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Psychosocial Aspects of Substance Dependency: Examining the Contribution of Social and Environmental Influences to the Formation and Sustenance of Substance Use Disorders

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Abstract

The development and maintenance of a substance use disorder (SUD) is a function of individual vulnerabilities and larger social contexts. The present systematic integrative review looked into psychosocial, social and environmental factors affecting the development and maintenance of SUDs. Empirical studies published between 2021 and 2026 that were identified via PubMed/MEDLINE, Europe PMC and DOAJ. There were 710 records identified, 25 studies were eligible and appraised using the Mixed Methods Appraisal Tool (MMAT). The results of thematic synthesis showed six themes: family dysfunction and early-life adversity; peer networks and social reinforcement; socioeconomic and environmental disadvantage; psychological distress and emotion regulation; social support, stigma and recovery; and interaction between psychosocial and environmental levels. Peer influence and disadvantaged environments played an important role in the formation of SUDs, whereas housing instability, social stigma, and barriers to social support and treatment were important factors for persistence and poorer outcomes of recovery. Family support, engagement and recovery were promoted by recovery networks and supportive communities, on the other hand. The results confirm a multi-level perspective of substance dependence, which calls for a multi-layered psychological, relational and structural response to substance dependency.

Keywords: substance use disorder; psychosocial factors; social determinants; addiction; relapse; recovery

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1. Introduction

The term "psychoactive substance" is not sufficient to explain a person's dependency on the substances. A contemporary view of addiction research transforms the concept of SUD into a dynamic process that is heterogeneous and involves an interaction over time between biological vulnerability, psychological functioning, relationships and social context [1]. This is important as the situation when the drug is first used, and when it becomes a problem, can be different from the situation in which it becomes a dependency. Parental support, peer influence, neighbourhood instability, employment, and housing and criminal-justice involvement are all influences that occur at various points along life-course trajectories of SUDs, as revealed by recent life-course evidence [2].

These are influenced by psychological and interpersonal processes. Meta-analytical evidence shows that there are significant emotion-regulation problems among people with SUD [3] and that evidence from long-term studies, such as the study by Watts et al. (2024) [4] indicate that peer behaviour has a significant impact on their substance use. Social recovery is embedded in recovery. The re-construction of trust, identity and participation can occur in supportive and non-stigmatising communities [5] while barriers to engagement in addiction care may be due to stigma among healthcare professionals [6].

Despite this evidence, the literature continues to be quite disjointed with regards to childhood adversity, family influences, peer influences, psychological coping, socio-economic factors, stigma and recovery. However, reviews often focus on a single determinant or a single stage of the trajectory of addiction [2], [8], [9] and do not consider the multi-level interaction between these determinants in formation and sustaining the addiction. Therefore, the purpose of this review is to systematically investigate the role of psychosocial, social and environmental factors in the development and maintenance of SUDs; and the interactions that occur between each of these factors in the individual, interpersonal and broader environmental factors. To answer the questions, the following three research questions are posed:

RQ1: What are the psychosocial, social and environmental factors which drive the development and course of SUD?

RQ2: What non-clinical, such as psychosocial, social and environmental factors are associated with treatment engagement/recovery, persistence and relapse?

RQ3: What is the interaction among individual, interpersonal and wider environmental factors in the process of SUDs formation and maintenance?

2. Conceptual and Theoretical Background

The main theoretic principles of this review are the biopsychosocial principles. Current models of addiction have shifted from simple biological and behavioural explanations to understanding the relationships between neurobiological processes, cognition, affect, social and developmental factors in understanding addiction [1].

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A socio-ecological perspective adds to this by situating substance-related behaviour in the context of multiple individuals, family, peer, community and structural contexts.

Childhood adversity could contribute to vulnerability during the formation process, by way of chronic stress, family relationship issues and challenges with emotional regulation. Substance use may be more appealing as an avoidant coping strategy or short-term problem-solving tool when there are trauma and emotion regulation issues [3], [8]. This could, in turn, lead to a normalisation of consumption and influence perceived behavioural norms, especially going through adolescence [4]. Limited access to protective environments may be further exacerbated by socio-economic disadvantage, by neighbourhood instability and by exposure to violence [2].

There is a different configuration with reliance on the supplies of dependency. After problematic use has occurred, craving, learned reinforcement and emotional distress combined with housing insecurity, unemployment, stigma, and limited social support and barriers to treatment. Social relationships can help to sustain substance-using identities, but can also help to establish recovery capital through supportive family, peers and community connections [5,7]. Stigma is especially relevant because it can be internal, interpersonal, institutional and impact one's self-concept, as well as their access to services [6, 9].

As per this, formation and sustenance must not be considered as two linear processes. Instead, risk and protection can build up over psychological and social dimensions over the course of a substance dependence.

3. Methodology

A systematic integrative literature review, using thematic narrative synthesis, was conducted. Reporting followed the guidelines suggested in the PRISMA 2020 statement and in its explanation and elaboration guidance [10] and [11] whilst search reporting was guided by PRISMA-S [12].

PubMed/MEDLINE, Europe PMC and DOAJ were looking for English language, peer-reviewed studies from 2021-2026. Search terms grouped together three concept groups of terms: terms related to SUD/addiction, psychosocial/social and environmental factors, and formation, progression, persistence, relapse, treatment or recovery. The detailed search strategy, search terms and eligibility criteria are explained in Appendix A.

Eligible papers were original empirical papers within the human field which directly examined at least one psychosocial, social or environmental factor impacting problematic substance use, SUD formation, persistence, relapse, treatment engagement or recovery. All quantitative, qualitative and mixed method studies were included. Studies that did not include any psychosocial evidence and purely behavioural or genetic studies, pharmacological-only studies without any psychosocial evidence, animal studies, and prevalence-only studies were excluded.

A total of 692 database records were identified as well as 18 additional records, for a total of 710 records. Of the 486 titles/abstracts screened 389 were excluded after duplicates were removed. A total of 72 of the 97 articles were excluded due to one or more of the eligibility criteria, for a total of 13%.

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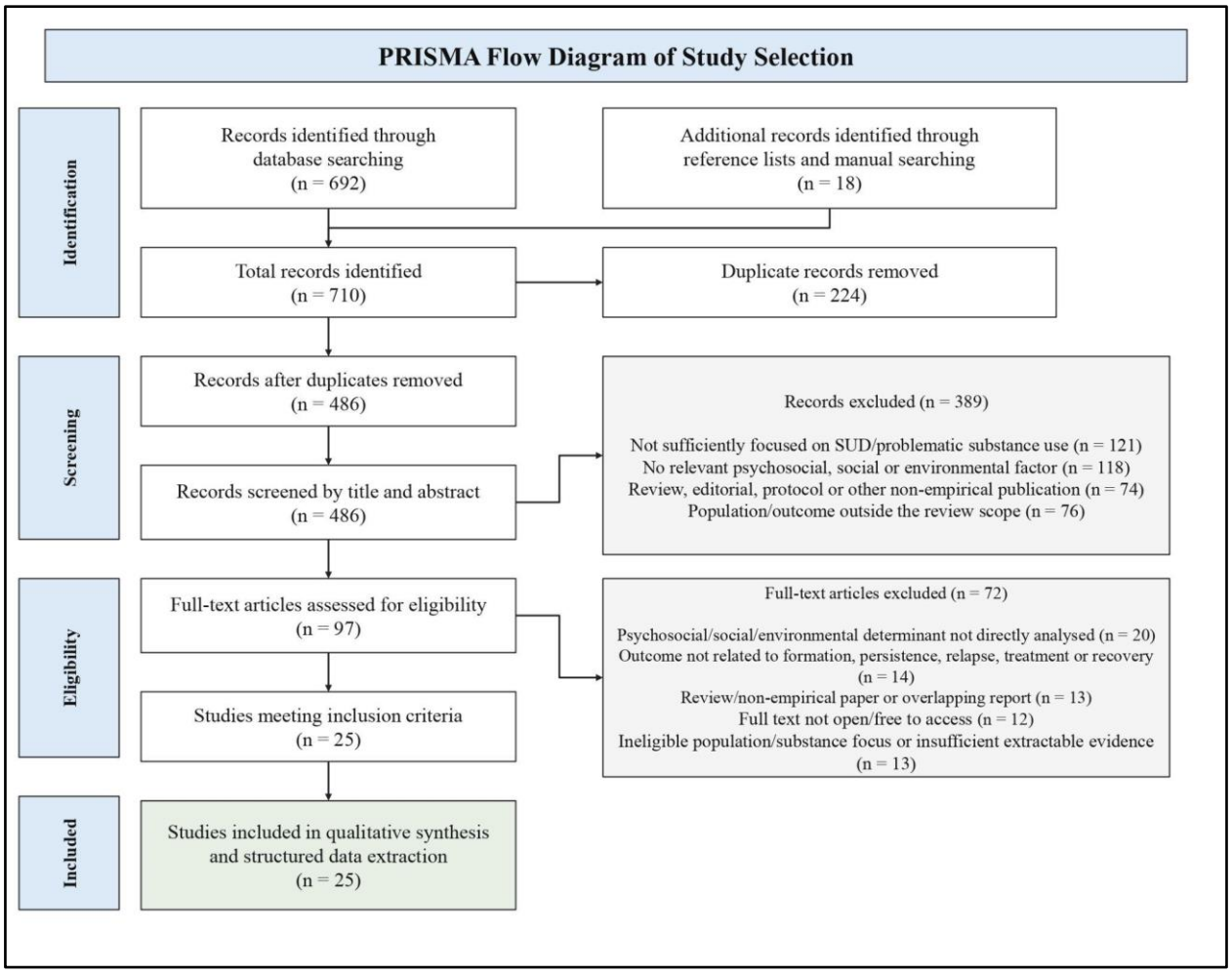

Figure 1. PRISMA 2020 Flow Diagram of Study Identification and Selection

Data were retrieved by country, methodology, sample, substance-related outcome, psychosocial/environmental factor and stage of dependency and main findings. Complete data-extraction matrix for the 25 studies included is presented in Appendix C. Methodological quality was evaluated by the MMAT, rather than being translated into a numerical score for quality of the study [13]. The populations, exposures, and outcomes were very heterogeneous and prevented the use of meta-analysis. The data was then coded for analysis and the results compared thematically. The full study level MMAT appraisal is given in Appendix B.

4. Results

4.1 Characteristics of Included Studies

The 25 studies are from 2021 to 2026. Twenty-one used Quantitative (non-randomised) designs and four used qualitative designs. 17 studies were from the USA, 4 from India and 1 each from Norway, Canada, Tanzania and China. Nineteen mainly studied SUD formation, thirteen studied sustenance, treatment/recovery and three provided evidences on both phases.

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Table 1. Characteristics of the Included Evidence

Characteristic	Category	n
Design	Quantitative non-randomised	21
	Qualitative	4
Primary stage	Formation	9
	Sustenance/treatment/recovery	13
	Both	3
Country	United States	17
	India	4
	Norway, Canada, Tanzania and China	4
Total studies		**25**

4.2 Family Dysfunction and Early-Life Adversity

The theme of early life adversity was most clearly identifiable in the form of adverse events that occurred during childhood years. Research in India and the USA linked ACEs, family dysfunction and childhood maltreatment to increased vulnerability to substance-use and increased risk of course of substance-use [14, 17, 25, 33]. Adolescent ACEs have been associated with the development of alcohol and illicit drug use disorders in later life in Norway [24]. Maternal SUD also interacted with maltreatment in the prediction of substance-related issues in the offspring in adulthood [32].

This finding indicates that the concept of adversity is not one-time, stand-alone adverse experience. It can produce a developmental context where chronic stress exists, modelling of problematic behaviour occurs, attachment is disrupted and subsequent emotional insecurity, which puts a child at risk of future problematic use.

4.3 Peer Networks and Social Reinforcement

Initiation/Escalation was significantly influenced by peer and community relationships. Family and community substance use were linked to an increased risk for adolescent substance use in India [15] and neighbourhood drug exposure, delinquent peers and decreased parental supervision were linked to an increased likelihood of adolescent substance use in the United States [16]. Longitudinal analysis also revealed a part of the relationship between ACE exposure and subsequent use accounted for by peer substance use and unstructured socialising [21]. Other pathways that are influenced by parental monitoring and neighbourhood cohesion are related to antisocial peer relationships [23].

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Peer influence as a mechanism of translating wider social disadvantage into everyday norms, opportunities and reinforcement favouring substance use, therefore, seems to be one mechanism in which this happens.

4.4 Socioeconomic and Environmental Disadvantage

Sustenance and treatment were especially characterized by issues of structural disadvantage. Mortality was significantly lower for those who remained in the programme, but treatment retention was low among people who are homeless and have OUD [18]. Longer term functioning after AUD treatment was related to community and individual socioeconomic status factors as well [19].

Treatment trajectories for OUD were impacted by housing [26] and income [26] as well as education and criminal-justice involvement [26]. Qualitative evidence indicated that service availability, policy changes and the local drug environment can present as barriers and facilitators to engagement [30]. A similar pattern was found in national US evidence, which included nearly seven million treatment episodes, and showed a link between unemployment and treatment outcomes, as well as housing instability and outcomes [36].

4.5 Psychological Distress, Emotion Regulation and Maladaptive Coping

The psychological processes linking social adversity to continued problematic use. Emotion dysregulation and affective impulsivity were pathways whereby ACE was related to problematic cannabis use among Canadian university cannabis users [27]. Increased social support buffered some associations between childhood trauma and problematic trajectories of alcohol and drug use, but childhood trauma was still associated with problematic alcohol and drug-use trajectories overall [25].

Another Chinese rehabilitation study also found that there were interrelationships between social support, meaning in life, addiction related memory, and addiction related craving [38]. This implies that the psychological coping processes must be considered not exclusively as individual lacks but are manifested and function in interpersonal contexts.

4.6 Social Support, Stigma, Treatment Engagement and Recovery

Social support was always found to be a recovery resource. Increased support led to more improvements in treatment among SUD and PTSD co-occurring individuals [22]. Young adults involved in OUD treatment were more likely to be involved in family activities that promoted participation in OUD treatment and recovery peers and sober-community contacts were important sources of recovery specific support [31, 34].

On the other hand, alcohol dependence was associated with family stigma that made it difficult to reintegrate the person into their family and alcohol-using family members were reluctant to seek care for their relatives' alcohol use, which led to family, community and institutional stigma, in Tanzania [35]. However, the association between stigma and treatment outcomes was not consistent across all treatment outcomes where Campbell et al. (2026) [37] reported high stigma and no overall associations between perceived stigma and short-term uptake of buprenorphine, highlighting the need for context and type of stigma.

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4.7 Interaction Across Psychosocial and Environmental Levels

The last theme combined the other themes. Family problems may impact one's coping ability and peer relationships, neighbourhood problems may influence the parental monitoring of their child, and treatment engagement may also be influenced by housing, policy, interpersonal relationships, and health care organizations [23],[30]. In particular, women's accounts showed the intergenerational nature of substance use and the role it might play in initiating and recovering from substance use, through intimate relationships, peer pressure and family support [28].

Table 2. Thematic Synthesis of the 25 Included Studies

Theme	Principal contribution	Representative studies
Family dysfunction and early adversity	Trauma, developmental vulnerability and family modelling	[14], [17], [24], [32], [33]
Peer networks and social reinforcement	Norms, opportunities and peer-mediated escalation	[15], [16], [21], [23]
Socioeconomic/environmental disadvantage	Housing, employment, neighbourhood and service barriers	[18], [19], [26], [30], [36]
Psychological distress and emotion regulation	Coping, impulsivity, craving and self-regulation	[25], [27], [38]
Support, stigma and recovery	Treatment engagement, reintegration and recovery capital	[22], [29], [31], [34], [35], [37]
Cross-level interaction	Reciprocal individual, relational and structural pathways	[23], [28], [30], [36]

5. Discussion

The findings address RQ1 by showing that early-life stressors, patterns of substance use in the family and in peers and in neighbourhood disadvantage are particularly associated with the formation of SUDs. It is consistent with other evidence on the life course that social determinants affect initiation and escalation [2] and with meta-analytic evidence on peer effects in adolescence [4]. Psychological mechanisms also seem to play a role where emotion regulation problems have been shown to enhance the risk for substance use as a short-term coping strategy for distress [3, 8].

The environment surrounding continued use was a strong determinant of the maintenance of dependency and progression towards recovery for RQ2. Practical obstacles to treatment and low social support, stigma, and

housing instability run the risk of negatively affecting treatment engagement. Family engagement, a recovery peer network and supportive communities fostered recovery capital, however. This is consistent with the evidence that social communities that are non-stigmatising and safe support recovery [5] and professional stigma can have a negative impact on addiction care [6].

A socio-ecological understanding is the best way to explain RQ3. Adverse experiences can both affect psychological coping, and be a part of it; coping takes place in networks of family and peers; and these networks exist in neighbourhoods, labour markets, housing systems and treatment institutions. Therefore, protective factors can build up at various levels and so can risks. The environment of stable housing, supportive relationships and services that are easily available can change outcomes for people who have significant developmental hardships.

Thus, the results validate the multidimensional biopsychosocial models of addiction, instead of the linear model of addiction [1]. A trauma-informed, family strengthening, peer-focused prevention and consideration of disadvantaged community environments are all needed for a comprehensive prevention strategy. Treatment should also evaluate housing, employment, family relationships, and stigma and social support as well as clinical symptoms. Recovery should focus on providing adequate social engagement and support networks rather than defining recovery as a person's abstinence from drugs and alcohol.

6. Limitations, Future Research and Conclusion

The evidence base was not homogeneous in terms of population, substance type and outcome, allowing for no statistical pooling of the data. The majority of studies were observational, some were cross-sectional, and the majority of studies were self-reported, which posed the risk of recall bias and restricted the ability to make causal inferences. The majority of studies are from the U.S. context further reducing the global transferability. Some study designs, such as longitudinal and cross-national designs, which are able to clarify interactions between psychological, relational and structural determinants and which allow for good differentiation of formation and relapse or recovery processes, should be applied in future research.

The overall picture of substance dependency suggests that conditions in the social and environmental domain influence one another and contribute to the development and maintenance of substance dependency. Individual behaviour change, therefore, should not be the only focus of effective prevention and treatment, as emotional coping, family and peer relationships, socioeconomic disadvantage, stigma, and treatment and recovery organisation must all be tackled.

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International Journal of Advanced Multidisciplinary Research and Innovation
E-ISSN: 3107-6157 editor@ijamri.com
Volume 2, Issue 5, September-October 2026

Appendix A. Search Strategy and Eligibility Criteria

Table A1. Search Strategy

Item	Details
Databases	PubMed/MEDLINE, Europe PMC, DOAJ
Supplementary sources	Publisher websites, institutional repositories and reference-list searching
Publication period	2021–2026
Language	English
Access	Open access or legally free full text
Study type	Original peer-reviewed empirical studies
Population	Human participants
Main focus	Psychosocial, social and environmental influences on substance use disorders

Search String

("substance use disorder" OR "substance dependence" OR addiction OR "alcohol use disorder" OR "opioid use disorder" OR "problematic substance use")
AND
(psychosocial OR social OR environmental OR trauma OR "adverse childhood experiences" OR family OR peer OR "social support" OR stigma OR socioeconomic OR housing OR neighbourhood OR stress)
AND
(onset OR development OR progression OR persistence OR relapse OR recovery OR "treatment retention" OR "treatment engagement")

Table A2. Eligibility Criteria

Inclusion	Exclusion
Published 2021–2026	Published before 2021
English language	Non-English
Open/free full text	Paywalled or abstract-only
Original empirical research	Reviews, meta-analyses, editorials, protocols

International Journal of Advanced Multidisciplinary Research and Innovation
E-ISSN: 3107-6157 editor@ijamri.com
Volume 2, Issue 5, September-October 2026

Inclusion	Exclusion
Human participants	Animal/laboratory-only studies
Examines psychosocial/social/environmental factors	Purely biological/genetic focus
Relevant to SUD formation, persistence, relapse, treatment or recovery	Prevalence-only or unrelated outcomes
Quantitative, qualitative or mixed-method studies	Behavioural addictions without substance use

Appendix B. Mixed Methods Appraisal Tool (MMAT) Quality Assessment of Included Studies

The methodological quality of 25 studies included was evaluated with the Mixed Methods Appraisal Tool (MMAT) 2018. The two screening questions and five criteria were applied to each study in turn, according to the design of each study. The responses were scored as Yes (Y), No (N), or can't tell (CT). No overall numerical quality score was calculated as per MMAT guidance.

Key: Y = Yes; N = No; CT = Can't Tell.

Screening criteria:

S1: Are there clear research questions?

S2: Do the collected data allow the research questions to be addressed?

Table B1. MMAT Appraisal of Quantitative Non-Randomised Studies

No.	Study	S1	S2	Q1	Q2	Q3	Q4	Q5
1	Fernandes et al. (2021)	Y	Y	CT	Y	Y	Y	Y
2	Srivastava et al. (2021)	Y	Y	Y	Y	Y	Y	Y
3	Sigal et al. (2021)	Y	Y	CT	Y	Y	CT	Y
4	Davis et al. (2021)	Y	Y	CT	Y	CT	Y	Y
5	Fine et al. (2021)	Y	Y	CT	Y	Y	Y	Y
6	Swan et al. (2021)	Y	Y	CT	Y	Y	Y	Y
7	Zemore et al. (2021)	Y	Y	CT	Y	Y	Y	Y
8	Stritzel (2022)	Y	Y	Y	Y	CT	Y	Y
9	Jarnecke et al. (2022)	Y	Y	CT	Y	Y	Y	Y
10	Booth and Shaw (2023)	Y	Y	N	Y	CT	Y	Y
11	Broekhof et al. (2023)	Y	Y	Y	Y	Y	Y	Y

International Journal of Advanced Multidisciplinary Research and Innovation
E-ISSN: 3107-6157 editor@ijamri.com
Volume 2, Issue 5, September-October 2026

12	Rogers et al. (2023)	Y	Y	CT	Y	CT	Y	Y
13	Cook et al. (2023)	Y	Y	CT	Y	Y	Y	Y
14	Vieira et al. (2024)	Y	Y	N	Y	Y	CT	Y
16	Rathee et al. (2024)	Y	Y	N	Y	Y	N	Y
19	Ross et al. (2025)	Y	Y	CT	Y	Y	Y	Y
20	Chaudhary et al. (2025)	Y	Y	N	Y	Y	Y	Y
21	Patterson et al. (2025)	Y	Y	N	Y	Y	Y	Y
23	Chavez et al. (2025)	Y	Y	Y	CT	Y	Y	Y
24	Campbell et al. (2026)	Y	Y	N	CT	Y	Y	Y
25	Chen, Yao and Xiong (2026)	Y	Y	N	Y	Y	N	Y

Quantitative non-randomised MMAT criteria

- **Q1:** Are the participants representative of the target population?
- **Q2:** Are measurements appropriate regarding both outcome and exposure/intervention?
- **Q3:** Are there complete outcome data?
- **Q4:** Are confounders accounted for in the design and analysis?
- **Q5:** During the study period, was the exposure/intervention administered or assessed as intended?

Table B2. MMAT Appraisal of Qualitative Studies

No.	Study	S1	S2	Q1	Q2	Q3	Q4	Q5
15	Jones et al. (2024)	Y	Y	Y	Y	Y	Y	Y
17	Patel et al. (2024)	Y	Y	Y	Y	Y	Y	Y
18	Porter et al. (2024)	Y	Y	Y	Y	Y	Y	Y
22	Admase et al. (2025)	Y	Y	Y	Y	Y	Y	CT

Qualitative MMAT criteria

- **Q1:** Is the qualitative approach appropriate to answer the research question?
- **Q2:** Are the qualitative data-collection methods adequate to address the research question?
- **Q3:** Are the findings adequately derived from the data?
- **Q4:** Is the interpretation of results sufficiently substantiated by the data?
- **Q5:** Is there coherence between qualitative data sources, collection, analysis and interpretation?

International Journal of Advanced Multidisciplinary Research and Innovation
E-ISSN: 3107-6157 editor@ijamri.com
Volume 2, Issue 5, September-October 2026

Note: Twenty-five of the studies included in this review responded to the two initial questions on the MMAT. The methodological limitations identified at the criterion level were taken into account in the interpretation of the review findings, but not calculated in a numerical quality score.

Appendix C. Data Extraction Matrix for Included Studies

25 studies were considered and the following matrix summarizes the characteristics and findings of those studies. Data were retrieved based on the study setting, methodological design, sample, substance-related outcome, psychosocial/social/environmental factors, dependency stage and principal findings/thematic classification.

Table C1. Data Extraction Matrix of Included Studies

ID	Study	Country	Design and Sample	Substance / Outcome	Main Psychosocial, Social or Environmental Factors	Stage	Key Extracted Finding	Theme
S1	Fernandes et al. (2021)	India	Multisite cross-sectional cVEDA cohort; **n = 9,010**	Substance misuse/risk	Adverse childhood experiences (ACEs), family adversity, violence and household dysfunction	Formation	Greater exposure to ACEs was associated with increased vulnerability to substance misuse among young people.	T1, T6
S2	Srivastava et al. (2021)	India	Cross-sectional population survey; **n = 5,969 adolescent boys**	Adolescent substance use	Family substance use, community substance-use environment and household/social characteristics	Formation	Substance use within the family substantially increased adolescent substance-use risk; high community use also elevated risk.	T1, T2, T3

International Journal of Advanced Multidisciplinary Research and Innovation
E-ISSN: 3107-6157 editor@ijamri.com
Volume 2, Issue 5, September-October 2026

ID	Study	Country	Design and Sample	Substance / Outcome	Main Psychosocial, Social or Environmental Factors	Stage	Key Extracted Finding	Theme
S3	Sigal et al. (2021)	USA	Cross-sectional survey/path analysis; **n = 797 adolescents**	Adolescent substance use	Parental monitoring, peer delinquency, victimisation, neighbourhood crime and drug exposure	Formation	Strong parental monitoring was protective, whereas peer delinquency and adverse neighbourhood exposure increased substance-use risk.	T2, T3
S4	Davis et al. (2021)	USA	Longitudinal cohort; **n = 2,880**	Substance-use trajectories	ACEs and cumulative childhood adversity	Both	Exposure to childhood adversity increased the likelihood of remaining in higher-risk substance-use trajectories over time.	T1, T6
S5	Fine et al. (2021)	USA	Retrospective treatment cohort; **n = 1,467**	Opioid use disorder (OUD), treatment retention	Homelessness, housing instability and service engagement	Sustenance / Recovery	Unstable housing was associated with substantial treatment attrition; continued programme engagement was associated with improved outcomes.	T3, T5
S6	Swan et al. (2021)	USA	Longitudinal secondary analysis; **n = 664**	Alcohol use disorder (AUD) recovery	Income, education and neighbourhood/community socioeconomic conditions	Sustenance / Recovery	Socioeconomic disadvantage was associated with poorer longer-term functioning following AUD treatment.	T3

International Journal of Advanced Multidisciplinary Research and Innovation
E-ISSN: 3107-6157 editor@ijamri.com
Volume 2, Issue 5, September-October 2026

ID	Study	Country	Design and Sample	Substance / Outcome	Main Psychosocial, Social or Environmental Factors	Stage	Key Extracted Finding	Theme
S7	Zemore et al. (2021)	USA	Prospective observational outpatient study; **n = 156**	SUD treatment completion	Logistical barriers, social concerns, perceived treatment value and substance-related concerns	Sustenance	Treatment retention was influenced by practical, interpersonal and motivational barriers rather than clinical factors alone.	T5, T6
S8	Stritzel (2022)	USA	Longitudinal multilevel study; **n = 1,912**	Adolescent substance use	ACEs, peer use, unstructured socialising and community collective efficacy	Formation	Peer behaviours and unstructured social interaction explained part of the relationship between ACEs and subsequent substance use.	T1, T2, T6
S9	Jarnecke et al. (2022)	USA	Longitudinal treatment analysis; **n = 81**	Co-occurring SUD and PTSD	Social support	Sustenance / Recovery	Greater social support strengthened reductions in substance use and trauma-related symptoms during treatment.	T5
S10	Booth and Shaw (2023)	USA	Five-wave longitudinal study; **n = 228**	Adolescent substance use	Neighbourhood disadvantage, social cohesion, parental monitoring and antisocial peers	Formation	Neighbourhood disadvantage influenced substance use indirectly through family supervision and peer relationships.	T2, T3, T6

International Journal of Advanced Multidisciplinary Research and Innovation
E-ISSN: 3107-6157 editor@ijamri.com
Volume 2, Issue 5, September-October 2026

ID	Study	Country	Design and Sample	Substance / Outcome	Main Psychosocial, Social or Environmental Factors	Stage	Key Extracted Finding	Theme
S11	Broekhof et al. (2023)	Norway	Prospective population cohort; **n = 8,199**	Later diagnosed AUD/illicit-drug use disorder	ACEs and childhood adversity	Formation	Childhood adversity prospectively predicted later diagnosed substance use disorders over long-term follow-up.	T1
S12	Rogers et al. (2023)	USA	Longitudinal growth-curve study; **n = 1,404**	Alcohol/drug-use trajectories	Childhood adversity and social support	Both	ACEs predicted more problematic substance-use trajectories, while stronger social support attenuated some adverse effects.	T1, T5, T6
S13	Cook et al. (2023)	USA	Secondary clinical analysis; **n = 114**	OUD treatment initiation and use trajectory	Housing, income, education, criminal-justice involvement and healthcare history	Sustenance / Recovery	Social determinants influenced initiation of medication treatment and subsequent substance-use patterns.	T3, T5
S14	Vieira et al. (2024)	Canada	Cross-sectional moderated-mediation study; **n = 586 cannabis users**	Problematic cannabis use	ACEs, emotion dysregulation and affective impulsivity	Formation / Maintenance	Emotion dysregulation partly explained the association between childhood adversity and problematic cannabis use.	T1, T4

International Journal of Advanced Multidisciplinary Research and Innovation
E-ISSN: 3107-6157 editor@ijamri.com
Volume 2, Issue 5, September-October 2026

ID	Study	Country	Design and Sample	Substance / Outcome	Main Psychosocial, Social or Environmental Factors	Stage	Key Extracted Finding	Theme
S15	Jones et al. (2024)	USA	Qualitative interviews; **n = 42**	OUD/SUD experiences among women	Family substance use, intimate relationships, peer pressure, family strain and support	Both	Intergenerational substance use and relationship contexts influenced initiation, persistence and recovery experiences.	T1, T2, T5, T6
S16	Rathee et al. (2024)	India	Cross-sectional study; **50 patient-family pairs**	Alcohol dependence and family reintegration	Affiliate stigma, family integration and social support	Recovery	Greater stigma was associated with poorer family integration, whereas social support facilitated reintegration.	T5
S17	Patel et al. (2024)	USA	Qualitative interviews; **n = 28**	Injection-drug use and SUD treatment engagement	Housing, service availability, policies, family/social relationships and drug environment	Sustenance / Recovery	Treatment engagement was shaped by interacting structural, service-level and interpersonal barriers and facilitators.	T3, T5, T6
S18	Porter et al. (2024)	USA	Qualitative interviews; **n = 25 young adults**	OUD treatment and recovery	Family and significant-other involvement	Recovery	Family support encouraged treatment participation, and many participants desired greater family involvement during recovery.	T5

International Journal of Advanced Multidisciplinary Research and Innovation
E-ISSN: 3107-6157 editor@ijamri.com
Volume 2, Issue 5, September-October 2026

ID	Study	Country	Design and Sample	Substance / Outcome	Main Psychosocial, Social or Environmental Factors	Stage	Key Extracted Finding	Theme
S19	Ross et al. (2025)	USA	Longitudinal cohort; **n = 405**	Alcohol dependence symptoms	Childhood maltreatment and maternal substance dependence	Formation	Combined childhood maltreatment and maternal polysubstance dependence predicted greater later alcohol-dependence symptoms.	T1
S20	Chaudhary et al. (2025)	India	Cross-sectional university study; **n = 1,813**	Alcohol/tobacco substance-use risk	ACEs, household dysfunction, bullying and community violence	Formation	Multiple forms of adversity were associated with elevated substance-use and addiction risk among young adults.	T1, T3, T6
S21	Patterson et al. (2025)	USA	Social-network study; survey **n = 137**, network interviews **n = 79**	SUD recovery	Recovery peers, mentors, sober-community contacts and network support	Recovery	Recovery-specific social networks were important sources of practical and emotional support for maintaining recovery.	T5
S22	Admase et al. (2025)	Tanzania	Qualitative interviews and focus groups	OUD treatment with medication	Family/community stigma, institutional stigma, employment and transport barriers	Sustenance / Recovery	Stigma and structural barriers interfered with adherence and retention in medication treatment for OUD.	T3, T5

International Journal of Advanced Multidisciplinary Research and Innovation
E-ISSN: 3107-6157 editor@ijamri.com
Volume 2, Issue 5, September-October 2026

ID	Study	Country	Design and Sample	Substance / Outcome	Main Psychosocial, Social or Environmental Factors	Stage	Key Extracted Finding	Theme
S23	Chavez, Peltier and McKee (2025)	USA	National retrospective treatment dataset; approximately **7 million treatment episodes**	SUD treatment completion/outcomes	Housing, employment, insurance, criminal-justice involvement and socioeconomic circumstances	Sustenance / Recovery	Multiple adverse social determinants independently predicted treatment non-completion and poorer substance-use status at discharge.	T3, T5, T6
S24	Campbell et al. (2026)	USA	Cross-sectional secondary analysis; **n = 97**	OUD and buprenorphine engagement	Stigma and healthcare discrimination	Sustenance / Treatment	Overall perceived stigma was not consistently associated with short-term engagement, although healthcare discrimination showed an important relationship.	T5
S25	Chen, Yao and Xiong (2026)	China	Cross-sectional moderated-mediation study; **n = 454**	Moderate/severe SUD, craving and relapse vulnerability	Social support, meaning in life, addiction-related memory and craving	Sustenance / Relapse	Social support operated through psychological pathways involving meaning and craving, demonstrating interaction between social and intrapersonal processes.	T4, T5, T6

Thematic Coding Key

Code	Theme
T1	Family dysfunction and early-life adversity

International Journal of Advanced Multidisciplinary Research and Innovation
E-ISSN: 3107-6157 editor@ijamri.com
Volume 2, Issue 5, September-October 2026

T2	Peer networks and social reinforcement
T3	Socioeconomic and environmental disadvantage
T4	Psychological distress, emotional regulation and maladaptive coping
T5	Social support, stigma, treatment engagement and recovery
T6	Interaction of psychosocial and environmental influences

Dependency-Stage Coding

Formation: Studies examining initiation, escalation, transition to problematic use or development of substance use disorder.

Sustenance: Studies examining continued use, dependency maintenance, relapse, craving or treatment disengagement.

Recovery: Studies examining treatment engagement, retention, social reintegration or maintenance of recovery.

Both: Studies providing evidence relevant to both development and persistence/recovery pathways.

Note: Some studies were counted more than once in thematic categories as the psychosocial and environmental influences were often manifested at various socio-ecological levels. Thematic coding was thus not mutually exclusive.