

**The Impact of Family Dynamics on Suicidal Ideation and Substance Use: Examining Lived Experiences of Persons Who Use Drugs (PWUDs)**

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# **The Impact of Family Dynamics on Suicidal Ideation and Substance Use:**

## Examining Lived Experiences of Persons Who Use Drugs (PWUDs)

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Suicide remains a pressing global public health issue, especially among vulnerable populations such as Persons Who Use Drugs (PWUD). Guided by the integrated motivational-volitional (IMV) model of suicidal behavior and the transactional theory of stress and coping, this study explores the lived experiences of Filipino PWUDs with suicidal ideation, focusing on family dynamics—parental relationships, caregiving, cohesion, and adaptability. The study uses Interpretative Phenomenological Analysis (IPA) to analyze in-depth interviews with six (6) PWUDs in rehabilitation at the Department of Health - Drug Abuse Treatment and Rehabilitation Center, Agusan del Sur, Philippines. Results show that parental separation, neglect, and low family cohesion created a motivational context of defeat and entrapment. Acute triggers such as domestic violence, grief, and rejection further intensified suicidal ideation. Ongoing rejection and emotional neglect sustained these feelings. Rehabilitation emerged as both a risk and protective factor. It initially created feelings of separation but eventually fostered resilience through faith, therapy, and peer support. The findings highlight the centrality of family-based vulnerabilities and support in the emergence and mitigation of suicidality. This underscores the importance of integrating family-centered approaches in suicide prevention and substance rehabilitation programs.

**KEYWORDS:** drug dependence; family dynamics; Persons Who Use Drugs; PWUDs; rehabilitation center; suicidal ideation

## 1. INTRODUCTION

Suicide is a significant global health issue. Over “720,000 people die by suicide” annually, ranking it among the leading causes of death (World Health Organization 2024). Even with more mental health services available, suicide rates are continually increasing, suggesting that prevention depends not just on access but also on personal readiness and willingness to seek help (O’Connor and Kirtley 2018). In the Philippines, suicide is a particularly pressing concern with cases steadily rising. In 2019, about 2,429 suicide deaths were recorded—around seven per day—highlighting a growing concern, especially among young adults (Statista 2024; Maligalig 2021). The passing of Republic Act 11036, Mental Health Act, safeguards the mental health of Filipinos. However, the law does not confront the problem of suicide (Quintos 2024). Specific bills on the matter are still pending with no certainty as to their eventual passing. This study, therefore, examines the intersection of substance use and suicidal ideation through the lived experiences of Filipino persons with substance use disorders and who are undergoing drug abuse treatment and rehabilitation.

As a fact, suicide remains an enigma that concerns human generativity in sustaining life. As part of the aim of United Nations Sustainable Development Goal 3 (Good Health and Well-being) to improve health and reduce early deaths from non-communicable diseases and mental health conditions, looking into this matter is pressing (United Nations Statistics Division 2023; Quintos 2024). Among persons with substance use problems, suicidality is a heightened risk. Substances such as opioids, methamphetamines, alcohol, and cannabis not only alter cognitive and emotional functioning but also exacerbate the risk of suicidal ideation and attempts (Alvarez-Subiela et al. 2022; Donath et al. 2014; Hesse et al. 2020). Substance use often arises from unresolved trauma, chronic stress, or family conflict. Ultimately, however, it intensifies despair and hopelessness, increasing vulnerability to suicide (Rogers et al. 2023; Overholser, Freiheit, and DiFilippo 1997).

Research has shown that the interplay between substance use and suicidal ideation is strongly mediated by family dynamics, including parental conflict, disrupted attachments, and family maladaptation. Dysfunctional family relationships, neglect, and violence create conditions of alienation, failed belongingness, and maladaptive coping, all of which are precursors to suicidal ideation (Arria et al. 2009; Reinherz et al. 1995). Under these circumstances, substance use is not only a maladaptive coping strategy but also a risk factor that intensifies psychological distress (Herrenkohl et al. 2012).

In the Filipino context, family dynamics hold particular cultural significance. The Filipino family is often described as close-knit, child-centered, and value-laden. In addition, parents are expected to play a highly protective and directive role (Morillo, Capuno, and Mendoza 2013). However, this strong orientation toward involvement can, in certain contexts, blur boundaries and become controlling, creating conflict and resentment (Bartolome, Mamat, and Masnan 2017). Prior studies suggest that such family conditions, when combined with poor parental monitoring, emotional neglect, or parental psychopathology, heighten the risk of both substance use and suicidality (Chen et al. 2023; Ader et al. 2024). Moreover, despite the prevalence of these challenges, little research has explored how individuals with substance use disorders in rehabilitation facilities understand and make sense of their suicidal ideation in relation to family dynamics.

This study addresses this gap by investigating how family dynamics influence the suicidal ideation of PWUDs (Persons Who Use Drugs) in rehabilitation. Family dynamics, particularly parental stability, cohesion, adaptability, and caregiving roles, have been shown to influence psychological resilience and vulnerability (Javier et al. 2018). In dysfunctional families, disrupted cohesion and caregiving may serve as precursors to defeat and hopelessness, while acute triggers such as violence, loss, and rejection may act as catalysts for suicidal crises (Javier et al. 2018; Lagman et al. 2021). Rehabilitation further complicates this dynamic, simultaneously isolating individuals from their

families while providing access to therapeutic and spiritual resources (Co and Canoy 2022). Therefore, this study seeks to answer the following questions:

1. What existing family dynamics have contributed to the emergence of suicidal ideation?
2. How do the identified family dynamics play a role in the formation of suicidal thoughts?
3. Does their treatment and rehabilitation serve as a protective factor or risk factor?

## **2. METHODS**

This study examines the lived experiences of individuals in treatment and rehabilitation, offering nuanced insights into the complex relationship between family dynamics, substance use, and suicidality within the Philippine context. It is theoretically anchored on O'Connor and Kirtley's (2018) integrated motivational-volitional (IMV) model of suicidal behavior and Lazarus and Folkman's (1984) transactional theory of stress and coping. Purposive sampling was employed in selecting PWUDs as participants given that there is an existing comorbidity between substance use and suicide (Overholser, Freiheit, and DiFilippo 1997). Further, the study utilized preliminary surveys to screen prospective participants for in-depth interviews using the Columbia-Suicide Severity Rating Scale (C-SSRS) and Family Adaptability and Cohesion Evaluation Scale (FACES III). These standardized tools were selected due to their reliability and validity in assessing suicidality and family dynamics. These instruments also enhanced the depth of the unstructured interview data by offering quantifiable measures of key variables while allowing the interviews to capture more detailed, subjective experiences. Data from the interviews were analyzed using Interpretative Phenomenological Analysis (IPA), which focuses on exploring and interpreting how individuals make sense of their lived experiences (Smith, Flowers, and Larkin 2009). To

maintain methodological rigor, the study emphasized reflexivity throughout, wherein the researchers engaged in continual self-examination of assumptions and potential biases.

## 2.1 THEORETICAL FRAMEWORK

The IMV model recognizes that individual vulnerabilities confer elevated risk for developing suicidal ideation when activated by the presence of stressors. The theory centralizes its tenets on a three-phase biophysical process: The pre-motivational phase highlights the interaction between the diathesis (the environment and the stressor). The pathway moves to the motivational phase, which focuses on psychological aspects that lead to the formation of the “ideation”. This is followed by the volitional phase, where the person shifts ideation to behavioral action of materializing the ideation (O’Connor and Kirtley 2018).

The IMV model provides a framework for understanding the trajectory from pre-motivational factors (such as life events, family conflict, and substance use), to the motivational phase (characterized by feelings of defeat, humiliation, entrapment, and hopelessness), and ultimately to the volitional phase, where suicidal ideation may escalate into action. The present study contends that the model’s conceptual lens will provide a critical understanding of how psychological, social, and contextual factors shape participants’ meaning-making of their own experience. Therefore, this study draws on the IMV model to examine how family dynamics and substance use contribute to the emergence and intensification of suicidal thoughts.

## 2.2 DATA GATHERING PROCEDURES

### *SCREENING OF PARTICIPANTS*

The study was conducted from November to December of 2024. The participants of the study are persons with substance use disorder (SUD) who are 18 to 35 years old, representing both early and middle adulthood. At the time, all participants were

undergoing rehabilitation in the Department of Health - Drug Abuse Treatment and Rehabilitation Center (DOH - DATRC) located in Barangay Alegria, San Francisco, Agusan del Sur. The only selection criteria for the participants is that they had a personal account of past suicidal ideation or attempts. As a limitation, the study did not consider the participants' length of stay in the facility during the selection process.

The study utilized two self-administered surveys, the C-SSRS and the FACES III, as screening questionnaires for the initial pool of fifteen (15) male and eleven (11) female participants. The initial participants were identified based on their voluntary report that they had thoughts of ending their life prior to their admission in the center. Based on the results of the screening tools employed, participants scoring high in suicidal behavior indicators and low in family cohesion and flexibility were prioritized for the study's aims of investigating the experiences among those facing these specific challenges. During the screening process, participants who were identified as high risk were referred to mental health support to ensure timely and appropriate care.

The C-SSRS is a semi-structured interview-based tool with six key items, measuring the presence, severity, and frequency of suicidal behavior within a specific evaluation period. It is widely used and validated, particularly for adolescents, and helps assess critical aspects of suicidal ideation and behavior (Posner et al. 2011). FACES III is a 20-item scale designed to measure the levels of cohesion and flexibility within family systems as perceived by adolescents. Grounded in the Olson Circumplex Model, the scale evaluates family functioning across three categories: compensated family functioning, decompensated family functioning, and very decompensated family functioning (Joh et al. 2013).

C-SSRS and FACES III served as the standardized backbone for the data, ensuring a structured foundation for the qualitative insights gathered from the semi-structured interview questions that provide valuable, in-depth, moment-by-moment, intensive, and informative data responsive to the participants'

narratives. The C-SSRS enables the research to gauge both the quantitative severity of suicidal thoughts and behaviors and to gather rich, narrative-based contexts from the participants' experiences. FACES III offers a structured framework to assess family dynamics, providing insight into how family adaptability and cohesion influence the individual's well-being.

## *INTERVIEW*

Based on the results of the screening surveys, six (6) participants, three (3) males and three (3) females, who presented with (a) high-risk suicidal behavior in terms of presence, severity, and frequency; and (b) family systems characterized by disengaged to separated cohesion, flexible to very flexible adaptability, and moderately balanced functioning were selected for the in-depth interviews. Regardless of age and gender, the top six (6) identified participants were pooled as final respondents for the semi-structured interviews. The interviews were designed to provide participants with space to narrate their experiences while also allowing the researcher to probe emerging areas of interest. This flexible format encouraged rich and detailed accounts of lived experience.

Twelve (12) open ended interview questions were adapted from prior qualitative studies on suicidality,<sup>1</sup> ensuring both relevance and openness. In line with the research questions, the interview was concerned with: suicidality (2 questions), family dynamics (5 questions), suicidality and family dynamics (2 questions), and rehabilitation treatment (3 questions). A registered psychologist working in the DOH - DATRC facility was on standby during all interviews to provide immediate intervention if participants experienced distress. Additionally, narratives were triangulated with the participants' own storytelling to ensure accuracy and depth of interpretation.

## *ETHICAL PROTOCOLS*

Informed consent was obtained prior to participation in the study, after the initial screening but before the interview process.

All participants, pre-screening and post-screening, were provided with a clear explanation of the nature of the study and its objectives, their rights (including the right to withdraw at any time), and the measures in place for their safety.

Since participants were undergoing rehabilitation at DOH - DATRC, collaboration with the facility was sought. The researchers disclosed their employment affiliation and status to DOH - DATRC to minimize conflicts of interest and ensure transparency. To avoid biases, the researchers who are affiliated with the facility were excluded from the in-depth interviews to avoid confirmatory biases and power dynamics that may alter the responses of the participants. During the thematic analysis of the interview results, these researchers took a neutral stance, reinforcing their professional understanding in the area of interest. Applicable institutional clearances were secured and coordinated throughout the study.

To further safeguard the participants' well-being, a registered psychologist and mental health practitioners at DOH - DATRC were informed of the participants' involvement so that immediate psychological support was available during interviews. Post-interview follow-up calls were conducted three weeks later to check on the participants' well-being as informed by culturally sensitive practices of community support and ongoing mental health monitoring.

## 2.3 DATA ANALYSIS

The researchers analyzed the qualitative data from the interviews using IPA, allowing for a detailed examination of individual cases before moving toward shared patterns of meaning among participants. Unlike thematic analysis, IPA is idiographic and interpretative, emphasizing both participants' meaning-making and the researcher's reflexive engagement in understanding that meaning. The iterative and interpretative nature of IPA also supports deeper, latent engagement with the data, ensuring that the findings went beyond simple thematic categorization to reveal the layered and nuanced meanings participants attributed to their experiences.

In this study, the participants' narratives were not only described but also interpreted, enabling the researcher to move beyond surface-level accounts to explore underlying beliefs, values, and emotional processes. This interpretative stance allowed the study to capture the complexity of suicidality as it is lived and understood within family relationships.

The analysis of data followed several stages. First, the researchers engaged in familiarization by immersing themselves in the transcripts through repeated reading and note-taking, allowing key phrases, emotions, and experiential claims to emerge. Next, initial noting was conducted, focusing on descriptive comments (what participants said), linguistic comments (how they expressed it), and conceptual comments (researcher's interpretative reflections). From these notes, emergent themes were developed to capture essential aspects of the participants' experiences.

The subsequent stage involved connecting emergent themes within each case, clustering related ideas into superordinate themes. After an idiographic analysis of each case, the researchers proceeded to look for patterns across cases, identifying convergences, divergences, and shared experiential meanings. To ensure quality and validity, the researchers engaged in reflexivity throughout the process, keeping analytic memos to acknowledge potential biases and preconceptions. Peer debriefing was also employed to check the consistency of interpretations, while maintaining an audit trail of analytic decisions, which enhanced transparency. Direct quotations from participants were included in the analysis to ground interpretations in the data and preserve the authenticity of the participants' voices. This analytic approach allowed the study to remain faithful to the participants' subjective experiences while also producing interpretative insights relevant to the research questions.

### 3. RESULTS

#### 3.1 PARTICIPANTS' DEMOGRAPHICS

Table 1 presents the screening results of the assessed participants using C-SSRS and FACES III. The results indicate that all participants coded with “M” for male and “F” for female with the numerical order assigned for them (M3, M9, M12, F7, F10, and F11) were classified as *high risk for suicide* according to the C-SSRS. This finding highlights a pressing need for prompt psychosocial and clinical support for each screened individual.

Table 1. Screening Statistics of C-SSRS Risk Level and Faces III Dimensions

Coding Order	Screening Code	C-SSRS	FACES III	
			Cohesion	Adaptability
P1	M3	High Risk	Separated	Flexible
P2	M9	High Risk	Disengaged	Flexible
P3	M12	High Risk	Separated	Very Flexible
P4	F7	High Risk	Disengaged	Structured
P5	F10	High Risk	Disengaged	Flexible
P6	F11	High Risk	Separated	Very Flexible

**Legend:** P = Participant; M = Male; F = Female

In terms of family functioning, as measured by FACES III, the majority of participants reported low levels of family cohesion with three classified as *separated* (M3, M12, F11) and three as *disengaged* (M9, F7, F10). Such patterns of low cohesion may imply that the participants have limited access to consistent emotional support within their family systems, which can exacerbate vulnerability to psychological distress and suicidal ideation.

For family adaptability, the results revealed varied patterns. Half of the participants (M3, M9, F10) belonged to the flexible category, reflecting families that are capable of adjusting roles and rules in response to situational demands. Two participants

(M12, F11) were categorized as very flexible, indicating an even higher degree of adaptability, while one participant (F7) was identified as structured. Despite these variations in adaptability, the consistently low levels of cohesion suggest that the families, although adaptive in some respects, may not be meeting the emotional needs of the participants. This suggests that a pattern wherein high suicide risk co-occurs with weak family emotional bonding, regardless of the level of adaptability, is present.

Table 2 summarizes the demographic profile of the interviewed participants. Their ages range from 22 to 33 years, indicating that all individuals are young to early middle-aged adults. These age groups are often characterized by significant life transitions and psychosocial stressors that may influence mental health vulnerabilities (Matud et al. 2023).

Table 2. Demographic Profile of Participants

Coding Order	Screening Code	Years of Suicidal Ideation	Age	Birth Order	Number of Siblings	Caregiver
P1	M3	2 years	28	Second	3	Parents
P2	M9	More than 2 years	25	Eldest	0	Grandparents
P3	M12	More than 2 years	33	Third	4	Parents
P4	F7	More than 2 years	22	Third	5	Parents
P5	F10	2 years	26	Eldest	4	Parents
P6	F11	1 year	26	Eldest	3	Parents

**Legend:** P = Participant; M = Male; F = Female

For the duration of suicidal ideation, three participants (M9, M12, F7) reported experiencing suicidal thoughts for more than two years, two participants (M3, F10) reported two years, and one participant (F11) indicated one year. This suggests that for most participants suicidal ideation has been persistent and chronic rather than acute, which may require more intensive and long-term psychosocial support and intervention.

For their birth order, three participants (M9, F10, F11) are the eldest in their families, two participants (M12, F7) are third-born, and one participant (M3) is second-born. Notably, a majority of participants are either the eldest or hold a significant family role, which might be associated with added familial responsibilities and expectations that could contribute to psychological distress.

Furthermore, the number of siblings varied among participants with one being an only child (M9), while others reported having between three and five siblings. For the primary caregiver, most participants (five out of six) reported their parents as their main caregivers, while one participant (M9) reported being under the care of grandparents. The predominance of parental caregiving suggests that family remains the central support system for most participants. However, the presence of suicidal ideation despite familial caregiving highlights the importance of exploring the quality of emotional and relational support within these families. These demographic patterns reflect a sample composed of young adults with chronic suicidal ideation and who are mostly living within family structures that vary in size and caregiver dynamics.

### 3.2. EMERGING THEMES

The following themes that capture the lived experiences of people with suicidal ideation and substance use were identified through qualitative data analysis after participant demographics and screening profiles were presented: (1) family factors; (2) learned maladaptive coping strategies; (3) protective factors in rehabilitation; (4) support needs; (5) cognition; (6) triggering factors; and (7) substance use. Table 3 provides a summary of these emergent themes, which were identified by thematic analysis. The intricate interactions between personal, interpersonal, and environmental elements that impact suicidality are reflected in each theme. Direct quotes from participants are utilized to highlight these issues in the sections that follow. The participant number is indicated by the label “P”. The coded passage from the interview transcript that corresponds to that individual is indicated by the label “C” with the corresponding numerical representative value.

Table 3. Emergent Themes from Qualitative Data Analysis

<b>Emergent Themes</b>	<b>Codes</b>
Family Factors	1. Failed marital relationship of parents impacting childhood
	2. Emotional pain due to family members
	3. Exposure to forms of violence (parents)
	4. Neglective acts of family
	5. Controlling family upbringing
Learned Maladaptive Coping	6. Displacement of negative feelings (external)
	7. Not expressing true emotions
	8. Dwelling on negative emotions
	9. Avoidance of uncontrollable or stressful situations
Protective factors of Rehabilitation	10. Feels safe, guided, and accepted
	11. Learned positive behaviors while in rehabilitation treatment
	12. Renewed positive view of future
	13. Personal reflections
Support Needed	14. Secure attachment and love
	15. Personal relationship with God
Cognition	16. Stopping ideas, preventing the enactment of suicidal ideations
	17. Existential thinking
	18. Rumination on ideas of death
	19. Thinking of death as escape
Triggering Factors	20. Watching suicide-related information
	21. Death of a loved one
	22. Compulsion to hurt self because of negative feelings
	23. Romantic relationships ending (physical abuse)
Substance Use	24. Judgement from other people
	25. Involvement or relationship with a person with substance use problems
	26. Using drugs as a means of escape

## *FAMILY FACTORS*

According to the emergent themes from the data, participants consistently described dysfunctional family relationships as central to their suicidal ideation. Parental separation, neglect, and weak emotional bonds left many with feelings of abandonment and hopelessness.

“When my parents separated, it felt like no one cared where I would end up. That’s when I started thinking, maybe I shouldn’t even be here.” (P3, C1)

FACES III scores confirmed low cohesion among participants. Although some families were adaptable, this did not compensate for weak emotional bonds. Eldest children faced added caregiving duties, increased stress, and suicidal ideation.

“Being the eldest, I had to take care of my siblings when my parents left. It felt like I had no childhood. I would rather disappear than continue carrying all this.” (P6, C4)

These findings highlighted the participants’ narratives on the emotional toll of unstable family environments and the heavy burdens placed on young individuals who were often left to cope without adequate support.

## *LEARNED MALADAPTIVE COPING STRATEGIES*

Maladaptive coping strategies emerged as a prominent theme, illustrating how participants attempted to navigate and regulate overwhelming emotional experiences. Several participants reported mechanisms aimed at regaining control, managing distress, or self-protection from further psychological harm. The participants also often described a painful ambivalence: craving love and connection while simultaneously harboring resentment and hopelessness.

Displacement of negative affect, frequently manifesting as aggression toward others, was common.

“My mindset is that violence is always the answer . . . even with a small disagreement, I get into fights.” (P2, C6)

This externalization of emotional pain underscores how unresolved suffering was redirected onto others in contexts where self-expression was constrained within the home environment. Accounts of emotional suppression were equally salient.

“Every time we cried, we’d be told, ‘Don’t cry.’ I tend to isolate myself whenever I feel something.” (P2, C7)

Such silencing, often reinforced by shame and fear, promoted withdrawal and self-reliance often to the detriment of adaptive coping.

Sulking and immersion in negative emotions constituted another recurrent motif. For example, the impact of parental abandonment was evident.

“My dad is only there when I ask him for something, but when it comes to love, there’s none.” (P4, C8)

Avoidant behaviors, such as isolating themselves or seeking distraction, further characterize these maladaptive patterns.

“I would stay in my dark room. That’s what I wanted. But in that darkness, when more problems came, it got worse.” (P3, C9)

Avoidance thus functioned not merely as disengagement but as a means to numb emotional pain, albeit at the expense of deeper isolation and heightened suicidal ideation.

### *PROTECTIVE FACTORS OF REHABILITATION*

Participants also described protective factors that contributed to resilience, particularly within the context of rehabilitation. Recurrent themes included experiences of safety and acceptance.

“I feel safe here because the staff respect me and guide me, and for that, I am deeply grateful.” (P4, C10)

Acquisition of adaptive behaviors, such as boundary setting and cooperation, was also noted, enabling the development of healthier relational dynamics. Another participant remarked,

“I started to understand the purpose of the discipline shown to me. I’m not here to just rest; I’m here to heal myself, to reflect.” (P4, C13)

These findings suggest that participants began to reinterpret their challenges and emotional pain, viewing them not as sources of defeat but as opportunities for healing and transformation. Rehabilitation thus served as a meaningful space for developing self-awareness, emotional regulation, and healthier relational patterns.

### *SUPPORT NEEDS*

Regarding support needs, participants emphasized the significance of secure attachment and expressions of love as foundational supports. Grandparents frequently emerged as protective figures, offering unconditional care.

“My recovery here isn’t just for myself but for the person who truly loves me, and I draw my strength from her.” (P4, C14)

For some, faith and a personal relationship with God served as vital resources, instilling a sense of purpose and mitigating despair. These accounts underscore the central roles of both familial and spiritual attachments in the recovery process.

### *COGNITION*

Additionally, participants described cognitive processes related to suicidality, including protective internal dialogues that deterred suicidal behavior. As one participant noted,

“There’s still a voice in my mind saying, ‘Don’t do it,’ like my brain is reasoning with itself.” (P3, C16)

Conversely, others reported persistent rumination and existential questioning that exacerbated suicidal ideation. For some, thoughts of death were conceptualized as a means of escaping social judgment and misunderstanding.

“No matter how hard you try to live a good life, some still won’t understand you . . . that’s why others end up feeling lost or overwhelmed.” (P2, C24)

These accounts illustrate a cognitive tension between hope and despair with protective reasoning coexisting alongside intrusive suicidal thoughts.

### *TRIGGERING FACTORS*

Participants highlighted a number of experiences, including maltreatment, exposure to substance use and internet media, losing important people, and criticism from others, as crucial triggers for suicide ideation.

Physical abuse experiences reinforced emotions of helplessness and imprisonment by creating a general sense of chaos and terror. Numerous participants talked about being both victims and spectators to violent cycles.

“When his abusive nature started to show, he would hit me. That was the lowest point of my life and led to my last suicide attempt.” (P4, C22)

“I would see my father physically hurt my mother.” (P1, C23)

In addition, participants described how regular exposure to suicide-related content normalized self-destructive ideas and behaviors, making online media exposure a potent trigger. They also shared how suicidal thoughts are frequently triggered or exacerbated by the death of a loved one, particularly family members or caregivers. This shed light on how emotional instability and hopelessness were entwined with grief.

“Whenever I saw suicide-related videos on YouTube, how they did it, I would want to try.” (P3, C20)

“When my grandfather died, my suicidal ideation started . . . I would storm inside the room, lock it, and think about death.” (P4, C21)

Participants also described compulsions toward self-harm, often experienced as overwhelming urges. Such intrusive thoughts illustrate how compulsive tendencies can escalate suicidal risk.

“Whenever I am alone, I have these urges to self-harm . . . I would want to hurt myself and just be gone.” (P4, C22)

The end of romantic relationships was similarly destabilizing, often tied to perceptions of abandonment and worthlessness.

“When my boyfriend decided to break up with me . . . I did it [suicide attempt] because I think that I have no value. I have no one to take care of me.” (P4, C23)

Furthermore, judgment from others intensified distress. Criticism about academic or personal shortcomings reinforced feelings of inadequacy.

### *SUBSTANCE USE*

Substance use surfaced as both a relational and psychological anchor within participants’ accounts of suicidality. Together with the triggering factors, substance abuse surfaced as a maladaptive coping strategy. Many described using drugs or alcohol as a short-term fix for intense stress, familial strife, or emotional suffering. However, these actions often made interpersonal conflicts worse and increased their feelings of rejection and helplessness. Substance abuse became a part of a harmful cycle that promoted impulsivity and hopelessness rather than reducing misery.

In particular, drug use was depicted not merely as a habitual behavior but as a coping mechanism for managing fractured relationships, emotional neglect, and existential distress. For instance, one participant described how involvement with a partner struggling with addiction provided both a sense of attachment and a source of harm.

“I have a boyfriend who is an addict [substance abuser]. My family is against him because they profiled him as no good. We lived together despite my family’s opinion. When we were together, I got pregnant, but he physically abused and neglected me. He is also the one who influenced me to use substances. When I have thoughts, I would use [drugs] as recreation.” (P4, C25)

Thus, despite her family’s disapproval, the participant clung to the relationship, suggesting a search for attachment and belonging in the absence of familial affirmation. Another participant emphasized the psychological function of drugs as a coping mechanism, highlighting its role in temporarily numbing emotional pain and existential questioning.

“Whenever I am under the influence of drugs, I isolate myself from the family and blame my parents for what happened to me and my life. I would think about regret and worthlessness. I even came to a point to question God for what he did to me.” (P6, C26)

This account demonstrates how substance use was not only a form of self-isolation but also a way of managing unresolved anger and deep-seated feelings of worthlessness. This suggests that substance use functioned as an escape from overwhelming family conflict, abusive relationships, and unresolved existential pain.

#### **4. DISCUSSION**

The experiences of the participants shed light on the following themes: “family factors,” “learned maladaptive coping strategies,” “protective factors of rehabilitation,” “support needed,” “cognition,” “triggering factors,” and “substance use.” Similar to the studies of Joiner (2005) and Van Orden et al. (2010), violence, grief, and rejection acted as acute triggers. In addition, the present study found that weak family cohesion and inconsistent caregiving provided the motivational foundation for suicidality. These results support the IMV model’s emphasis on feelings of defeat, humiliation, and entrapment as precursors to suicidal ideation.

The theme on “triggering factors” provides support on the pre-motivational phase of IMV, where there is an interaction among the “diathesis-environment-life events triad” (O’Connor and Kirtley 2018, 3). The themes “maladaptive coping strategies” and “cognition” support the “motivational phase” factors that may play a role in the reported volitional phase, where self-harming actions are committed. Therefore, the results of the study shed light on the dynamic interplay of chronic family dysfunction, acute triggers, sustained rejection, and rehabilitation in shaping suicidality among PWUDs.

According to Castellví et al. (2016), childhood neglect resulting from failed parental relationships profoundly disrupts emotional development, leaving individuals vulnerable to internalized guilt and despair. In addition, experiencing or witnessing violence creates negative perceptions of life and fosters hopelessness, increasing suicide risk. Furthermore, according to Gould et al. (1998), parental separation and conflict heighten suicide risk.

Morillo, Capuno, and Mendoza (2013) found that the Filipino family values manifested change and evolution in the practice of child rearing. Concurrent with the study of Dizon and Alampay (2024), parental control is associated with internalized and externalized symptoms of distress. In particular, high “family obligation values” (FOV) act as a buffer that nurtures family cohesion (closeness and well-being) in shaping the meaning and interpretation of parent-child relationships. As implied, the contrary level of FOV exacerbates child distress—acting out of anger or frustration, seeking attention, risky behaviors, and negative influence of peers—by suppression of emotional expression and autonomy through psychological controlling of parents. For the present study, the findings revealed that dysfunctional parental relationships, neglect, and exposure to violence are significant contributors to the development of suicidal ideation. In addition, sustained neglect perpetuating suicidal ideation often intertwined with substance use as a maladaptive coping mechanism.

As presented in the results, participants reported triggers beyond formative family dynamics discussed by Arria et al.

(2009). In particular, these additional triggers are grief, judgment from others, romantic breakups, and exposure to suicide-related content. Several participants explained how seeing these kinds of videos supplied cognitive scripts for suicidal behavior and normalized self-harm. Others, however, pointed out that these same depictions strengthened their conviction that life was still worthwhile by discouraging suicidal behavior. This duality highlights the importance of individual meaning as a crucial factor in determining whether triggers escalate ideation or foster resilience. Maladaptive coping behaviors, such as avoidance and substance use, emerged as attempts to regulate overwhelming emotions. Moreover, these strategies often deepened the distress of the argument that unresolved emotional pain frequently translates into harmful behavior (Patel and Patel 2019).

As for the relationships between identified family dynamics in the formation of suicidal thoughts and treatment and rehabilitation as a protective or risk factor, rehabilitation programs and structured support were found to provide significant protective factors. Although initially isolating, rehabilitation ultimately emerged as a context for resilience through faith, therapy, and peer support. Participants highlighted how rehabilitation fostered positive behavioral change, self-reflection, and renewed hope for the future. According to Honari and Saremi (2015), secure attachment to supportive caregivers or mentors promoted emotional stability and healthier coping. The integration of spirituality and faith, particularly a personal relationship with God, also emerged as a crucial buffer against suicidal ideation because of the role of faith and hope in reducing existential despair as discussed in other studies (Metry, Strodl, and Sadia 2025; Ropaj 2023). Furthermore, these protective elements counteract volitional moderators in the IMV model (O'Connor and Kirtley 2018) that might otherwise escalate ideation into action.

In the experiences of the participants, therefore, the rehabilitation setting thus functioned as a corrective environment, offering safety, discipline, and belonging, which are often absent in family dynamics. Meanwhile, relationships with

substance-abusing peers or partners intensified cycles of neglect, abuse, and dependency, deepening emotional distress and hopelessness. This underscores the transactional perspective that maladaptive coping strategies, while initially serving as an escape, ultimately worsen the stressor they attempt to alleviate. Breaking this cycle requires addressing underlying trauma while simultaneously equipping individuals with healthier coping strategies. These findings are consistent with other research showing that supportive environments impede the transition from suicide ideation to action. Furthermore, the results suggest that the participants' assessments of family stress, whether as unavoidable or controllable, determined their coping mechanisms.

## 5. IMPLICATIONS

The study found that negative family dynamics such as failed parental relationships, childhood neglect, and exposure to violence significantly influence the development of suicidal ideation among PWUDs. Lack of parental care and controlling or neglectful family environments often result in emotional challenges that may lead to maladaptive coping mechanisms, including substance use and self-destructive behaviors. Furthermore, the results suggest that family systems have a substantial impact on both vulnerability and resilience (Smith et al. 2022).

The study also revealed significant protective factors. Rehabilitation programs, secure attachments, personal reflection, and spirituality emerged as important resources that foster resilience, instill hope, and promote recovery. Rehabilitation settings that provide safety, acceptance, and guidance allow individuals to reframe their experiences, develop healthier coping strategies, and restore a sense of purpose. Taken together, the results highlight both the risks associated with family dysfunction and the opportunities for recovery through structured support systems.

The findings of this study carry important implications for psychology, mental health, and suicide prevention, particularly in Global South contexts like the Philippines, wherein the importance of mental health is tied to vulnerability (Smith et al. 2022).

Programs must extend beyond individual treatment to include family education and counseling, addressing dysfunctional dynamics that serve as precursors to suicidal ideation (Quintos 2022). In collectivist contexts, where family involvement is both protective and potentially harmful, culturally sensitive approaches must balance respect for cultural values with the need to foster autonomy and emotional expression (Chen et al. 2021). Rehabilitation centers should incorporate psychosocial support, mentorship, and faith-based resources, recognizing the protective role of spirituality in fostering resilience (Lee et al. 2019). Given the centrality of substance use as both a coping strategy and a risk factor, targeted interventions that integrate trauma-informed care with addiction treatment are essential (World Health Organization 2021). Suicide prevention frameworks in the Global South should prioritize structural support for at-risk families, recognizing that economic hardship and social stigma compound family dysfunction and psychological distress (United Nations 2020).

Therefore, this study recommends that family-centered interventions should actively involve families in mental health and rehabilitation programs. Counseling and psychoeducation can help address dysfunctional dynamics and strengthen supportive relationships. In collectivist contexts, such as the Philippines, culturally sensitive approaches to interventions should strike a balance between respecting cultural norms and promoting autonomy and emotional expression. This ensures relevance and effectiveness in the Global South setting, highlighting the importance of psychological distress and suicide risk as influenced by micro level factors of family and community (Patel et al. 2018). Additionally, strengthening rehabilitation services should integrate structured psychosocial support, mentorship, and spiritual care to reinforce resilience and reduce relapses. Furthermore, public awareness and stigma reduction around mental health and substance use encourage families to seek help early. Lastly, further studies should investigate culturally specific protective and risk factors as well as evaluate the long-term effectiveness of family-inclusive and rehabilitation-based interventions in suicide prevention. By implementing these

recommendations, mental health practitioners, policymakers, and communities can build environments that reduce risk, foster resilience, and promote recovery for individuals with substance use disorders and who are experiencing suicidal ideation.

## TABLES

- 1 Screening Statistics of C-SSRS Risk Level and Faces III Dimensions
- 2 Demographic Profile of Participants
- 3 Themes from Qualitative Data Analysis

## NOTES

- 1 See Fergusson, Woodward, and Horwood (2000) and Joiner (2005).

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