The Interplay of Early Attachment Difficulties and Long-Term Substance Use: A Clinical Case Study

Laiba Tehreem [1] Farhan Hashmi [2*] Syed Haider Tashfeen Bukhari [3]

[1] MS, Clinical Psychology Unit, Government College University, Lahore, Punjab, Pakistan.
Email: laiba.tahrim@gmail.com
[2] Lecturer, Clinical Psychology Unit, Government College University, Lahore, Punjab, Pakistan.
Email: farhanhashmi@gcu.edu.pk
[3] PGDCAP at Clinical Psychology Unit, Government College University, Lahore, Punjab, Pakistan.
Email: hbukhari46@gmail.com

ABSTRACT: The current paper presents the case of a 33-year-old male, who was presented with the psychiatric day program because of constant anger, abusive behavior, social withdrawal, irritability, self-talk, self-laugh, auditory hallucinations, and lack of interest in daily activities. The clinical history showed that patient had substance use disorder, predominantly tobacco, with a current smoking of at least 10 cigarettes daily which had led to repeated and extended psychiatric hospitalization over a period of about 15 years. His clinical picture was in line with DSM-V TR criteria of Substance-Induced Psychotic Disorder with hallucinations being the result of Tobacco Use Disorder which was determined according to the temporal interrelation of substance use and remission of some of the symptoms during supervised abstinence. Mental Status Examination, Behavioral Observation, Clinical Interview and Subjective Symptom Ratings were assessed, along with such formal measures as Positive and Negative Symptom Scale (PANSS), Brief psychiatric Rating Scale (BPRS) and Rotter Incomplete Sentence Blank (RISB), as moderate positive symptoms, significant negative symptoms, and significant general psychopathology with depressive characteristics were observed. The client had auditory hallucinations that expressed early attachments disruption and family relationships. The intervention involved the use of Cognitive Behavioral Therapy (Cognitive Restructuring, Triple Column Technique, Thoughts Create Feelings, Graded Task, Mastery and Pleasure Techniques), Medication Adherence Interventions, Relaxation Techniques, and Psychoeducation of the client and his mother, including the overprotective and overbearing behaviors. After the intervention, the client improved significantly in general functioning, and psychotic symptoms, anger, and withdrawal had decreased.

KEYWORDS: Substance Induced Psychotic Disorder, Social Withdrawal, Anger, Relapse Prevention, Psychoeducation, Cognitive Behavior Therapy

Pages: 57 – 70
Volume: 5
Issue: 1 (2026)

Corresponding Author
Farhan Hashmi
✉ farhanhashmi@gcu.edu.pk

Cite this Article: Tehreem, L., Hashmi, F., & Bukhari, S. H. T. (2026). The Interplay of Early Attachment Difficulties and Long-Term Substance Use: A Clinical Case Study. *The Regional Tribune, 5*(1), 57-70. https://doi.org/10.55737/trt/v-i.202

Introduction

The severe mental health problems are usually reflected in the alterations of feelings, behavior, and perception of reality. People will face problems with managing strong emotions, controlling aggression in interactions, and social withdrawal. Once enjoyable things become meaningless and do not evoke motivation. Other people might experience some abnormal internal feelings, including hearing voices or reacting to things that do not exist, which can be confusing and upsetting. These changes and the disturbance of daily responsibilities point to the presence of deeper psychological and environmental factors that are influenced by time (American Psychiatric Association, 2022).

Childhood experiences are considered to be crucial in later exposure to psychopathology. Interference of parental relationships, especially paternal absence and provision of uneven caregiving is correlated with poor social development and predisposition to aggressive mental illnesses. Studies prove that a specific early life stressful event can add to the risk of experiencing psychotics and substance use disorders in adulthood such as losing parents, absence of affection, and disrupted attachment (Varese et al., 2012; Bentall et al., 2014). On large scale evidence shows that people who experienced significant childhood adverse events have two to three-fold higher chances of developing a psychotic disorder or psychotic-like experience, which points to the importance of early traumatic experiences in the risk of psychosis (Brain & Behavior Research Foundation, 2025). Adolescence literature also indicates that childhood trauma combines with cognitive bias, neuroticism, and mood symptoms to cause psychotic like experiences and stress on the effects of internal psychological mechanisms in this developmental pathway (Xi et al., 2025). Typical psychotic symptoms and poorer quality of life were also reported in the young adults with first-episode psychosis and their unaffected siblings in childhood adversity, highlighting the importance of long-term functional consequences of early trauma (Yao et al., 2025)

Attachment theory offers a framework on the role of early caregiving in influencing emotion regulation, coping and interpersonal functioning (Bowlby, 1982). Insecurely attached individuals are anxious, avoidant or disorganized and are soaring bridges between early adversity and the future psychopathology and maladaptive behaviors. People, who possess an insecure attachment, become more vulnerable to drug or alcohol use, and drugs or alcohol help them to control the number of emotions, the load of stress, or the control of intrusive thoughts on traumatic events (Migalova et al., 2025; Schindler et al., 2005). Moreover, insecure attachment would imply the worse treatment attendance and worse adherence to therapy, which could worsen the chronic psychiatric symptoms. At the population level, the exposure to various negative childhood events is often linked to the lack of secure attachment, social isolation, and emotional dysregulation, and early psychosocial adversities are closely related to the risk of developing mental and physical health issues in the future (Flinn et al., 2025)

The responses to stress and adversity through coping are crucial to the process of thinking about the susceptibility to substance use and long-term mental health outcomes. Those who do not have proper coping strategies are more vulnerable to maladaptive behaviors, such as substance abuse, aggression, and reclusiveness, which may enhance the onset of psychiatric disorders (Avcı, 2025). Weaknesses in solving problems, emotional control systems, seeking social support make a person more susceptible to stress, thereby supporting the use of substances as a coping mechanism in the short term. Against the backdrop of early attachment disorder, insecure attachment may also exacerbate adaptive coping mechanisms and result in individuals becoming increasingly susceptible to resolving the upsetting affective states or being affected by thoughts of traumatic experiences with substances. This reliance on maladaptive coping may reinforce a cycle of chronic substance abuse that with time may lead to a predisposition to chronic psychiatric symptoms, including psychosis (Migalova et al., 2025; Schindler, 2019). Alternatively, early adversity can be offset, the dependency on substances can be decreased, and the susceptibility to future mental health issues can

be reduced with the help of adaptive coping, including cognitive reframing, relaxation, emotion regulation, and social support seeking (Avcı, 2025; Bowlby, 1982).

One protective factor against long term psychopathology is to promote secure attachment throughout the development. Consistent, responsive caregiving opportunities which promote positive parent child interactions and environments which facilitate emotional validation and autonomy can promote secure attachment. Formation of attachment bonds during adulthood could be encouraged by the help of psychoeducation, empathetic family interventions and systematic therapy in order to improve emotional regulation and lessen the propensity to practice maladaptive coping strategies including substance use. Studies show that the perpetration of families with reinforcement training and systematic behavioral strategies enhance the effectiveness of treatment, emotionality, and adaptive coping among substance use disorder patients (Hogue et al., 2021).

Childhood neurodevelopmental stressors have the ability to sensitize stress-response systems, and remodel neural circuits involved in emotion regulation and cognition, increasing the risk of psychosis and other psychiatric disorders in adulthood, especially when environmental factors like substance use are on board (McCrory et al., 2011; Read et al., 2014)

Even when psychoactive substances are regularly used by an individual with a long history of substance use and an individual has been abstinent, repeated exposure to psychoactive substances may also lead to persistent psychotic symptoms such as hallucinations, delusions, and disorganized thought processes (Ricci et al., 2024). The systematic reviews also affirm that childhood adversity, escalated by maladaptive coping and lifetime substance use, foretell post-traumatic stress disorder and mood disorders, as well as chronic psychotic disorders as some of the outcomes of such adversity on long-term psychopathology are minimized by early intervention and the use of a trauma-informed approach (Umar et al., 2025).

Irrespective of these risks, the heterogeneity of resilience is a fact. The relationship between childhood adversities and mental health symptoms in adulthood might be mediated by the protective factors, including strong social support, school connectedness, adaptive coping and stress relief, as well as effective functional outcome. Knowledge of these mediating pathways demonstrates the need to promote resilience, secure attachment, and adaptive coping throughout development in order to disrupt the developmental pathway toward early adversity to substance use and serious, enduring psychopathology.

History of Present Illness

The current paper presents the case of Mr. X, a 33-year-old male with a lower-middle socioeconomic status. He has an extensive psychiatric history and has been hospitalized in a psychiatric facility in both acute and sub-acute units for about 15 years. He is already on a day-member program and is attending outpatient follow-ups regularly. He lives with his mother and has two sisters who are married and live independently. His father abandoned the family when he was a teenager and later remarried but his mother kept this a secret and told him that his father had moved to another country for work. The client has a high degree of emotional reliance on his mother who is the only breadwinner in the family. His attachment style can be described as anxious, which is probably due to the overprotective care of his mother. According to the client, he only has a few memories about his father because he marginally involved in his life. His parents were reported to have had a dysfunctional marriage relationship, which contributed to the constant sense of loneliness and emotional insecurity, which eventually resulted in severe social disengagement.

Mr. X was first referred to psychiatric care because of acute tobacco use disorder. According to him, he started smoking tobacco in his teenage years, at the age of 16-17 years. With time, his consumption increased tremendously and resulted in psychological dependence. He explained that tobacco use was one of the major coping mechanisms to deal with frustration, anger, and internal distress and at times he smoked two to three packs a day. His symptoms were severe, and he was severely impaired in terms of his functionality, which required long-term institutional care. He spent almost 15 years in the psychiatric facility and was treated at various levels of care such as acute and sub-acute wards, then moved to day-member and outpatient program.

As the client continued to use the substance, he slowly developed psychotic symptoms, such as perceptual disturbances, self-directed speech, aggressive behavior, and social withdrawal that led to frequent hospitalizations. He also complained of auditory hallucinations, where he heard voices at some points, which sounded like a father or an authority figure. These were usually critical in nature and contained phrases like مجھے تم پر شرم آتی ہے (I am ashamed of you) and تم ٹھیک نہیں کر رہے (You are not doing well) that were very much emotionally disturbing. The psychotic symptoms partially improved during the intervals of organized care and limited access to substances, which further confirms the substance-induced nature of his condition. Despite having his symptoms under check in the recent years and being enrolled in the day member program, he still smokes cigarettes at intervals, usually taking one to two tobacco filled cigarettes a day. This persistent substance use is still a possible risk factor of symptom maintenance and relapse.

Psychological Assessment

A comprehensive assessment was conducted by using Presenting complaints, Mental Status Examination, and a detailed substance use history. Diagnostic clarification was done by using standardized psychological tests like Incomplete Sentence Blank (RISB) by Rotter, the Positive and Negative Syndrome Scale (PANSS), and the Brief Psychiatric Rating Scale (BPRS). The RISB scores were moderate maladjustment. The clinical interviews with the client, hospital staff, and family members always indicated that psychotic characteristics developed after the onset and intensification of tobacco use and were not present before the exposure to the substance.

The results of the formal assessment instruments, such as the PANSS and BPRS, proved the existence of persistent psychotic symptomatology. Clinical history also indicated variability in the severity of symptoms with regard to availability of substances and adherence to medication. The pre-substance psychotic symptoms and the continuation of symptoms in the presence of ongoing tobacco use were also indicative of a Substance-Induced Psychotic Disorder and not a primary psychotic disorder.

Positive and Negative Syndrome Scale (PANSS) is a popular clinician-rated instrument that is used to determine the severity of positive, negative, and general psychopathology symptoms in patients with schizophrenia and other psychotic disorders (Kay, et al., 1987).

Table 1

Table shows the scores of PANSS across different domains

Subscale	Raw Score	Severity
Positive Symptoms	19	Moderate
Negative Symptoms	29	Moderate-Severe
General Psychopathology	54	Moderate-Severe
Total	102	Moderate

The PANSS results indicate an overall moderate to severe level of psychopathology

The results of PANSS showed that the level of psychopathology was moderate to severe. The symptom profile was characterized by a high level of negative symptoms, high level of depressive symptoms, and high level of general psychopathology, and the positive symptoms were relatively mild. The general psychopathology and depression scores are high, and anergia and significant negative symptoms are present, which indicates a complicated symptom profile. The client seems to be experiencing a variety of distressing symptoms, both the cognitive and affective aspects of schizophrenia.

Brief Psychiatric Rating Scale (BPRS) is a clinician-administered instrument that is used to assess psychiatric symptoms, such as depression, anxiety, hallucinations, and abnormal behavior, especially in patients with moderate to severe psychosis (Overall & Gorham, 1962).

Table 2

Table shows the scores BPRS

Score	Range	Category
44	31-53	Moderately ill

The BPRS Scores indicate a moderate level of illness

The client has a BPRS score of 44, which shows that he is in the moderately ill range, which is a moderate degree of overall psychiatric symptomatology. This implies that there are clinically significant symptoms, such as mild affective disturbances and psychotic symptoms, which are functional impairing but not at an extreme level of severity.

Case Conceptualization

Client was diagnosed with Substance-Induced Psychotic Disorder with hallucinations, based on the DSM-5 criteria, due to Tobacco Use Disorder, on the basis of the mental status examination, formal psychological assessment tools, and the symptom reports provided by the client, the staff, and the family members. A close examination of his developmental history showed that he had suffered a lot of early-life adversities especially paternal abandonment, inconsistent caregiving and overprotective maternal parenting, which seems to have played a major role in his psychological vulnerability.

Attachment theory focuses on the long-term issues of emotional regulation, independence, and interpersonal functioning that may be caused by disruptions in early attachment relationships, particularly, parental separation and emotional unavailability (Bowlby, 1982; Ma, 2006). The acute disappearance of the father and the consequent withholding of the facts by the client's mother only helped in the unresolved sense of abandonment, mistrust and emotionally dependent feelings. These relational disturbances in early years seem to be the cause of his anxious attachment pattern, which made him more dependent on his mother to be emotionally secure and restrict the development of adaptive coping patterns (Migalova et al., 2025). Therefore, in situations of stress or bad mood, he resorted to substances, including tobacco, as a dysfunctional coping strategy to control excessive emotions and intrusive thoughts (Avcı, 2025). In the long run, this tendency towards dependence on substance use, increased by an insecure attachment and chronic stress, probably increased his risk of sustained psychopathology, such as psychotic symptoms, social withdrawal, and affective disturbances (Brain & Behavior Research Foundation, 2025; Read, et al., 2005).

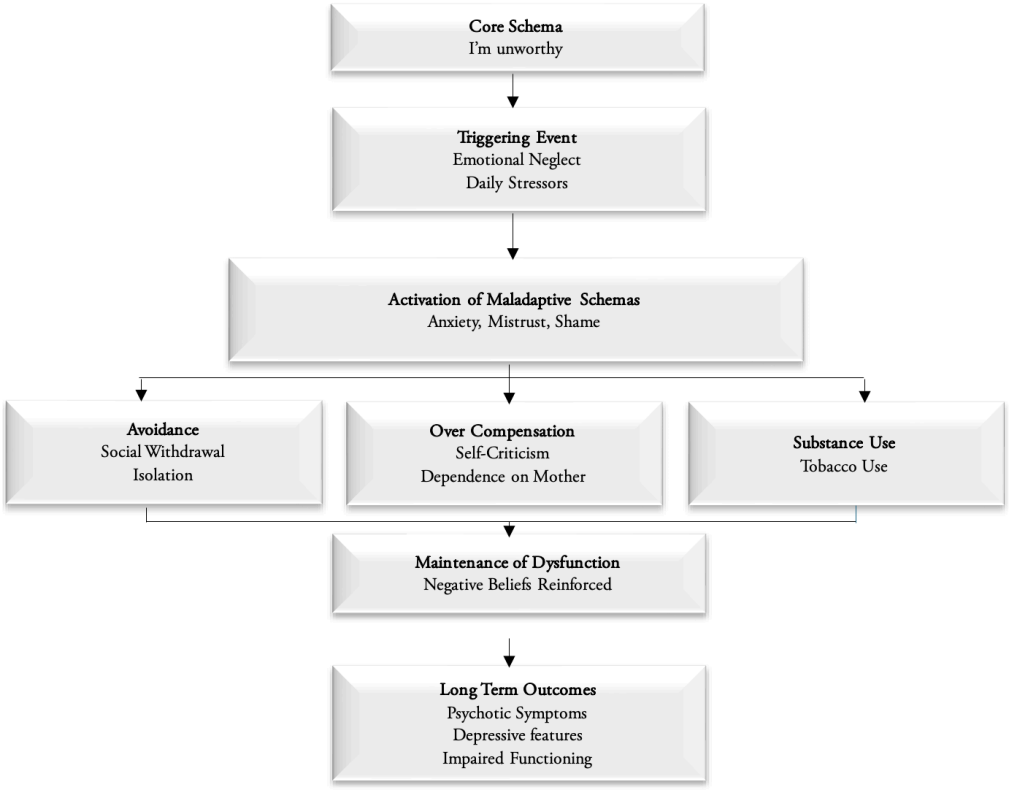
Cognitively, negative childhood experiences also cause maladaptive core beliefs and schemas, especially those concerning abandonment, vulnerability, and lack of trust in others (Beck, 1976; Beck and Haigh, 2014; Read, et al., 2005; Varese et al., 2012). The cognitive model suggests that such schemas can be dormant and triggered by subsequent stressors or interpersonal struggles or maladaptive coping mechanisms, such as substance consumption (Garety et al., 2001). In this case, childhood emotional deprivation, unreliable care giving, and poor social exposure seem to have contributed to the formation of negative self-beliefs, other and world beliefs as unsafe or rejecting (Bowlby, 1982; Ma, 2006). The onset of tobacco consumption during adolescence could have strengthened these perceptions because it was a temporary coping mechanism to deal with distressing emotions and intrusive thoughts, and cognitive vulnerabilities and substance use were reinforced by each other (Avcı, 2025; Han, et al., 2023; Gurillo, et al., 2015). It is likely that this process led to increased solidarity of the rigid and idiosyncratic perceptions of experiences, including hypersensitivity to criticism, ongoing guilt, and hypervigilance to the perceived threats (Quigley and MacCabe, 2019; Mustonen, et al., 2018). These individualized patterns in the development of cognition form the basis of the idiosyncratic model where patterns of thinking and responding to stressors and relational factors suggest unique ways in which Mr. X might develop as a result of life events, stressors, and relational dynamics (Garety et al., 2001; Gage et al., 2015). These cognitive patterns of the individual and the personal differences in the behavior patterns are significant because they allow us to adjust interventions that focus on the maladaptive schemas as well as the coping techniques such as chronic substance use which perpetuate his psychopathology (Ma, 2006; Chaaya et al., 2025).

Chronic tobacco uses in the clinical presentation of client served as a precipitating and maintaining factor of psychosis. Studies show that the use of substances in the key neurodevelopmental stages such as adolescence, may predispose psychosis, especially in individuals with underlying psychological and social vulnerabilities (Tervo-Clemmens et al., 2019). The stress vulnerability model also states that early life stress can sensitize neurobiological stress response systems, which in turn makes one vulnerable to psychotic symptoms in combination with exposure to substances or psychosocial stressors (Zubin and Spring, 1977; McCrory et al., 2011). There is also emerging evidence of a relationship between tobacco smoking and schizophrenia spectrum disorders, with meta-analytic studies showing that there is a twofold higher risk of incident psychosis in smokers, despite confounding variables (Gurillo et al., 2015; Hunter et al., 2018).

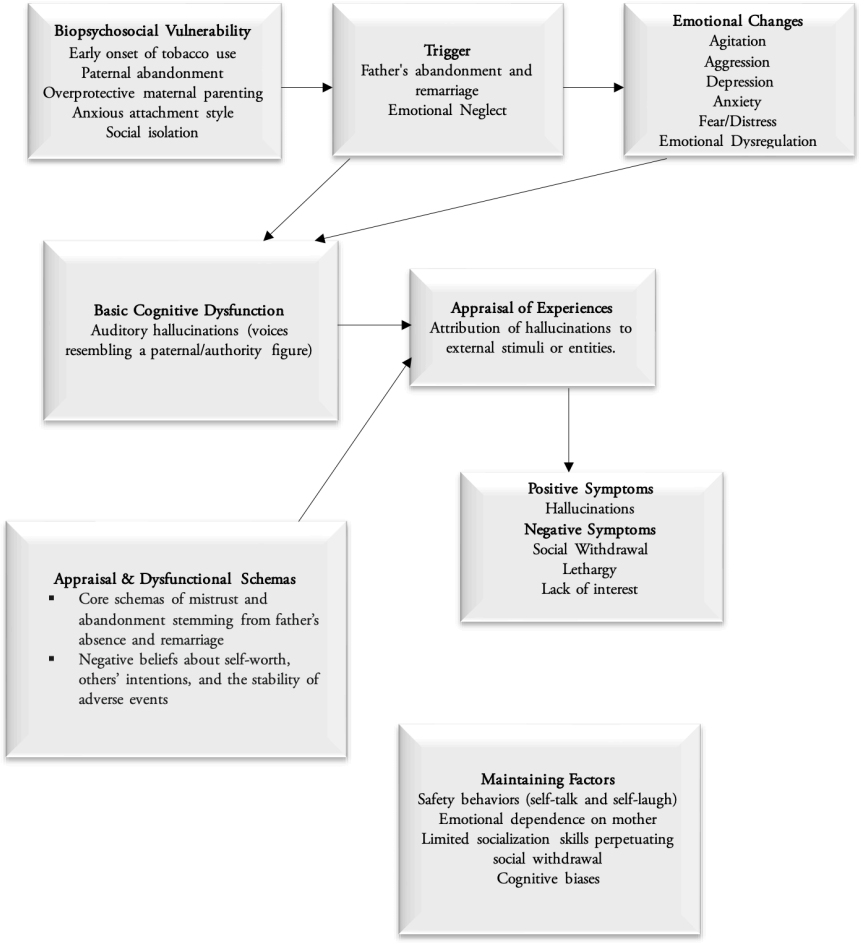
Clinically, auditory hallucinations were experienced by the client with the voices usually being fatherly or authoritative. These were generally critical voices, which were characterized by statements of disapproval or shame, and they seemed to reflect his undecided paternal conflict and negative self-schemas. These were other experiences that strengthened emotional distress, withdrawal, and maladaptive coping behaviors.

Besides substance use, persistent psychosocial stress factors, such as social isolation, emotional reliance on his mother, poor social skills, and extended institutionalization have also helped to sustain his symptoms. Social withdrawal and lack of meaningful peer relationships are well-reported maintaining factors in psychosis because they support negative beliefs and safety behaviors including self-directed speech and inappropriate laughter (Garety et al., 2001). Despite the fact that the condition of client has stabilized over the last few years and he is now on a day-member program, he still smokes one to two tobacco filled cigarettes per day. This continued nicotine consumption is a major perpetuating factor since chronic nicotine exposure has been known to increase psychotic susceptibility, especially in those with a history of developmental disadvantages and psychosocial stress.

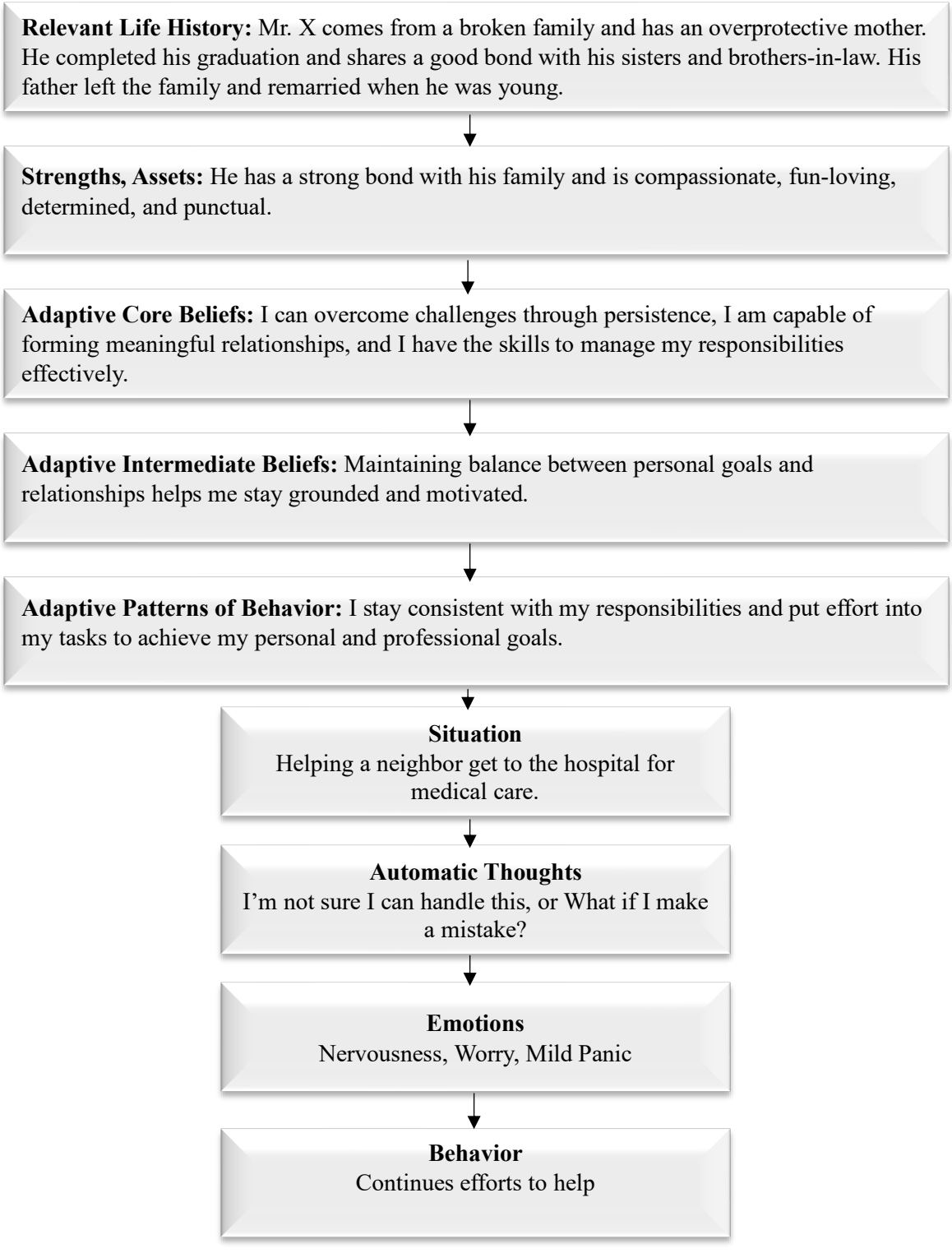
Idiosyncratic Model of CBT (Beck, 1976; Persons, 1989)



Garety Model of Psychosis (Garety & Freeman, 2001)



Strength based Model (SB-CCD) (Padesky & Mooney, 2012)



Therapeutic Interventions

The quality of life of Mr. X was still impaired by persistent problems in emotional regulation, social withdrawal, maladaptive thinking patterns, and daily functioning, even with the continued pharmacological treatment of psychotic symptoms. An intervention plan was created, which included Cognitive Behavioral Therapy (CBT), Medication Adherence, Relaxation Techniques, Psychoeducation, and Relapse Prevention (Beck, 1976; Beck, 2011; Morrison et al., 2011).

Psychoeducation was provided to both the client and his mother about substance induced psychosis, early warning signs of relapse, stress management techniques and the need to maintain consistent treatment and family support to maintain recovery (Zubin and Spring, 1977; Mueser et al., 2003). Particular care was taken to make the mother realize how paternal rejection, overprotective and overbearing maternal attitude, and social seclusion led to the psychological vulnerability and the use of substances by the client (Bowlby, 1982; Parker, 1983). The intervention would establish a therapeutic environment that would support recovery and long-term functional improvement by raising awareness and supporting more balanced and supportive family interactions.

Insight into illness, ambivalence to pharmacological treatment and the risk of relapse due to continued tobacco use were enhanced by medication adherence therapy and motivational interviewing (Miller and Rollnick, 2013; Kemp et al., 1996). Methods focused on the interrelation between psychotic symptom exacerbation and substance use (Mueser et al., 2003).

Client was assisted in recognizing and changing maladaptive beliefs that caused anger, mistrust, abandonment, and low self-worth using cognitive restructuring techniques such as the ABC model, thoughts create feelings, and the Triple Column Technique (Beck, 1976; Beck, 2011). These strategies aimed at negative schemas that were developed as a result of early paternal abandonment and maternal overprotection (Young et al., 2003). Further attention was paid to beliefs related to hallucinations, which allowed him to distinguish between reality and perceptual distortions, dispute external attributions of voices, and minimize emotional distress caused by auditory hallucinations (Morrison et al., 2011; Chadwick et al., 1996).

The inactivity, lethargy, and social withdrawal were treated with behavioral strategies including graded task assignment, mastery and pleasure techniques, and activity scheduling (Beck et al., 1979). The purpose of these interventions was to promote involvement in everyday activities, motivation, and social functioning. The exposure-based strategies were slowly implemented to minimize the avoidance behaviors related to social anxiety and dependence on his mother (Hofmann et al., 2012).

Deep breathing, progressive muscle relaxation, and guided imagery were also implemented as relaxation methods to assist in controlling irritability, physiological arousal, and agitated periods (Jacobson, 1938; Bernstein et al., 2000). Emotional regulation was strengthened to help him deal with the triggers associated with paternal abandonment and the constant stressors (Gross, 2015).

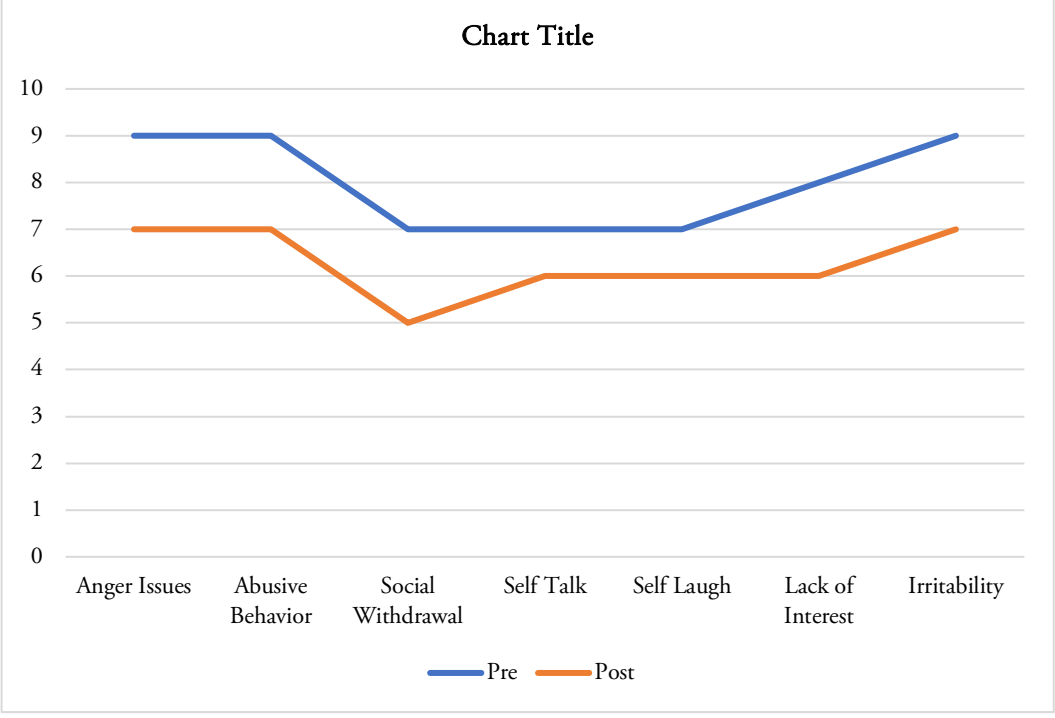
The interventions were designed to deal with the hallucinations, self-talk, and self-laughter of the client with the help of reality testing, coping statements, and grounding techniques (Chadwick et al., 1996; Morrison et al., 2011). Emphasis was put on enhancing adaptive coping mechanisms to decrease the use of tobacco as a maladaptive mechanism of coping with stress and emotional distress to promote better symptom management and overall functioning (Mueser et al., 2003).

Outcome

The intervention program was implemented within a period of about six weeks, which included fifteen formal sessions. After the intervention, Mr. X noted that his anger, irritability, social withdrawal, and self-talk and hallucinations frequency improved. Positive changes in emotional regulation, social engagement, and daily functioning were also indicated by informal observations of the therapist, the staff, and the family members. Subjective ratings after intervention showed a significant decrease in perceived severity of symptoms as compared to pre-intervention ratings.

Figure 1

Figure showing Comparison of Pre and Post Management Subjective Ratings of the Client's Symptoms



Conclusion

The case study points to the key role of early attachment disruptions in determining long-term substance use and psychotic symptoms. Lack of paternity and unreliable caregiving by the client contributed to anxious attachment, maladaptive core beliefs, and emotional dependence. Lack of coping skills also caused him to develop tobacco as a composite process of self-comforting, and the overprotective family situation supported reliance and impaired independence. The combined effects of these attachment related vulnerabilities ensured a loop of distress, drug use and worsening of psychotic symptoms leading to repeated psychiatric hospitalizations in 15 years.

An important part of the intervention was psychoeducating the mother of the client on her overprotective and overbearing nature, which probably led to the psychological distress and maladaptive coping of the client by using substances. The home environment of the client was made more conducive to recovery by raising her awareness and encouraging more supportive and balanced parenting strategies. The results show that dysfunctional family relationships may worsen substance use and psychotic symptoms, and that psychoeducation can be used to reduce these impacts. The multi-pronged nature of the intervention, which included Cognitive Behavioral Therapy, family involvement, and sustainability in the long term, made sure that the improvements were not only immediate but also long-term. On the whole, this piece of work indicates the significance of developmentally informed, family-centered interventions and demonstrates how cautious clinical practice can have a significant effect even in a single case.

Maladaptive family dynamics, early attachment disturbances and negative childhood experiences are risk factors contributing to substance induced psychosis, and this is why early assessment and intervention are essential. Psychotic episodes may be triggered by substance use and thus they need integrated care that includes mental health and substance use. Interventions that are family centered, developmentally informed provide better treatment adherence, functional recovery and gains that are sustainable. Cognitive Behavioral Therapy has been found to be effective in symptom reduction and functioning improvement particularly when applied with systemic family interventions.

These observations are especially applicable in Pakistan, where the prevalence of substance use indicates the clinical issues that are evident in this case. Recent national statistics indicate that more than 23 percent of adults consume tobacco products, and the average number of cigarette sticks smoked per day is 10-15 sticks per user, which is also reflected in the client and demonstrates the threat of psychiatric complications in the long term in case of chronic tobacco use (World Health Organization, 2015). The prevalence of tobacco and illegal drugs is evidenced by the fact that over 9,280 kilograms (approximately 9.3 metric tons) of illicit drugs were seized and dozens of traffickers were arrested in coordinated actions across multiple regions of the country (Anti-Narcotics Force Pakistan, n.d.). These statistics indicate that tobacco use by client is a component of a broader social trend, which supports the significance of multifaceted, family-focused, and developmentally sensitive interventions to reduce not only substance use but also psychotic symptoms.

Implications

- The results of the current case study indicate the significance of healthier attachment figures during a formative stage of childhood, a healthy parental relationship, and the existence of healthy coping strategies to address emotion regulation.
- Another important lesson of the case study is the dangers of prolonged substance use that exposes an individual to ongoing recovery and relapse.
- The case study also brings out the contribution of at least one enabler, which is mostly a family, to the addiction related behavior of an addict.
- The case study can be applied to the development of management plans of other clients with mental health issues, particularly addiction related and it's comorbid disorders.

Suggestions

- Follow-up and ongoing intervention are also recommended and should be supported by training other clinicians to make it sustainable.
- Frequent interruptions of the sessions by the environment underscore the importance of having distraction-free, well-outfitted therapy rooms to maximize results.

References

ANF || Anti-Narcotics Force Pakistan. (n.d.). https://www.anf.gov.pk/press_release.php

APA. (2022). *Diagnostic and Statistical Manual of Mental Disorders.*

Avcı, M. (2025). Adolescents' experiences with substance use: risks, protective factors and interventions. *BMC Psychology*, *13*(1), 802. https://doi.org/10.1186/s40359-025-03125-w

Beck, A. T. (1976). *Cognitive therapy and the emotional disorders.* International Universities Press.

Beck, A. T. (1979). Cognitive therapy and the emotional disorders. *In Internet Archive. New York : Meridian Book. https://archive.org/details/cognitivetherapy0000beck_e3y7*

Beck, A. T., & Haigh, E. A. (2014). Advances in Cognitive Theory and Therapy: The Generic Cognitive Model. *Annual Review of Clinical Psychology*, *10*(1), 1–24. https://doi.org/10.1146/annurev-clinpsy-032813-153734

Beck, J. S. (2011). Cognitive behavior therapy: Basics and beyond, 2nd ed. *Book*. http://psycnet.apa.org/record/2011-22098-000

Bentall, R. P., De Sousa, P., Varese, F., Wickham, S., Sitko, K., Haarmans, M., & Read, J. (2014). From adversity to psychosis: pathways and mechanisms from specific adversities to specific symptoms. *Social Psychiatry and Psychiatric Epidemiology*, *49*(7), 1011–1022. https://doi.org/10.1007/s00127-014-0914-0

Bernstein, D. A., Borkovec, T. D., & Hazlett-Stevens, H. (2000). *New directions in progressive relaxation training: A guidebook for helping professionals.* Praeger.

Bowlby, J. (1982). *Attachment and loss: Vol. 1. Attachment; Vol. 3. Loss* (2nd ed.). Basic Books.

Chadwick, P., Birchwood, M. J., & Trower, P. (1996). *Cognitive therapy for delusions, voices and paranoia*. John Wiley & Sons.

Flinn, A., Hefferman-Clarke, R., Parker, S., Allsopp, K., Zhou, L., Begemann, M., Bentall, R., & Varese, F. (2025). Cumulative exposure to childhood adversity and risk of adult psychosis: a dose–response meta-analysis. *Psychological Medicine*, *55*, e162. https://doi.org/10.1017/s0033291725001138

Garety, P. A., Kuipers, E., Fowler, D., Freeman, D., & Bebbington, P. E. (2001). A cognitive model of the positive symptoms of psychosis. *Psychological Medicine*, *31*(2), 189–195. https://doi.org/10.1017/s0033291701003312

Gross, J. J. (2015). Emotion Regulation: Current status and future Prospects. *Psychological Inquiry*, *26*(1), 1–26. https://doi.org/10.1080/1047840x.2014.940781

Gurillo, P., Jauhar, S., Murray, R. M., & MacCabe, J. H. (2015). Does tobacco use cause psychosis? Systematic review and meta-analysis. *The Lancet Psychiatry*, *2*(8), 718–725. https://doi.org/10.1016/s2215-0366(15)00152-2

Han, B., Aung, T. W., Volkow, N. D., Silveira, M. L., Kimmel, H. L., Blanco, C., & Compton, W. M. (2023). Tobacco use, nicotine dependence, and cessation methods in US adults with psychosis. *JAMA Network Open*, *6*(3), e234995. https://doi.org/10.1001/jamanetworkopen.2023.4995

Hofmann, S. G., Asnaani, A., Vonk, I. J. J., Sawyer, A. T., & Fang, A. (2012). The Efficacy of Cognitive Behavioral therapy: A review of Meta-analyses. *Cognitive Therapy and Research*, *36*(5), 427–440. https://doi.org/10.1007/s10608-012-9476-1

Hogue, A., Becker, S. J., Wenzel, K., Henderson, C. E., Bobek, M., Levy, S., & Fishman, M. (2021). Family involvement in treatment and recovery for substance use disorders among transition-age youth: Research bedrocks and opportunities. *Journal of Substance Abuse Treatment*, *129*, 108402. https://doi.org/10.1016/j.jsat.2021.108402

Hunter, A., Murray, R., Asher, L., & Leonardi-Bee, J. (2018). The effects of tobacco smoking, and prenatal tobacco smoke exposure, on risk of schizophrenia: A Systematic Review and Meta-Analysis. *Nicotine & Tobacco Research*, *22*(1), 3–10. https://doi.org/10.1093/ntr/nty160

Jacobson, E. (1938). *Progressive relaxation.* University of Chicago Press.

Kay, S. R., Fiszbein, A., & Opler, L. A. (1987). The Positive and Negative Syndrome Scale (PANSS) for schizophrenia. *Schizophrenia Bulletin*, *13*(2), 261–276. https://doi.org/10.1093/schbul/13.2.261

Kemp, R., Hayward, P., Applewhaite, G., Everitt, B., & David, A. (1996). Compliance therapy in psychotic patients: randomised controlled trial. *BMJ*, *312*(7027), 345–349. https://doi.org/10.1136/bmj.312.7027.345

Ma, K. (2006). Attachment theory in adult psychiatry. Part 1: Conceptualisations, measurement and clinical research findings. *Advances in Psychiatric Treatment*, *12*(6), 440–449. https://doi.org/10.1192/apt.12.6.440

McCrory, E., De Brito, S. A., & Viding, E. (2011). The Impact of Childhood Maltreatment: A review of neurobiological and genetic factors. *Frontiers in Psychiatry*, *2*, 48. https://doi.org/10.3389/fpsyt.2011.00048

Migalova, E., Furstova, J., Hasto, J., Tavel, P., & Kascakova, N. (2025). The link of adverse childhood experiences and attachment to maladaptive personality traits in adults diagnosed with substance use disorder. *BMC Psychology*, *13*(1), 974. https://doi.org/10.1186/s40359-025-03331-6

Miller, W. R., & Rollnick, S. (2013). *Motivational interviewing: helping people change*.

Morrison, A. P., Hutton, P., Wardle, M., Spencer, H., Barratt, S., Brabban, A., Callcott, P., Christodoulides, T., Dudley, R., French, P., Lumley, V., Tai, S. J., & Turkington, D. (2011). Cognitive therapy for people with a schizophrenia spectrum diagnosis not taking antipsychotic medication: an exploratory trial. *Psychological Medicine*, *42*(5), 1049–1056. https://doi.org/10.1017/s0033291711001899

Mueser, K. T., Noordsy, D. L., Drake, R. E., Fox, L., & Barlow, D. H. (2003). *Integrated Treatment for Dual Disorders: A Guide to Effective practice*.

Mustonen, A., Niemelä, S., McGrath, J. J., Murray, G. K., Nordström, T., Mäki, P., Miettunen, J., & Scott, J. G. (2018). Adolescent inhalant use and psychosis risk – a prospective longitudinal study. *Schizophrenia Research*, *201*, 360–366. https://doi.org/10.1016/j.schres.2018.05.013

Overall, J. E., & Gorham, D. R. (1962). The brief Psychiatric rating scale. *Psychological Reports*, *10*(3), 799–812. https://doi.org/10.2466/pr0.1962.10.3.799

Padesky, C. A., & Mooney, K. A. (2012). Strengths-Based Cognitive–Behavioural therapy: A Four-Step model to build resilience. *Clinical Psychology & Psychotherapy*, *19*(4), 283–290. https://doi.org/10.1002/cpp.1795

Parker, G. (1983). *Parental overprotection: A risk factor in psychosocial development.* Grune & Stratton.

Persons, J. B. (1989). *Cognitive Therapy in Practice: A Case Formulation approach.*

Psychosis risk is 2-3 times greater in those with major childhood adversities, study Finds | Brain & Behavior Research Foundation. (2025, July 10). Bbrfoundation. https://bbrfoundation.org/content/psychosis-risk-2-3-times-greater-those-major-childhood-adversities-study-finds

Quigley, H., & MacCabe, J. H. (2019). The relationship between nicotine and psychosis. *Therapeutic Advances in Psychopharmacology*, *9*, 2045125319859969. https://doi.org/10.1177/2045125319859969

Read, J., Fosse, R., Moskowitz, A., & Perry, B. (2014). The traumagenic neurodevelopmental model of psychosis revisited. *Neuropsychiatry*, *4*(1), 65–79. https://doi.org/10.2217/npy.13.89

Read, J., Van Os, J., Morrison, A. P., & Ross, C. A. (2005). Childhood trauma, psychosis and schizophrenia: a literature review with theoretical and clinical implications. *Acta Psychiatrica Scandinavica*, *112*(5), 330–350. https://doi.org/10.1111/j.1600-0447.2005.00634.x

Ricci, V., Martinotti, G., & Maina, G. (2024). Substance-Induced Psychosis: diagnostic challenges and phenomenological insights. *Psychiatry International*, *5*(4), 759–772. https://doi.org/10.3390/psychiatryint5040052

Schindler, A. (2019). Attachment and Substance Use Disorders—Theoretical models, Empirical evidence, and Implications for Treatment. *Frontiers in Psychiatry*, *10*, 727. https://doi.org/10.3389/fpsyt.2019.00727

Schindler, A., Thomasius, R., Sack, P., Gemeinhardt, B., KÜStner, U., & Eckert, J. (2005). Attachment and substance use disorders: A review of the literature and a study in drug dependent adolescents. *Attachment & Human Development*, *7*(3), 207–228. https://doi.org/10.1080/14616730500173918

Umar, M., Mustajab, M., Fatima, Z., Richard, R. M., Qureshi, S. R., Muneer, S. U., Shamim, L., Ahmed, S., Hashim, H. T., & Basalilah, A. F. M. (2025). The impact of adverse childhood experiences in the development of post-traumatic stress disorder in adults over 18 years of age: a systematic review. *BMC Psychiatry*, *25*(1), 759. https://doi.org/10.1186/s12888-025-07090-x

Varese, F., Smeets, F., Drukker, M., Lieverse, R., Lataster, T., Viechtbauer, W., Read, J., Van Os, J., & Bentall, R. P. (2012). Childhood adversities Increase the risk of Psychosis: A Meta-analysis of Patient-Control, Prospective- and Cross-sectional Cohort Studies. *Schizophrenia Bulletin*, *38*(4), 661–671. https://doi.org/10.1093/schbul/sbs050

World Health Organization. (2015). *Global Adult Tobacco Survey (GATS) Pakistan 2014: Executive summary* [PDF]. World Health Organization.

Xi, C., Xu, X., & Wang, S. (2025). Predicting psychotic-like experiences among adolescents: the interplay of childhood trauma, cognitive biases, neuroticism, and depression. *Child and Adolescent Psychiatry and Mental Health*, *19*(1), 20. https://doi.org/10.1186/s13034-025-00878-5

Yao, B., Hall, M., Tusuzian, E., Cohen, B., Öngür, D., & Chouinard, V. (2025). Childhood adverse events and their association with psychotic symptoms and quality of life in young adults with first episode psychosis and unaffected siblings. *Schizophrenia Research*, *283*, 137–143. https://doi.org/10.1016/j.schres.2025.07.006

Young, J. E., Klosko, J. S., & Weishaar, M. E. (2003). *Schema therapy: A practitioner's guide.* Guilford Press.

Zubin, J., & Spring, B. (1977). Vulnerability: A new view of schizophrenia. *Journal of Abnormal Psychology*, *86*(2), 103–126. https://doi.org/10.1037/0021-843x.86.2.103