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Family Dynamics and Mental Health Outcome Among Substance Abusers

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Abstract
Substance use disorders (SUDs) constitute a significant public health concern and are frequently associated with adverse mental health outcomes. Although existing research has largely emphasized biological and individual psychological determinants, the role of family dynamics in shaping mental health during treatment has received limited quantitative attention in the Indian socio-cultural context. The present study examines the relationship between family dynamics and mental health outcomes among individuals undergoing treatment for substance use disorders.
Using a quantitative correlational research design, data were collected from 200 individuals receiving treatment at the 'Punarjanm' Integrated Rehabilitation Centre for Addicts (IRCA) in Gorakhpur, Uttar Pradesh. Family dynamics and perceived familial support were assessed using standardized, culturally validated instruments, while mental health outcomes including depression, anxiety, and psychological distress were measured using widely accepted clinical scales. Correlational and multiple regression analyses were employed to examine associations between family-related factors and mental health outcomes.
The findings indicate that positive family characteristics, emotional cohesion, open communication, and perceived familial support are associated with lower levels of depression, anxiety, and psychological distress. In contrast, family conflict and excessive control are linked to poorer outcomes. Perceived familial support remained a protective factor.

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INTRODUCTION

Substance use disorders (SUDs) are a growing global public health concern, with significant implications for individuals, families, and communities. The World Health Organization (2023) estimates that over 35 million people worldwide suffer from drug use disorders, many of whom also experience co-occurring mental health conditions such as anxiety, depression, and suicidal ideation. While much of the literature has focused on the biological and psychological mechanisms of addiction, increasing attention is being paid to the role of the social environment—particularly family dynamics—in influencing both the development and outcome of substance abuse and its related mental health issues.

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Family dynamics, defined as the patterns of interaction, emotional bonding, communication, and role distribution within a household, play a critical role in shaping an individual's emotional resilience and behavioral responses. In functional family systems—marked by emotional support, clear communication, and consistent boundaries—individuals may develop healthier coping mechanisms that protect against both substance use and psychological distress. On the other hand, dysfunctional families, characterized by neglect, conflict, abuse, or inconsistent parenting, often contribute to emotional dysregulation, increased stress, and vulnerability to both substance dependency and mental health disorders (Lander, Howsare, & Byrne, 2013).

In the **Western context**, a number of studies have demonstrated that adverse family environments are closely linked to the onset and severity of substance abuse as well as poor psychological outcomes. For instance, poor parental monitoring, emotional neglect, and family conflict have been associated with higher rates of depression, anxiety, and continued substance use among both adolescents and adults (Schmidt et al., 2016; Park & Schepp, 2014). Conversely, supportive family engagement has been shown to promote recovery, improve adherence to treatment, and reduce the risk of relapse.

In the **Indian context**, family structures hold a uniquely central place in shaping individual identity and decision-making. Indian families are typically interdependent, multigenerational, and collectivist in nature, which can either serve as a buffer against or a source of emotional strain in cases of substance abuse. Cultural expectations related to obedience, family honor, and caregiving roles can contribute to both protective and risk factors. Studies from India highlight that substance abuse is frequently linked to strained familial relationships, domestic violence, and lack of emotional intimacy (Murthy, 2017; Kumar, 2020). Furthermore, Indian households often take on the role of primary caregivers, but unresolved interpersonal conflicts and traditional hierarchies can lead to increased psychological distress among both the substance user and their family members.

The Magnitude of Substance Use in India report by Ambekar et al. (2019) notes that over 57 million people in India engage in harmful use of substances like alcohol, opioids, and cannabis. Many live in environments where the family is both the first source of emotional support and, at times, the source of emotional trauma. Despite this, most Indian rehabilitation and treatment models continue to focus on the individual in isolation, with limited integration of family-based therapeutic approaches.

Given these gaps in research and practice, particularly in the Indian setting, this study aims to explore the correlation between family dynamics and mental health outcomes—specifically symptoms of depression, anxiety, and psychological distress—among individuals undergoing treatment for substance use disorders. Drawing on international frameworks and culturally grounded perspectives, the research utilizes quantitative data collected from 200 participants at Punarjanm Integrated Rehabilitation Center for Addicts (IRCA), located in Sonbarasa, Gorakhpur. Validated tools are used to assess both family functioning and mental health indicators.

By analyzing the association between perceived family support or dysfunction and psychological well-being, this study seeks to provide evidence that can inform the design of more holistic and culturally sensitive substance abuse treatment programs. The ultimate goal is to advocate for the integration of family-based interventions, which can significantly improve treatment outcomes and promote long-term recovery.

Background and Literature Review

Substance use disorders (SUDs) are chronic, relapsing conditions that impair a person's cognitive, behavioral, and emotional functioning, often co-occurring with mental health issues such as depression, anxiety, and psychological distress. According to the World Health Organization (2023), over 35 million people globally live with drug use disorders, many of whom experience dual diagnoses that complicate recovery and reduce quality of life. Among the many contributing factors to these outcomes, **family dynamics** play a pivotal but often underestimated role.

Family Systems and Substance Use: Theoretical Foundations

According to **Family Systems Theory** (Bowen, 1978), individual behavior cannot be fully

understood in isolation but must be seen within the emotional and interactional context of the family. In families affected by substance abuse, maladaptive patterns frequently emerge. Roles such as the "enabler," "scapegoat," or "hero" develop as coping mechanisms, shaping not only the trajectory of addiction but also the mental well-being of all family members (Lander, Howsare, & Byrne, 2013). Dysfunctional communication, boundary violations, emotional neglect, and unresolved conflicts are frequently observed in such environments, contributing to emotional instability, low self-worth, and heightened psychological symptoms in substance users.

While biological, social, and environmental determinants of SUDs have been extensively studied, **family-related factors**—such as emotional support, relational stability, and parenting styles—are increasingly recognized as central to both the **onset of substance use** and the **outcomes of recovery** (Gonzales et al., 2018).

Global studies have consistently shown that poor family functioning is associated with adverse mental health outcomes among individuals with SUDs. For instance, Brook et al. (2011), in a longitudinal study in the United States, found that adolescents exposed to high levels of family conflict and parental substance use were more likely to develop depressive symptoms and engage in substance use later in life. Park and Schepp (2014) similarly noted that a lack of caregiver emotional responsiveness predicted anxiety and emotional dysregulation in young users.

Supportive family environments, by contrast, enhance the likelihood of positive treatment outcomes. Schmidt et al. (2016) observed that adolescents undergoing treatment for substance abuse in supportive family contexts reported lower rates of psychological comorbidity and relapse. Evidence-based interventions such as **Multidimensional Family Therapy (MDFT)**, widely practiced in Western countries, have demonstrated success in improving both substances use behaviors and family functioning (Liddle et al., 2009).Recent evidence increasingly supports the role of family-based and relational factors in recovery from substance use disorders *(Hogue et al., 2021; Esteban et al., 2023).*

These findings reinforce the need for family-inclusive approaches to substance abuse treatment, especially when addressing underlying emotional and psychological distress.

In **India**, the family serves as a central social institution with strong cultural, emotional, and practical significance. Unlike Western societies that often emphasize individual autonomy, Indian families tend to be interdependent, multigenerational, and collectivist in structure. These cultural norms can be protective in some cases, providing emotional and logistical support during recovery. However, they can also lead to secrecy, stigma, and emotional strain, especially when family honor or reputation is perceived to be at risk.

Murthy (2017) highlights that substance abuse in India is frequently accompanied by marital discord, domestic violence, and emotional alienation—factors that elevate the risk of mental health problems among users. In a related study, Kumar (2020) found that individuals from dysfunctional family backgrounds reported significantly higher levels of depression and anxiety than those from more cohesive and supportive homes.

The **Magnitude of Substance Use in India** report by Ambekar et al. (2019) estimates that over 57 million Indians engage in harmful use of alcohol, opioids, or cannabis. These individuals often live in households marked by rigid hierarchies, unresolved generational conflict, and limited communication—all of which can intensify psychological vulnerability and reduce the effectiveness of rehabilitation.

Despite this, treatment models in India have historically emphasized individual detoxification and behavioral counseling, often neglecting the social and emotional dynamics within the family system (Rao & Chandrashekar, 2018). There is a critical lack of structured family-inclusive models in Indian rehabilitation centers, even though research consistently points to the effectiveness of such interventions in enhancing treatment outcomes.

Identified Gaps in the Literature

Although family support is widely recognized as an important component of substance use recovery, its role as *perceived familial support during active treatment* remains insufficiently examined in the existing literature. International studies have primarily focused on family involvement in terms of treatment compliance,

relapse prevention, or post-treatment outcomes, while evidence regarding the association between perceived family support and concurrent mental health outcomes during treatment is limited and, in several cases, inconsistent.

In the Indian context, this gap is more pronounced. Research has largely emphasized prevalence, family burden, or structural aspects of family involvement, with minimal quantitative examination of individuals' subjective perceptions of familial support during rehabilitation. Where family support has been included, findings have often been ambiguous due to variations in measurement and treatment settings.

Consequently, there is a need for systematic quantitative investigation to clarify the role of perceived familial support during active treatment and its association with mental health outcomes. Addressing this gap is essential for informing culturally sensitive, family-inclusive substance use treatment models in India.

Rationale for the Present Study

In light of these gaps, the current study aims to investigate the **correlation between family dynamics and mental health outcomes**—particularly depression, anxiety, and psychological distress—among individuals undergoing treatment for substance use disorders. The research draws on data from 200 participants at Punarjanm Integrated Rehabilitation Center for Addicts (IRCA), Sonbarasa, Gorakhpur. By employing a quantitative, cross-sectional design and standardized psychometric instruments, the study seeks to produce generalizable findings that can guide clinical practice and policy.

Ultimately, the goal is to contribute to the development of culturally relevant, family-based intervention strategies that recognize the interconnected nature of substance use and mental health within the Indian familial context.

AIMS AND OBJECTIVES

The primary aim of this study is to investigate the relationship between family dynamics and mental health outcomes among individuals diagnosed with substance use disorders (SUDs) who are undergoing treatment.

The specific objectives are to:

1. Examine the nature and quality of family interactions, including communication patterns, emotional support, and conflict, as perceived by individuals with SUDs.
2. Assess the prevalence and severity of mental health symptoms—specifically depression, anxiety, and psychological distress—in the study population.
3. Analyze the correlation between different aspects of family dynamics and mental health outcomes among substance abusers.
4. Identify whether higher levels of familial support are associated with better mental health outcomes and if dysfunctional family relationships correspond to greater psychological distress.

Hypotheses: Based on previous research, theoretical frameworks and objectives, the study proposes the following hypotheses:

1. There will be a significant negative correlation between positive family dynamics (e.g., emotional support, open communication) and symptoms of depression, anxiety, and psychological distress among individuals with substance use disorders.
2. Dysfunctional family relationships (e.g., frequent conflict, poor communication, neglect) will be positively correlated with higher levels of depression, anxiety, and psychological distress in substance abusers.
3. Individuals who report higher perceived familial support will demonstrate lower severity of mental health symptoms compared to those who report lower familial support.
4. Family dynamics will significantly predict mental health outcomes in individuals undergoing treatment for substance use disorders, even after controlling for demographic variables such as age and gender.

Methodology

Research Design :

This study employed a quantitative correlational research design to examine the relationship between family dynamics and mental

health outcomes among individuals diagnosed with substance use disorders (SUDs). This design was appropriate for assessing the strength and direction of relationships between variables without manipulating any conditions.

Participants :

The study included 200 individuals undergoing treatment for substance use disorders at the 'Punarjanm' Integrated Rehabilitation Center for Addicts (IRCA) in Sonbarasa, Gorakhpur, UP, India. Participants were selected through convenience sampling based on their availability and consent. Eligibility criteria required them to be 18 years or older, formally diagnosed with a substance use disorder (e.g., alcohol, opioids, or cannabis), actively in treatment.

MEASURES

1. **Demographic Questionnaire:** Participants provided demographic information through a self-constructed questionnaire. Data collected included age, gender, level of education, marital status, type and duration of substance use, and family composition.
2. **Family Dynamics**: Family dynamics were assessed using the **Family Environment Scale** was used. This scale is constructed in Hindi language by Joshi and Vyas (1997) to assess the perception of family environment. Family environment scale contains a total of 79 items concerning ten sub scales, i.e. cohesion, expressiveness, conflict, independence, achievement orientation, intellectual-cultural orientation, active recreational orientation, moral-religious emphasis, organization and control. The reliability (r value for subscales ranged from .58 to .88) and validity (r value for subscale ranged from .28 to 41) of the scale are found significant. Participants were asked to respond on 5-point scale ranging from 0 to 4.

Scoring: Positive items were scored following 4, 3, 2, 1 and 0 order whereas, reverse pattern was followed in scoring of the negative items. The total summated scores for each domain represented the magnitude of family environment for substance users and non-users.

3. **Multidimensional Scale of Perceived Social Support (MSPSS)**: To assess perceived familial support, the study used the Hindi version of the Multidimensional Scale of Perceived Social Support (MSPSS-Hindi), originally developed by Zimet et al. (1988) and adapted for the Indian context by Verma and Singh (2022). The MSPSS-Hindi consists of 12 items across three subscales—Family, Friends, and Significant Others—rated on a 7-point Likert scale. Only the Family subscale (4 items) was used, measuring perceived emotional and instrumental support from family members. Higher scores indicate greater familial support, and the scale demonstrates strong internal consistency (Cronbach's $\alpha = 0.927$).
4. **Mental Health Outcomes:** Mental health outcomes were assessed using two validated instruments widely used in Indian clinical and research settings. Symptoms of depression and anxiety were measured by the 14-item **Hospital Anxiety and Depression Scale (HADS;Zigmond & Snaith, 1983),** which has been adapted and validated in Hindi and other Indian languages **(Avasthi et al., 2005)**. Psychological distress was assessed using the 10-item **Kessler Psychological Distress Scale (K10; Kessler et al., 2002)**, also translated and validated in Hindi as part of the National Mental Health Survey by NIMHANS. The HADS scores each item from 0 to 3, with subscale scores ranging from 0 to 21; scores of 0–7 indicate normal, 8–10 borderline, and 11 or above suggest abnormal symptoms. The K10 scores each item from 1 to 5, with total scores ranging from 10 to 50; scores of 10–19 indicate no distress, 20–24 mild, 25–29 moderate, and 30 or above severe distress. Both instruments demonstrate strong reliability and cultural relevance for assessing mental health among individuals with substance use disorders in India.

PROCEDURE:

After receiving ethical clearance from the institutional review board, participants were approached during their ongoing treatment at the rehabilitation centre and informed about the study purpose, procedures, confidentiality, and voluntary nature of participation. Written informed consent was obtained prior to data collection. Participants were recruited using convenience sampling based on availability and willingness to participate,

yielding a sample of 200 individuals, which was considered adequate for correlational and regression analyses in psychosocial research. Accordingly, parametric analyses were employed, as the sample size was sufficient and preliminary screening indicated acceptable distributional characteristics of the variables. Data were collected using self-administered questionnaires in a quiet and private setting, with assistance provided when required. Participants were informed of their right to withdraw at any stage without affecting their treatment, confidentiality was strictly maintained, and psychological support was available if participation caused any discomfort.

RESULTS

The data obtained from 200 individuals undergoing treatment for substance use disorders were analyzed using descriptive statistics, Pearson's product–moment correlation, and multiple regression analysis. Statistical analyses were conducted to examine the association between family dynamics and mental health outcomes, including depression, anxiety, and psychological distress. Statistical significance was set at $p < .05$.

Description of Family Environment and Mental Health Variables

Table 1 presents the mean scores and standard deviations for family environment dimensions, perceived familial support, and mental health indicators among individuals undergoing treatment for substance use disorders (N = 200).

Mean scores on the Hospital Anxiety and Depression Scale indicated that participants, on average, reported symptoms falling within the borderline to abnormal range for both depression (M = 10.92, SD = 4.18) and anxiety (M = 11.37, SD = 4.06). The mean score on the Kessler Psychological Distress Scale (M = 27.96, SD = 7.84) suggested a moderate level of psychological distress in the sample.

With regard to family environment, comparatively higher mean scores were observed for family conflict (M = 24.71, SD = 6.12) and family control (M = 23.89, SD = 5.77), indicating strained and restrictive interaction patterns within families. In contrast, mean scores for family cohesion (M = 22.48, SD = 5.36) and family organization (M = 21.03, SD = 5.02) reflected moderate levels of emotional bonding and structural stability.

Table-1 : Descriptive Profile of Family Factors and Psychological Wellbeing

Variable	Mean	SD
Family Cohesion	22.48	5.36
Family Expressiveness	19.62	4.89
Family Conflict	24.71	6.12
Family Organization	21.03	5.02
Family Control	23.89	5.74
Perceived Familial Support (MSPSS–Family)	16.48	5.41
Depression (HADS–D)	10.92	4.18
Anxiety (HADS–A)	11.37	4.06
Psychological Distress (K10)	27.96	7.48

N =200

Associations Between Family Dynamics and Mental Health Outcomes:

To explore how family dynamics relate to mental health, correlations were examined between family environment variables and symptoms of depression, anxiety, and psychological distress (Table-2). The findings show a clear pattern in which more positive family characteristics were associated with better mental health outcomes. In particular, family cohesion showed moderate and significant negative relationships with depression ($r = −.46$, $p < .01$), anxiety ($r = −.42$, $p < .01$), and psychological distress ($r = −.48$, $p < .01$). This suggests that individuals who experienced greater emotional closeness and support within their families tended to report fewer psychological symptoms.

Similarly, family expressiveness was found to be negatively related to depression ($r = −.39$), anxiety ($r = −.36$), and psychological distress ($r = −.41$). This pattern indicates that families where members are able to share thoughts and feelings openly tend to provide an emotional climate that protects against distress. Family organization also showed significant, though comparatively weaker, negative associations with all three mental health outcomes, suggesting that a well-structured and predictable family environment may contribute to better emotional well-being.

Table-2: Correlations Between Family Dynamics and Mental Health Outcomes

Family Variables	Depression	Anxiety	Psychological Distress
Family Cohesion	−.46**	−.42**	−.48**
Family Expressiveness	−.39**	−.36**	−.41**
Family Conflict	.51**	.48**	.54**
Family Organization	−.34**	−.31**	−.37**
Family Control	.29**	.33**	.35**
Perceived Familial Support	−.58**	−.55**	−.61**

N = 200, p < .01

In contrast, family conflict demonstrated strong **positive correlations** with depression (r = .51), anxiety (r = .48), and psychological distress (r = .54), indicating that higher levels of interpersonal tension and hostility within the family were associated with poorer mental health. Family control also showed significant positive associations, though of smaller magnitude, suggesting that excessive regulation and rigidity may contribute to emotional difficulties.

Notably, perceived familial support emerged as the strongest protective factor, showing the largest inverse correlations with depression (r = −.58), anxiety (r = −.55), and psychological distress (r = −.61). Overall, the correlation results highlight the central role of family environment in shaping mental health outcomes.

Predictive Role of Family Dynamics on Mental Health Outcomes:

To assess whether family dynamics predicted mental health outcomes beyond basic demographic factors, multiple regression analyses were carried out with age and gender included as control variables. As shown in Table 3, the model predicting depression was statistically significant and accounted for 42% of the variance in depression scores (R^2 = .42, F(5, 194) = 28.21, p < .001). Neither age nor gender made a significant contribution to the model

.**Table 3: Predictive Effects of Family Dynamics on Depression Scores (HADS–D)**

Predictor	B	SE B	β	t
Age	−0.03	0.02	−.08	−1.41
Gender	0.41	0.36	.06	1.14
Family Cohesion	−0.21	0.05	−.29**	−4.20
Family Conflict	0.26	0.06	.32**	4.53
Perceived Familial Support	−0.34	0.06	−.38**	−5.67
R^2 = .42, F(5, 194) = 28.21, p < .001				

Within the family variables, higher levels of family cohesion were linked to lower depression scores (β = −.29, p < .01), suggesting that close and emotionally connected family relationships may help protect against depressive symptoms. In contrast, family conflict was a strong positive predictor of depression (β = .32, p < .01), indicating that frequent tension and disagreements within the family were associated with greater depressive distress. Perceived familial support emerged as the most powerful protective factor (β = −.38, p < .01), emphasising the importance of feeling supported and understood within the family.

Table 4: Predictive Effects of Family Dynamics on Anxiety Scores (HADS–A)

Predictor	B	SE B	β	t
Age	−0.02	0.02	−.06	−1.09
Gender	0.47	0.35	.07	1.34
Family Cohesion	−0.19	0.05	−.27**	−3.86
Family Conflict	0.24	0.06	.30**	4.12
Perceived Familial Support	−0.31	0.06	−.35**	−5.18
R^2 = .39, F(5, 194) = 25.03, p < .001				

As shown in Table 4, the regression model for anxiety was statistically significant and explained 39% of the variance in anxiety scores (R^2 = .39, F(5, 194) = 25.03, p < .001). Age and gender did not make a significant contribution to the model.

Among the family variables, greater family cohesion was associated with lower anxiety levels (β = −.27, p < .01), whereas family conflict was linked to higher anxiety (β = .30, p < .01). Perceived familial support continued to act as a strong protective factor (β = −.35, p < .01), suggesting that supportive and harmonious family environments may help buffer against anxiety.

Table 5: Predictive Effects of Family Dynamics on Psychological Distress (K10)

Predictor	B	SE B	β	t
Age	−0.07	0.04	−.09	−1.63
Gender	0.92	0.71	.06	1.29
Family Cohesion	−0.48	0.11	−.31**	−4.32
Family Conflict	0.62	0.13	.34**	4.87
Perceived Familial Support	−0.71	0.14	−.41**	−5.92
R^2 = .46, F(5, 194) = 33.14, p < .001				

As presented in Table 5, the regression model for psychological distress was statistically significant and explained the largest share of variance among the three outcomes (46%; R^2 = .46, F(5, 194) = 33.14, p < .001). Age and gender did not significantly contribute to the model.

Higher levels of family cohesion were associated with lower psychological distress (β = −.31, p < .01), while family conflict showed a strong positive relationship with distress (β = .34, p < .01). Perceived familial support emerged as the strongest predictor in this model (β = −.41, p < .01), indicating that individuals who felt emotionally and practically supported by their families reported markedly lower levels of overall distress.

Taken together, the findings across all analyses show that family dynamics play a consistent and meaningful role in mental health. Supportive family characteristics particularly cohesion and perceived supportwere linked to lower levels of depression, anxiety, and psychological distress, whereas family conflict repeatedly emerged as a key risk factor. These relationships remained significant even after accounting for age and gender, highlighting the importance of the family environment in psychological well-being, especially during substance abuse treatment.

DISCUSSION

The present study examined the association between family dynamics and mental health outcomes among individuals undergoing treatment for substance use disorders and provides robust evidence that recovery is influenced not only by individual characteristics but also by the relational contexts in which individuals live and receive care. The findings clearly demonstrate that the quality of the family environment is closely linked to psychological well-being during the treatment phase, underscoring the importance of viewing substance use recovery as a socially embedded process rather than an exclusively individual endeavour.

Drawing on family systems theory, which conceptualizes individual psychological functioning as deeply interconnected with family interaction patterns (Bowen, 1978; Minuchin, 1985), the study found that positive family characteristics—particularly family cohesion, emotional expressiveness, and perceived familial support—were associated with lower levels of depression, anxiety, and psychological distress. Families characterized by warmth, emotional openness, and mutual support may provide a sense of safety and acceptance that is especially critical during treatment, when individuals often experience emotional vulnerability, stigma, and uncertainty about recovery. Such supportive environments may foster adaptive coping strategies, reduce feelings of isolation, and enhance engagement with therapeutic interventions. These findings are consistent with earlier empirical work and recent systematic reviews indicating that family involvement and perceived support predict better psychological adjustment and treatment engagement among individuals with substance use disorders (Moos & Moos, 2006; Hogue et al., 2021; Esteban et al., 2023).

In contrast, family conflict emerged as the strongest correlate of adverse mental health outcomes. Persistent interpersonal tension, criticism, or unresolved disputes within the family may operate as chronic stressors, contributing to emotional exhaustion, heightened stress reactivity, and increased vulnerability to anxiety and depressive symptoms. During the treatment phase, individuals may be particularly sensitive to negative family interactions, as they are simultaneously managing withdrawal symptoms, cravings, and identity-related changes associated with recovery. Similarly, excessive family control was associated with greater psychological distress, suggesting that overly restrictive or authoritarian family practices may undermine autonomy, self-efficacy, and emotional regulation. These findings align with previous research demonstrating that hostile or rigid family environments are linked to emotional dysregulation, poorer treatment adherence, and elevated risk of relapse (Velleman et al., 2005; Kumpfer et al., 2010).

A particularly noteworthy finding of the present study is the strong protective role of perceived familial support. Even after controlling for age and gender, perceived support remained the most robust predictor of mental health outcomes. This highlights the importance of individuals' subjective experiences of being understood, valued, and supported, rather than the mere presence or involvement of family members. Contemporary research increasingly suggests that perceived support is more closely associated with psychological well-being than structural indicators of social ties (Thoits, 2011; Cai et al., 2022). In the Indian socio-cultural context, where family involvement in care is normative and often extensive, this distinction becomes especially important. Family presence does not necessarily translate into emotional safety; rather, the quality of interactions and the individual's perception of support appear to play a decisive role in shaping emotional stability and motivation during treatment (Murthy, 2017; Rao & Chandrashekar, 2018; Sharma et al., 2024).In the Indian context, where families often remain actively involved in decision-making, caregiving, and treatment adherence, family dynamics may exert a stronger influence on psychological well-being compared to more individualistic settings, making family-based approaches particularly relevant for substance use treatment.

While family dynamics accounted for a substantial proportion of variance in mental health outcomes, it is essential to situate these findings within a broader clinical and social framework. Mental health outcomes among individuals with substance use disorders are influenced by multiple interacting parameters, including the duration and severity of substance use, type of substance consumed, co-occurring psychiatric conditions,

treatment stage, and socioeconomic stressors. Although these factors were not directly examined in the present study, they may interact with family dynamics in complex ways. For instance, supportive family environments may buffer the psychological impact of severe substance dependence, whereas high family conflict may exacerbate distress among individuals with comorbid mental health conditions. Future research employing longitudinal and multivariate designs would be well positioned to examine these interactive and developmental processes over the course of recovery.

Beyond its theoretical contributions, the study has important clinical and practical implications. The findings suggest that routine assessment of family dynamics—particularly family conflict and perceived support—should be integrated into substance use treatment planning. Identifying individuals exposed to high family conflict or low perceived support may help clinicians tailor interventions and provide additional psychological support. At the intervention level, incorporating structured family-based components, such as family psychoeducation, communication skills training, and conflict-resolution strategies, may enhance treatment effectiveness by addressing relational patterns that contribute to psychological distress. Such approaches are especially relevant in collectivist settings such as India, where families remain central to caregiving, decision-making, and recovery processes (Kumpfer& Alvarado, 2003; Orford, 2013).

Overall, the present findings reinforce the need to move beyond an exclusively individual-centred approach to substance use treatment. By acknowledging and addressing the relational environments in which recovery unfolds, treatment programmes may better support psychological well-being and promote sustained recovery. Focusing on family dynamics not only enhances understanding of mental health outcomes during treatment but also offers actionable pathways for improving care within culturally responsive and contextually grounded frameworks.

CONCLUSION

The present study demonstrates that family dynamics play a significant and consistent role in shaping mental health outcomes among individuals undergoing treatment for substance use disorders. Supportive family characteristics—particularly family cohesion, emotional expressiveness, and perceived familial support—were associated with lower levels of depression, anxiety, and psychological distress, whereas family conflict and excessive control emerged as key risk factors. Importantly, perceived familial support remained the strongest protective predictor across all analyses, even after controlling for age and gender.

These findings reinforce family systems theory (Bowen, 1978) and stress-buffering models of social support (Cohen & Wills, 1985), highlighting that recovery from substance use disorders is embedded within relational and social contexts rather than being solely an individual process. In the Indian socio-cultural setting, where family involvement in care is extensive, the subjective experience of being emotionally and practically supported appears especially critical for psychological well-being during treatment.

Overall, the study underscores the need to move beyond exclusively individual-centred treatment models and to integrate structured, culturally responsive family-based approaches within substance abuse rehabilitation programmes. Addressing family conflict and strengthening supportive family interactions may substantially improve mental health outcomes and support sustained recovery.

Limitations and Implications

Despite its contributions, the present study has several limitations that should be considered when interpreting the findings. First, the cross-sectional design restricts causal inference; while family dynamics were strongly associated with mental health outcomes, the directionality of these relationships cannot be established. Longitudinal studies are needed to determine whether changes in family cohesion, conflict, or perceived support lead to subsequent improvements in depression, anxiety, and psychological distress during recovery.

Second, the study relied exclusively on self-report measures, which may be influenced by social desirability bias or participants' current emotional states. In particular, perceptions of family support and conflict may not fully reflect actual family interactions. Future research should incorporate multi-informant data, including reports from family

members and clinician-rated assessments, to provide a more objective evaluation of family functioning.

Third, the sample was drawn from a single rehabilitation centre using convenience sampling, which limits generalizability. Family dynamics and treatment experiences may vary across regions, treatment models, and cultural subgroups within India. Replication across multiple centres, including outpatient and community-based settings, would enhance external validity.

Finally, although age and gender were controlled for, other clinically relevant variables—such as duration and severity of substance use, type of substance, stage of treatment, psychiatric comorbidity, and socioeconomic stressorswere not included in the regression models. These factors may interact with family dynamics and should be examined in future multivariate and longitudinal designs.

Despite these limitations, the study has important clinical and practical implications. The strong predictive role of family conflict and perceived familial support suggests that routine assessment of family environment should be integrated into substance use treatment. Screening for high family conflict and low perceived support can help clinicians identify individuals at greater psychological risk and tailor interventions accordingly.

At the intervention level, the findings support the inclusion of structured family-based components, such as family psychoeducation, communication skills training, and conflict-resolution strategieswithin rehabilitation programmes. In the Indian context, where family involvement is extensive, guiding families toward supportive rather than controlling roles may substantially improve psychological outcomes.

From a policy perspective, the results underscore the need for national treatment guidelines to incorporate family-inclusive models of care. Training mental health professionals in culturally responsive family-based interventions may strengthen treatment effectiveness and promote sustained recovery.

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