviour, which need at least a minimum of positive stable interpersonal relationship; therefore, an individual who develops problems in making and maintaining satisfactory relationship with the others will develop problems in satisfaction of the feeling of belonging, and this kind of deprivation leads to morbidity (Baumeister&Laery, 1995; Cacioppo, Ernst, Burleson, McClintock, Malarkey, &Hawkley, 2000; Brown, Ten Have, Henriques, Xie, Hollander, & Beck, 2005; Hawkley, Burleson, Berntson, &Cacioppo, 2003). Generally, drug abuse is a multi-factorial disorder in which every factor has its specific and common effects on the development and maintenance of addiction (Hosseinbor, Bakhshani, &Shakiba, 2012). Thus, any intervention concerning the prevention and treatment of addicted individuals should consider these factors or variables (Bakhshani, &Hosseinbor, 2013).

John Agwaya, Peter Aloka, and Pamela Raburu (2015) examined the relationship between locus of control and indulgence in behaviour problems among Kenyan students. They observed that indulgence in behaviour problems was mostly facilitated by external locus of control. This conclusion emphasizes that individual believes that something outside of them or various external situations controls life events. However, considering recent researches which has evaluated the close relationship existing between self-esteem and locus of control, it was reported that self-esteem often have a positive and meaningful relationship with locus of control (Maryam, &Mahsa, 2011). Farzad, Mehdi,&Behrooz, H. (2016) emphasize that self-esteem and behavioural consequences which are due to external or internal locus of control, are effective on academic achievement of students.

Okorodudu, (2010) carried out a research on the influence of parenting styles on adolescent's delinquency in Delta Central Senatorial District. Okorodudu observed that adolescents may exhibit suicidal tendencies, juvenile delinquency, vandalism, destruction of public property, maiming and murder of parents and violence against the larger society. Juvenile delinquency is noted byEkojo&Adole (2008) as gang delinquency. The gangs delinquent are group of adolescents and youths that exhibit criminal behaviour. Several researches reviewed on factors that precipitate delinquency among adolescents (Okorodudu&Okorodudu, 2003; Eke, 2004; Eke, 2004a, Eke, 2004b) stress that adolescence is a period of stress and storm. Eke also observed that the period is characterized by rebelliousness. This is caused by non-conducive environment. Okorodudu&Okorodudu (2003) listed environmental factors; social factors, physical factors, psychological factors; peer group influence, drug abuse and the family factor as causes of delinquency among adolescents.

Eke (2004) observes that causes of juvenile delinquency tend to find theoretical

explanations in the interaction between biological, environmental and social factors. She believes that the biological or genetic make-up of individuals can predispose adolescents" engagement in delinquent activities. Chromosomal abnormalities among the adolescents may predispose them to antisocial behaviours. The Nigerian Government had devised and employed several measures aimed at curbing adolescents" delinquency in our society but to no avail. For instance establishment and administration of juvenile justice; promulgation of juvenile laws and courts, establishment of remand homes, establishment of security and law enforcement agency etc. Many researchers agree that the foundation of adolescent delinquency is rooted in the kind of home the adolescent is brought up (Odebumi, 2007; Otuadah, 2008; Okpako, 2004; Utti, 2006). The basis for good behaviour orientation and good adolescents" attitude development is founded on positive parenting. Okpako (2004) stated that the parents should be blamed and be made to take responsibility for the misfortune that befalls the adolescents. Hence the study wishes to examine the relationship between adolescents" delinquency and parenting styles.

Edwards & Shane (2006) emphasized the importance of extended family ties in Latino culture as well as the strong identification and attachment of individuals with tier families. In Africa, parents expand beyond immediate mother and father to include members of the extended family, neighbours and every other person who in one way or the other is involved in upbringing of the child (Okpako, 2004). However, factors which constitute negative parenting (poor parenting) were equally identified as: parental harshness, aggression; lack of love, lack of affection, lack of care, adequate monitoring and supervision, and lack of control to mention but a few. These and a host of other conditions may prong the adolescents into delinquent behaviours and increase in crime rate. Besides, poor parenting may enhance adolescents" health problems. For instance, Kring et al (2007) reported a clinical case of a 19 year old man with irregular

breathing, a rapid pulse and dilated pupils. Diagnosed symptoms began after excessive drugs use resulting from poor and parental disharmony. Apart from addiction he was also into other delinquent activities such as: disobedience, disengagement from family activities, stealing and selling people's properties to get money for drugs and videos. Darling (2007) also observed that children and adolescents whose parents are uninvolved perform most poorly in all domains.

Okorodudu (2010) investigated the influence of parenting styles on adolescents' delinquency. 404 sample sizes were used for the study. 6 research questions and 6 research hypotheses were designed and formulated for the purpose of the study. Regression statistic was used for the analyses of the study. Irrespective of gender, location and age, the results of the analyses show that permissive parenting style effectively predicts adolescents' delinquency while authoritarian and authoritative did not. Parents who are positively oriented in their styles (demandingness and responsiveness) will make their adolescents socially competent and goal – directed. Parents who exerted control and monitored adolescent activities and promoted self-autonomy were found to have the most positive effects on adolescents' behaviour. Uninvolving parents and also non responsive to adolescents needs had negative impacts on their behaviour.

2.4. STATEMENT OF HYPOTHESIS

I. Loneliness will have a significant influence on substance use and abuse among undergraduates in Ekiti State Universities.

II. Parental bonding will have a significant influence on substance use and abuse among undergraduates in Ekiti State Universities.

III. Age and level of study will independently and jointly predict substance use and abuse among undergraduates in Ekiti State Universities.

IV. Male undergraduates will report more on substance use and abuse than female undergraduates in Ekiti State Universities.

2.5. OPERATIONAL DEFINITION OF TERMS

I. Loneliness: An individual's subjective feelings of depressed moments as well as feelings of social isolation as a result of being alone. It was measured using The UCLA loneliness scale (Russell, Peplau& Ferguson, 1978).Higher scores indicate higherloneliness scores; lower scores indicate level of loneliness.

II. Parental Bonding: Parenting attitude and behaviours in which parents raise their children either in an authoritarian, authoritative, permissive or neglectful way. It is known as the specific behaviours and emotional climate in which parent adopt to socialise their children. It was measured using the Parental Bonding Inventory (Parker, Tupling& Brown, 1979). Higher scores indicate higher sense of competence.

III. Parental care: Parental attitude and behaviours characterised by a degree of support, warmth and responsiveness offered to a child by the parent. As measured using the Parental Bonding Inventory (Parker, Tupling& Brown, 1979). Higher scores indicate high parental care; lower scores indicate low parental care.

IV. Parental overprotection: Parental attitude and behaviours characterised by a degree of control and force a parent exerts over their child. As measured using the Parental Bonding Inventory (Parker, Tupling& Brown, 1979). Higher scores indicate high parental overprotection; lower scores indicate low parental overprotection.

V. Authoritarian Parental Bonding: Parenting behaviours and attitudes characterised by high levels of control and low levels of warmth. As measured using the Parental Bonding Inventory (Parker, Tupling& Brown, 1979). High parental overprotection and low

parental care indicate Authoritarian parental bonding.

VI. Authoritative Parental Bonding: Parenting behaviours and attitudes characterised by high levels of control and high levels of warmth. As measured using the Parental Bonding Inventory (Parker, Tupling& Brown, 1979). High parental overprotection and high parental care indicate Authoritative parental bonding.

VII. Permissive Parental Bonding: Parenting behaviours and attitudes characterised by low levels of control and high levels of warmth. As measured using the Parental Bonding Inventory (Parker, Tupling& Brown, 1979). Low parental overprotection and high parental care indicate Permissive parental bonding.

VIII. Neglectful Parental Bonding: Parental behaviours and attitudes characterised by low levels of control and low levels of warmth. As measured using the Parental Bonding Inventory (Parker, Tupling& Brown, 1979). Low parental overprotection and low parental care indicate Neglectful parental bonding.

IX. Substance Abuse: Illegal or excessive drug use; deliberate use of an illegal drug or excessive use of a prescribed drug. It was measured using the Drug Abuse Screening Test (Skinner, H. 1982).

CHAPTER THREE
METHOD

3.1 RESEARCH DESIGN

The researcher adopted the use of ex-post facto research design because none of the variables of study was subjected to active manipulation; rather they were measured as they occurred. The independent variables are loneliness and parental bonding. The dependent variable is substance abuse.

3.2 SETTING AND PARTICIPANTS

The study was carried out among undergraduates in Ekiti state universities. The participants were 346 (172 male, 174 female) undergraduate with age range of 16 to 29 years and mean age of 20.27 years (SD = 2.24). One hundred and sixteen(116) (33.5%) of the participants were from FUOYE, 105 (30.3%) were from EKSU and 125 (36.1%) were from ABUAD

In terms of ethnic group, 276 (79.8%) are Yorubas, 46 (13.3%) are Igbos, 7 (2%) are Hausas, and 17 (4.9%) are from other minority ethnic group. Regarding religious affiliation, 294 (85%) were Christian, 50 (14.5%) were Moslems and 2 (0.6%) are Traditional worshippers.

The level of study indicated that 106 (30.6%) are in 100 level, 111 (32.1%) are in 200 level, 87 (25.1%) are in 300 level, 39 (11.3%) are in 400 level and 3 (0.9%) are in 500 level. The family type of participants revealed that 4 (1.2%) have no parent, 289 (83.5%) have both parents, 50 (14.5%) have only single parent, 2 (0.6%) are having parents not married and 1 (0.3%) Parents are separated from each other.

3.3 INSTRUMENT

A questionnaire was used to collect data from the field in this present study. The questionnaire was design in sections comprising of standardized scales as follows:

Section A comprises of the demographic characteristics of the undergraduate students, such as

their sex, age, marital status, education religion, rank status and years of service experience.

Section B measures loneliness using a 20 item UCLA loneliness scale developed by Russell, Peplau& Ferguson (1978). The scale has a 4 – point Likert response format ranging from "I often feel this way" (1) to "I never feel this way" (4). Higher scores indicate higher loneliness scores. The author reported a reliability coefficient of between .89 and .94, while in this present study; the researcher reported a reliability coefficient alpha of 0.88

Section C measures parental bonding using a 25-item parental bonding inventory developed by Parker, Tupling& Brown (1979). The scale has 5 point Likert response format, ranging from strongly disagree (1) to strongly agree (5). Higher scores indicate higher sense of competence. The authors reported a reliability coefficient of 0.76 and 0.63 for care and overprotection dimension, while in the present study; the researcher reported a reliability coefficient alpha of 0.78.

Section D measures substance abuse using 28-items drug abuse screening test DAST developed by Skinner, H. (1982).The scale is a YES or NO response format. High score indicate high level of substance abuse. The author reported a reliability coefficient of between .92 to .94, while in the present study; the researcher reported a reliability coefficient of 0.86.

3.4 PROCEDURE

The researcher began the research process by seeking an approval from his supervisor to begin the research. After the consent was approved, the researcher proceeded to the institutions where data were to be generated. The questionnaires were distributed to the participants in their regular classroom. In the course of the administration, emphasis was laid on the anonymity of the respondents and they were all assured of utmost confidentiality of their responses. At the end of the filling in the questionnaire the participants were thanked for taking their time.

3.5 STATISTICAL METHODS

The demographic data collected were analysed using descriptive statistics such as mean, range, standard deviation, frequency distribution and percentages. Hypotheses stated were analysed using inferential statistics. Hypotheses one, two and four were tested using t-test for independent groups in order to compare and establish group differences. Hypothesis three was tested using multiple regression analyses to determine independent and joint contributions of predictor variables on criterion variable.

CHAPTER FOUR
RESULTS

HYPOTHESIS ONE

Hypothesis one stated that loneliness will have a significant influence on substance abuse among undergraduates in Ekiti State Universities. The hypothesis was tested using t-test for independent group. The result is presented in Table 4.1.

Table 4.1: t-test for Independent group showing differences in High and Low Loneliness on Substance Abuse among Undergraduates.

Loneliness		N	Mean	SD	df	t	P
Substance Abuse	Low	171	30.66	7.27	344	1.77	>.05
	High	175	32.21	9.01			

From Table 4.2, the result of the t-test shows that undergraduates with high loneliness (X = 32.21) were not significantly different in substance abuse from those with low loneliness (X = 30.66), t = 1.77; df = 344, p >.05. The results imply loneliness did not significantly influence substance abuse among undergraduates. Therefore, hypothesis one was not confirmed.

HYPOTHESIS TWO

Hypothesis two stated that parental bonding will have a significant influence on substance abuse among undergraduates in Ekiti State Universities. The hypothesis was tested using t-test for independent group. The result is presented in Table 4.2.

Table 4.2: t-test for Independent group showing differences in High and Low Parental Bonding on Substance Abuse among Undergraduates.

Parental Bonding		N	Mean	SD	df	t	P
Substance Abuse	Low	113	31.66	11.85	344	-.349	>.05

High	233	31.33	5.71			

From Table 4.2, the result of the t-test shows that undergraduates with high parental bonding (X = 31.33) were not significantly different in substance abuse from those with low parental bonding (X = 31.66), t = -.349; df = 344, p >.05. The results imply that parental bonding did not significantly influence substance abuse among undergraduates. Therefore, hypothesis two was not confirmed.

HYPOTHESIS THREE

Hypothesis three stated that age and level will independently and jointly predict substance abuse among undergraduates in Ekiti State Universities. The hypothesis was tested using multiple regression. The result is presented in Table 4.3

Table 4.3 Multiple Regression Analysis of Substance Abuse by Age and Level of study

Variables	**ß**	**T**	**P**	**R**	**R^2**	**F**	**P**
Age	.22	3.34	<.01	.21	.04	7.36	<.01
Level	-.03	-.481	>.01				

From Table 4.3, it can be observed that age and level of study jointly predicted substance abuse. F (2, 331) = 7.36; p<.01 with R = 0.21, R^2 = 0.04. This suggests that both variables jointly accounted for 4% variation in substance abuse among undergraduates. However, only the contribution of age (β= .22; t = 3.34 p <.01) was significant in the joint prediction. Therefore, the hypothesis was partially confirmed.

HYPOTHESIS FOUR

Hypothesis four stated that male undergraduates will report more on substance abuse than female undergraduates in Ekiti State Universities. The hypothesis was tested using t-test for independent group. The result is presented in Table 4.4.

Table 4.4: t-test for Independent group showing differences in Male and Female Undergraduates on Substance Abuse

	Gender	N	Mean	SD	df	t	P
Substance Abuse	Male	172	31.44	8.66	344	-.001	>.05
	Female	174	31.44	7.78			

From Table 4.4, the result of the t-test shows that undergraduates who are males (X = 31.44) were not significantly different in substance abuse from those who are females (X = 31.44), t = -.001; df = 344, p >.05. The results imply that gender did not significantly influence substance abuse among undergraduates. Therefore, hypothesis four was not confirmed.

CHAPTER FIVE

DISCUSSION, CONCLUSION & RECOMMENDATIONS

In this chapter, the results of the study are discussed based on the data analysis made in chapter four, interpreted and inference drawn from them. Conclusions, implications and recommendations for further studies are made.

5.1. DISCUSSION OF THE FINDINGS

The study investigated the influence of loneliness and parental bonding on substance abuse among first to fifth year undergraduates in Ekiti State Universities. The study results emphasize that loneliness has no influence on substance use and abuse. Parental bonding has no influence on substance use and abuse. Age and level of study jointly predicts substance use and abuse. Gender did not influence substance use and abuse. However, the results of the study are discussed extensively.

Investigating the influence of loneliness on substance use and abuse revealed that loneliness has no significant influence on substance use and abuse. The research findings contradicts the works of Rychtarik, Foy, Scott, Lokey, &Prue (1987) where it was concluded that loneliness was associated with poorer substance abuse treatment outcomes. However, Oshagen and Allen (1992) noted that the prevalence of loneliness in the general population has been estimated to range from 15% to 28%. Studies have found a link between loneliness and alcohol and substance use, including the use of cocaine and analgesics (Akerlind&Hornquist, 1992; Hawkley&Cacciopo, 2010; Jylha, 1994; McWhirter, 1990; Rokach, 2002). In a study, loneliness was associated with poorer substance abuse treatment outcomes (Rychtarik, Foy, Scott, Lokey, &Prue, 1987). Studies by Baumeister&Laery (1995) argued about the basic needs and the feeling

of belonging as essential motivations in individual's emotion, thinking, and behaviour, which need at least a minimum of positive stable interpersonal relationship; therefore, an individual who develops problems in making and maintaining satisfactory relationship with the others will develop problems in satisfaction of the feeling of belonging, and this kind of deprivation leads to morbidity.

The examination of findings on parental bonding on substance use and abuse revealed that parental bonding has no influence on substance use and abuse. This contradicts the findings of researchers such as Odebumi (2007), Otuadah (2008), Okpako (2000), and Utti (2006) where it was agreed that the foundation of adolescent delinquency is rooted in the kind of home the adolescent is brought up. The basis for good behaviour orientation and good adolescents attitude development is founded on positive parenting. Darling (2007) also observed that children and adolescents whose parents are uninvolved perform most poorly in all domains. Also, Darling (2007) discloses that irrespective of gender, location and age, the results of the analyses show that permissive parenting style effectively predicts adolescents' delinquency while authoritarian and authoritative did not.

Investigating the influence of gender in substance use and abuse revealed that gender has no significant influence on substance use and abuse. This finding contradicts the findings of Jill & Ming (2009) when they stated that there is an underlying sex difference due to sexually dimorphic development of the brain that, in part, mediates the sex difference in drug abuse.

5.2. CONCLUSION

In light of the findings obtained in this study, the following conclusions are made.

1. The findings imply that loneliness has no significant influence on substance use and abuse.

2. It also revealed that parental bonding has no significant influence on substance use and abuse.
3. Moreover, age and level of study jointly predicts substance use and abuse and that age only independently predicts substance use and abuse.
4. Furthermore, gender has no significant influence on substance use and abuse.

5.3. IMPLICATIONS

The recent and continued increase in the development of maladaptive behaviour and upward trend in substance use and abuse is on a high rise. However, understanding what constitutes problems of substance use and abuse is the first step toward defining which acts violate conventional social norms and behaviours to self and others in the society. What has been known of this social problem is that if necessary measures are not taken to eradicate and curb this menace in the society, then the society is at a risk for further increase in behavioural problems.

5.4 RECOMMENDATIONS

In consideration of the above conclusion, the following recommendations are given:

1. There should be an improved generalizability of the findings on undergraduates' substance use and abuse by recruiting a more heterogeneous group of respondents.
2. Future research should improve statistical rigor on undergraduate substance use and abuse prevalence rate by securing a larger sample size and/or reduce level of significance from .05 (i.e., $P< .05$) to a more conservative .01 (i.e., $P< .01$) level.

3. More emphasis on the exploration of the contribution of other potential predictor variables (e.g., locus of control, self-esteem, self-efficacy, optimism, parental attachment, neuroticism and extroversion) and its roles in explaining more on development and understanding of substance use and abuse.
4. A longitudinal design should/could be utilised to establish a causal relations among measures of loneliness, parental bonding (care and overprotectiveness) and attachment, age and gender on delinquency, crime, substance use and abuse.
5. Further examination of the contributing factor of other socio-demographic variables (e.g., ethnicity, socio-economic status) towards the onset of substance use and abuse.
6. Parents should ensure effective supervision of their children and should not allow other home environment factor to distract their children. They should also adopt a proper and effective parental bonding technique in training their children in the socialisation process of child development.

5.5. LIMITATIONS OF STUDY

The findings of this research study must be interpreted with caution because of several important limitations. First, the sample of respondents was limited given the number of undergraduates in Ekiti state universities are quite a number. Respondents also represented a specific geographical area (i.e., South-western part) of Nigeria. In addition, the voluntary nature of participation, as well as relatively low substance use and abuse scores may suggest that these respondents represented a motivated group, with more successful academic backgrounds than other groups of undergraduate students. These factors all limit the generalizability of the findings. Also, undergraduates for the study comprised of those in the university while neglecting those in the polytechnics, monotechnics and college of educations.

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QUESTIONNAIRE

FEDERAL UNIVERSITY OYE-EKITI, EKITI STATE
FACULTY OF SOCIAL SCIENCES
DEPARTMENT OF PSYCHOLOGY

Dear respondent,

This study is conducted by ODUESO TAIWO JONATHAN, an undergraduate student in the department of psychology, Federal University Oye-Ekiti.
Please note that your answers will be confidential and NOT released to anyone else. Your honest answers will be highly appreciated.

Thanks for your co-operation

SECTION A

Name of University .....
University Type: Federal ( ) State ( ) Private ( )
Age .....**Gender:** Male ( ) Female ( )
Ethnic group: Yoruba ( ) Igbo ( ) Hausa ( ) Others ( )
Religious Affiliations: Christianity ( ) Islam ( ) Traditional ( )
Level: 100 ( ) 200 ( ) 300 ( ) 400 ( ) 500 ( )
Family Type: No Parents/ Both Parents/ Single Parents
(Choose one: Parents not married/ Seperated/ Divorced)

SECTION B

Instructions: Please indicate how often each of the statements below is descriptive of you.

S/No	Statement	"I often feel this way"	"I sometimes feel this way"	"I rarely feel this way"	"I never feel this way"
1	I am unhappy doing so many things alone				
2	I have nobody to talk to				
3	I cannot tolerate being so alone				
4	I lack companionship				
5	I feel as if nobody really understands me				
6	I find myself waiting for people to call or write				
7	There is no one I can turn to				
8	I am no longer close to anyone				
9	My interests and ideas are not shared by those around me				
10	I feel left out				
11	I feel completely alone				

12	I am unable to reach out and communicate with those around me				
13	My social relationships are superficial				
14	I feel starved for company				
15	No one really knows me well				
16	I feel isolated from others				
17	I am unhappy being so withdrawn				
18	It is difficult for me to make friends				
19	I feel shut out and excluded by others				
20	People are around me but not with me				

SECTION C

This part lists various attitudes and behaviours of parents. As you remember your **MOTHER** in your first 16years, kindly tick the most appropriate next to each question.

S/No	Statement	Very Likely	Moderately Likely	Moderately Unlikely	Very Unlikely
1	Spoke to me in a warm and friendly voice				
2	Did not helps me as much as I needed				
3	Let me do things I liked doing				
4	Seemed emotionally cold to me				
5	Appeared to understand my fears and worries				
6	Was affectionate to me				
7	Liked me to make my own decisions				
8	Did not want me to grow up				
9	Tried to control everything I did				
10	Invaded my privacy				
11	Enjoyed talking things over with me				
12	Frequently smiled at me				
13	Tended to baby me				
14	Did not seem to understand what I needed or wanted				
15	Let me decide for myself				
16	Made me feel I wasn't wanted				
17	Could make me feel better when I was upset				
18	Did not talk with me very much				
19	Tried to make me feel dependent on him				
20	Felt I could not look after myself unless she was around				
21	Gave me much freedom as I wanted				
22	Let me go out as often as I wanted				
23	Was overprotective of me				
24	Did not praise me				
25	Let me dress in any way I pleased				

This part lists various attitudes and behaviours of parents. As you remember your **FATHER** in your first 16years, kindly tick the most appropriate next to each question.

S/No	Statement	Very Likely	Moderately Likely	Moderately Unlikely	Very Unlikely
1	Spoke to me in a warm and friendly voice				
2	Did not helps me as much as I needed				
3	Let me do things I liked doing				
4	Seemed emotionally cold to me				
5	Appeared to understand my fears and worries				
6	Was affectionate to me				
7	Liked me to make my own decisions				
8	Did not want me to grow up				
9	Tried to control everything I did				
10	Invaded my privacy				
11	Enjoyed talking things over to me				
12	Frequently smiled at me				
13	Tended to baby me				
14	Did not seem to understand what I needed or wanted				
15	Let me decide things for myself				
16	Make me feel I wasn't wanted				
17	Could make me feel better when I was upset				
18	Did not talk with me very much				
19	Tried to make me feel dependent on him				
20	Felt I could not look after myself unless he was around				
21	Gave me as much freedom as I wanted				
22	Let me go out as often as I wanted				
23	Was overprotective of me				
24	Did not praise me				
25	Let me dress in any way I pleased				

SECTION D

The following questions concern information about your involvement with drugs. Consider the past year (12 months) and carefully read each statements. Then decide whether your answer is YES or NO and chack the appropriate space. Please be sure to answer every question.

S/N	STATEMENTS	YES	NO
1	Have you used drugs other than those required for medical reasons?		
2	Have you abused prescription drugs?		
3	Do you abuse more than one drug at a time?		

4	Can you get through the week without using drugs (other than those required for medical reasons?		
5	Are you always able to stop using drugs when you want to?		
6	Do you abuse drugs on a continuos basis?		
7	Do you try to limit your drug use to certain situations?		
8	Have you had "blackouts" or "flashbacks" as a result of drug use?		
9	Do you ever feel bad about your drug abuse?		
10	Does your parent ever complain about your involvement with drugs?		
11	Do your friends or relatives known or suspect you abuse drugs?		
12	Has drug abuse ever created problem between you and your parents?		
13	Has any family member ever sought help for problems related to your drug use?		
14	Have you ever loss friends because of your use of drugs?		
15	Have you ever neglected your family or school work because of your use of drugs?		
16	Have you ever been in touble at school because of drug abuse?		
17	Have you ever been rusticated from the university because of drug abuse?		
18	Have you gotten into fights when under the influence of drugs?		
19	Have you ever been arrested because of unusual behaviour while under the influence of drugs?		
20	Have you ever been arrested for driving while under the influence of drugs?		
21	Have you engaged in illegal activities in order to obtain drugs?		
22	Have you ever been arrested for possession of illegal drugs?		
23	Have you ever experience withdrawal symptoms as a result of heavy drug intake?		
24	Have you had medical problems as a result of your drug use (e.g, memory loss, hepatitis, convulsions, bleeding, etc.)?		
25	Have you ever gone to anyone for help for a drug problem?		
26	Have you ever been in a hospital for medical problems related to your drug use?		
27	Have you ever been involved in a treatment program specifically related to drug use?		
28	Have you been treated as an outpatient for problems related to drug abuse?		

APPENDIX

Frequencies

Statistics

		NameOfUniversity	UniversityType	Age	Gender	EthnicGroup	ReligiousAffiliation	Level	FamilyType
N	Valid	346	346	334	346	346	346	346	346
	Missing	0	0	12	0	0	0	0	0

Frequency Table

NameOfUniversity

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	FUOYE	116	33.5	33.5	33.5
	EKSU	105	30.3	30.3	63.9
	ABUAD	125	36.1	36.1	100.0
	Total	346	100.0	100.0	

UniversityType

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Federal	127	36.7	36.7	36.7
	State	100	28.9	28.9	65.6
	Private	119	34.4	34.4	100.0
	Total	346	100.0	100.0	

Gender

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Male	172	49.7	49.7	49.7
	Female	174	50.3	50.3	100.0
	Total	346	100.0	100.0	

EthnicGroup

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yoruba	276	79.8	79.8	79.8
	Igbo	46	13.3	13.3	93.1
	Hausa	7	2.0	2.0	95.1
	Others	17	4.9	4.9	100.0
	Total	346	100.0	100.0	

Religious Affiliation

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Christianity	294	85.0	85.0	85.0
	Islam	50	14.5	14.5	99.4
	Traditional	2	.6	.6	100.0
	Total	346	100.0	100.0	

Level

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	100 Level	106	30.6	30.6	30.6
	200 Level	111	32.1	32.1	62.7
	300 Level	87	25.1	25.1	87.9
	400 Level	39	11.3	11.3	99.1
	500 Level	3	.9	.9	100.0
	Total	346	100.0	100.0	

FamilyType

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No Parent	4	1.2	1.2	1.2
	Both Parents	289	83.5	83.5	84.7
	Single Parent	50	14.5	14.5	99.1
	Parents Not Married	2	.6	.6	99.7
	Separated	1	.3	.3	100.0
	Total	346	100.0	100.0	

Descriptives

Descriptive Statistics

	N	Minimum	Maximum	Mean	Std. Deviation
Age	334	16.00	29.00	20.2725	2.23688
Valid N (listwise)	334				

Reliability for Loneliness Scale: ALL VARIABLES

Case Processing Summary

		N	%
Cases	Valid	298	86.1
	Excluded[a]	48	13.9
	Total	346	100.0

a. Listwise deletion based on all variables in the procedure.

Reliability Statistics

Cronbach's Alpha	N of Items
.881	20

Item Statistics

	Mean	Std. Deviation	N
B1	2.6107	.99298	298
B2	2.0503	1.01544	298
B3	2.4027	1.02112	298
B4	1.7584	.84208	298
B5	2.6242	1.04753	298
B6	2.1846	1.04583	298
B7	1.9161	.96557	298
B8	2.1812	1.19231	298
B9	2.2819	.98869	298
B10	1.9866	1.06986	298
B11	1.9799	1.01815	298
B12	1.9329	.96515	298
B13	2.2416	1.02593	298
B14	1.9664	1.05036	298
B15	2.6275	1.07880	298
B16	1.9530	1.01395	298
B17	2.2685	1.57903	298
B18	1.9430	1.04129	298
B19	1.7718	.96135	298
B20	2.1711	1.08599	298

Item-Total Statistics

	Scale Mean if Item Deleted	Scale Variance if Item Deleted	Corrected Item-Total Correlation	Cronbach's Alpha if Item Deleted
B1	40.2416	128.702	.346	.880
B2	40.8020	123.203	.588	.872
B3	40.4497	132.572	.165	.885
B4	41.0940	128.570	.430	.877
B5	40.2282	124.231	.521	.874
B6	40.6678	122.977	.579	.872
B7	40.9362	126.383	.469	.876
B8	40.6711	120.767	.584	.872
B9	40.5705	125.014	.520	.874
B10	40.8658	121.598	.625	.871
B11	40.8725	121.061	.687	.869
B12	40.9195	123.125	.627	.871
B13	40.6107	127.545	.384	.879
B14	40.8859	124.014	.529	.874
B15	40.2248	123.353	.541	.874
B16	40.8993	125.364	.489	.875
B17	40.5839	124.129	.309	.886
B18	40.9094	124.669	.505	.875
B19	41.0805	125.946	.492	.875
B20	40.6812	124.090	.505	.875

Scale Statistics

Mean	Variance	Std. Deviation	N of Items
42.8523	137.493	11.72575	20

Reliability for Parental Bonding scale
Scale: ALL VARIABLES

Case Processing Summary

		N	%
Cases	Valid	239	69.1
	Excluded[a]	107	30.9
	Total	346	100.0

a. Listwise deletion based on all variables in the procedure.

Reliability Statistics

Cronbach's Alpha	N of Items
.775	50

Item Statistics

	Mean	Std. Deviation	N
M1	3.7113	1.98850	239
M2	3.9916	1.08074	239
M3	3.0879	.95959	239
M4	3.6820	1.05287	239
M5	3.1925	.91474	239
M6	3.3933	.84274	239
M7	3.0167	.93919	239
M8	4.2176	1.05058	239
M9	3.3305	1.09023	239
M10	3.7657	1.09021	239
M11	3.3222	.92171	239
M12	3.1255	1.01715	239
M13	2.9079	.98300	239
M14	3.7866	1.02514	239
M15	3.1841	.88379	239
M16	4.2259	1.05679	239
M17	3.0962	.90467	239
M18	3.9331	1.13191	239
M19	3.4979	.94324	239
M20	2.2594	1.13003	239
M21	3.4519	.97273	239
M22	3.4268	.97977	239
M23	3.5439	1.08715	239
M24	3.9665	1.03658	239
M25	3.8117	1.06615	239
F1	2.7406	.93466	239
F2	3.8410	1.08457	239
F3	3.4100	1.07652	239
F4	3.4017	1.05607	239
F5	3.1046	1.02569	239
F6	2.8828	.91376	239
F7	3.2636	.98815	239
F8	4.2469	.99248	239

F9	3.4603	.97311	239
F10	3.9079	1.03708	239
F11	3.2259	.96971	239
F12	3.2134	.98330	239
F13	3.5649	1.12411	239
F14	3.6444	.99319	239
F15	3.4268	.97977	239
F16	4.0167	1.07284	239
F17	3.4351	1.10906	239
F18	3.6151	1.03426	239
F19	3.3891	1.09008	239
F20	3.7782	1.10622	239
F21	3.5941	1.01591	239
F22	3.5690	1.03024	239
F23	3.4351	1.01407	239
F24	3.8033	1.00786	239
F25	3.6067	1.03109	239

Item-Total Statistics

	Scale Mean if Item Deleted	Scale Variance if Item Deleted	Corrected Item-Total Correlation	Cronbach's Alpha if Item Deleted
M1	170.7950	223.945	.001	.789
M2	170.5146	212.461	.455	.763
M3	171.4184	221.362	.199	.772
M4	170.8243	215.204	.377	.766
M5	171.3138	225.015	.077	.776
M6	171.1130	223.033	.168	.773
M7	171.4895	223.041	.144	.774
M8	170.2887	211.845	.491	.762
M9	171.1757	221.557	.161	.774
M10	170.7406	217.764	.280	.770
M11	171.1841	222.109	.182	.773
M12	171.3808	222.043	.161	.774
M13	171.5983	228.897	-.064	.781
M14	170.7197	213.253	.456	.764
M15	171.3222	227.093	.003	.778
M16	170.2803	208.850	.589	.758
M17	171.4100	222.142	.186	.773
M18	170.5732	207.573	.586	.758
M19	171.0084	219.798	.260	.770
M20	172.2469	241.153	-.412	.794
M21	171.0544	225.699	.045	.777
M22	171.0795	222.796	.144	.774
M23	170.9623	223.280	.108	.776
M24	170.5397	213.888	.429	.764
M25	170.6946	215.978	.346	.767
F1	171.7657	220.558	.235	.771
F2	170.6653	212.635	.447	.763
F3	171.0962	214.961	.375	.766
F4	171.1046	216.346	.338	.768
F5	171.4017	223.082	.125	.775
F6	171.6234	227.538	-.015	.779
F7	171.2427	221.193	.197	.772
F8	170.2594	216.344	.364	.767
F9	171.0460	223.145	.133	.774
F10	170.5983	219.443	.242	.771
F11	171.2803	223.110	.135	.774
F12	171.2929	223.855	.107	.775

F13	170.9414	218.148	.258	.770
F14	170.8619	216.380	.363	.767
F15	171.0795	219.435	.261	.770
F16	170.4895	216.385	.330	.768
F17	171.0711	225.823	.027	.779
F18	170.8912	222.181	.153	.774
F19	171.1172	222.835	.121	.775
F20	170.7280	217.611	.280	.769
F21	170.9121	217.425	.317	.768
F22	170.9372	215.378	.381	.766
F23	171.0711	220.478	.214	.772
F24	170.7029	217.445	.320	.768
F25	170.8996	215.620	.373	.766

Scale Statistics

Mean	Variance	Std. Deviation	N of Items
174.5063	227.965	15.09852	50

Reliability for Substance Abuse scale
Scale: ALL VARIABLES

Case Processing Summary

		N	%
Cases	Valid	308	89.0
	Excluded[a]	38	11.0
	Total	346	100.0

a. Listwise deletion based on all variables in the procedure.

Reliability Statistics

Cronbach's Alpha	N of Items
.857	28

Item Statistics

	Mean	Std. Deviation	N
D1	1.3214	.71553	308
D2	1.2175	.41324	308
D3	1.1786	.38362	308
D4	1.7922	.40639	308
D5	1.7987	.40162	308
D6	1.1136	.31789	308
D7	1.6331	.48274	308
D8	1.1623	.36936	308
D9	1.2955	.45699	308
D10	1.2305	.42185	308
D11	1.1136	.31789	308
D12	1.0942	.29252	308
D13	1.1039	.30562	308
D14	1.0942	.29252	308
D15	1.0617	.24098	308
D16	1.0682	.25247	308
D17	1.0584	.23496	308
D18	1.1006	.30135	308
D19	1.0519	.22228	308
D20	1.0844	.27846	308
D21	1.1039	.30562	308

D22	1.0617	.24098	308
D23	1.1104	.31388	308
D24	1.0649	.24681	308
D25	1.0942	.29252	308
D26	1.0812	.27354	308
D27	1.0682	.25247	308
D28	1.0779	.26849	308

Item-Total Statistics

	Scale Mean if Item Deleted	Scale Variance if Item Deleted	Corrected Item-Total Correlation	Cronbach's Alpha if Item Deleted
D1	31.9156	17.491	.241	.868
D2	32.0195	18.247	.291	.856
D3	32.0584	18.159	.348	.854
D4	31.4448	19.368	-.025	.866
D5	31.4383	19.400	-.033	.866
D6	32.1234	18.571	.282	.855
D7	31.6039	19.093	.028	.867
D8	32.0747	17.926	.442	.850
D9	31.9416	18.589	.164	.861
D10	32.0065	17.459	.513	.848
D11	32.1234	17.594	.656	.845
D12	32.1429	18.025	.537	.849
D13	32.1331	17.972	.532	.848
D14	32.1429	18.103	.505	.849
D15	32.1753	18.256	.549	.849
D16	32.1688	18.284	.508	.850
D17	32.1786	18.284	.550	.850
D18	32.1364	17.786	.617	.846
D19	32.1851	18.425	.509	.851
D20	32.1526	17.797	.668	.846
D21	32.1331	17.653	.661	.845
D22	32.1753	18.497	.430	.852
D23	32.1266	17.668	.636	.846
D24	32.1721	18.221	.552	.849
D25	32.1429	17.927	.578	.848
D26	32.1558	17.943	.616	.847
D27	32.1688	18.343	.480	.851
D28	32.1591	17.874	.661	.846

Scale Statistics

Mean	Variance	Std. Deviation	N of Items
33.2370	19.445	4.40968	28

Correlations

Descriptive Statistics

	Mean	Std. Deviation	N
Age	20.2725	2.23688	334
Level	2.1965	1.02524	346
Loneliness	42.5838	12.42789	346
ParentalBonding	162.5260	36.41079	346
SubstanceAbuse	31.4422	8.21757	346

Correlations

		Age	Level	Loneliness	ParentalBonding	SubstanceAbuse
Age	Pearson Correlation	1	.596**	.059	-.115*	.205**
	Sig. (2-tailed)		.000	.286	.036	.000
	N	334	334	334	334	334
Level	Pearson Correlation	.596**	1	.152**	-.108*	.083
	Sig. (2-tailed)	.000		.005	.045	.124
	N	334	346	346	346	346
Loneliness	Pearson Correlation	.059	.152**	1	-.159**	.141**
	Sig. (2-tailed)	.286	.005		.003	.009
	N	334	346	346	346	346
ParentalBonding	Pearson Correlation	-.115*	-.108*	-.159**	1	.111*
	Sig. (2-tailed)	.036	.045	.003		.040
	N	334	346	346	346	346
SubstanceAbuse	Pearson Correlation	.205**	.083	.141**	.111*	1
	Sig. (2-tailed)	.000	.124	.009	.040	
	N	334	346	346	346	346

**. Correlation is significant at the 0.01 level (2-tailed).
*. Correlation is significant at the 0.05 level (2-tailed).

T-Test for Hypothesis One

Group Statistics

	Loneliness	N	Mean	Std. Deviation	Std. Error Mean
SubstanceAbuse	High	175	32.2114	9.00676	.68085
	Low	171	30.6550	7.26500	.55557

Independent Samples Test

		Levene's Test for Equality of Variances		t-test for Equality of Means						
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	95% Confidence Interval of the Difference	
									Lower	Upper
SubstanceAbuse	Equal variances assumed	5.879	.016	1.767	344	.078	1.55646	.88091	-.17620	3.28911
	Equal variances not assumed			1.771	332.139	.077	1.55646	.87875	-.17217	3.28508

T-Test for Hypothesis Two

Group Statistics

	ParentalBonding	N	Mean	Std. Deviation	Std. Error Mean
SubstanceAbuse	High	233	31.3348	5.70688	.37387
	Low	113	31.6637	11.85222	1.11496

Independent Samples Test

		Levene's Test for Equality of Variances		t-test for Equality of Means						
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	95% Confidence Interval of the Difference	
									Lower	Upper
SubstanceAbuse	Equal variances assumed	37.693	.000	-.349	344	.727	-.32895	.94323	-2.18418	1.52627
	Equal variances not assumed			-.280	137.762	.780	-.32895	1.17598	-2.65425	1.99635

Regression for Hypothesis Three

Variables Entered/Removed[a]

Model	Variables Entered	Variables Removed	Method
1	Level, Age[b]	.	Enter

a. Dependent Variable: SubstanceAbuse
b. All requested variables entered.

Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.206[a]	.043	.037	8.12237

a. Predictors: (Constant), Level, Age

ANOVA[a]

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	971.326	2	485.663	7.362	.001[b]
	Residual	21837.033	331	65.973		
	Total	22808.359	333			

a. Dependent Variable: SubstanceAbuse
b. Predictors: (Constant), Level, Age

Coefficients[a]

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	15.096	4.438		3.402	.001
	Age	.829	.248	.224	3.344	.001
	Level	-.260	.540	-.032	-.481	.630

a. Dependent Variable: SubstanceAbuse

T-Test for Hypothesis Four

Group Statistics

	Gender	N	Mean	Std. Deviation	Std. Error Mean
SubstanceAbuse	Male	172	31.4419	8.66141	.66043
	Female	174	31.4425	7.77908	.58973

Independent Samples Test

		Levene's Test for Equality of Variances		t-test for Equality of Means						
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	95% Confidence Interval of the Difference	
									Lower	Upper
SubstanceAbuse	Equal variances assumed	.310	.578	-.001	344	.999	-.00067	.88486	-1.74108	1.73974
	Equal variances not assumed			-.001	339.232	.999	-.00067	.88541	-1.74225	1.74091

One-way ANOVA-Religious Affiliation on Substance Abuse

SubstanceAbuse

	N	Mean	Std. Deviation	Std. Error	95% Confidence Interval for Mean		Minimum	Maximum
					Lower Bound	Upper Bound		
Christianity	294	31.2279	8.46912	.49393	30.2558	32.2000	.00	51.00
Islam	50	32.4400	6.59363	.93248	30.5661	34.3139	.00	51.00
Traditional	2	38.0000	1.41421	1.00000	25.2938	50.7062	37.00	39.00
Total	346	31.4422	8.21757	.44178	30.5733	32.3111	.00	51.00

ANOVA

SubstanceAbuse

	Sum of Squares	Df	Mean Square	F	Sig.
Between Groups	149.293	2	74.646	1.106	.332
Within Groups	23148.051	343	67.487		
Total	23297.344	345			

One-way ANOVA- Family Type on Substance Abuse

Descriptives

SubstanceAbuse

	N	Mean	Std. Deviation	Std. Error	95% Confidence Interval for Mean		Minimum	Maximum
					Lower Bound	Upper Bound		
No Parent	4	26.7500	16.11159	8.05580	1.1129	52.3871	4.00	42.00
Both Parents	289	31.3183	8.43495	.49617	30.3418	32.2949	.00	51.00
Single Parent	50	32.3600	6.15368	.87026	30.6111	34.1089	.00	46.00
Parents Not Married	2	35.5000	2.12132	1.50000	16.4407	54.5593	34.00	37.00
Separated	1	32.0000	.	.	.	.	32.00	32.00
Total	346	31.4422	8.21757	.44178	30.5733	32.3111	.00	51.00

ANOVA

SubstanceAbuse

	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	167.861	4	41.965	.619	.649
Within Groups	23129.483	341	67.828		
Total	23297.344	345			