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Francis Kobina Nkrumah
https://orcid.org/0009-0007-6790-023X
MA in Clinical Mental Health Counseling
Ph.D. Candidate in Counselor Education and Supervision,
School of Psychology and Counseling, Regent University,
100 Regent University Drive, Virginia Beach, VA 23464, USA
frannkr@mail.regent.edu

Olya Zaporozhets
https://orcid.org/0000-0003-3206-7464
Ph.D. in Counseling Education and Supervision, Associate Professor,
The School of Psychology and Counseling, Regent University,
100 Regent University Drive, Virginia Beach, VA 23464, USA
ozaporozhets@regent.edu

EFFECTIVENESS OF COGNITIVE BEHAVIOR THERAPY IN TREATING STUDENTS' ADDICTIONS: APPLICATION IN UKRAINE DURING WARTIME

Substance use disorders (SUDs) remain a pressing global public health challenge, with students constituting a particularly vulnerable group due to academic stress, social influence, and limited access to mental health services. In Ukraine, these challenges have been magnified by the ongoing war, which has disrupted healthcare infrastructure, displaced populations, and heightened psychological distress. This narrative review synthesizes current evidence on the effectiveness of cognitive behavior therapy (CBT) for treating alcohol and other drug use disorders among higher education students, in resource-limited and unstable contexts such as wartime Ukraine. CBT interventions, including motivational enhancement, contingency management, relapse prevention, cognitive restructuring, and skills training, have consistently demonstrated positive outcomes in promoting abstinence, reducing cravings, and improving psychosocial functioning. However, implementation in Ukraine is hindered by barriers such as limited infrastructure, shortages of trained professionals, and persistent stigma surrounding addiction and mental health care. A case example is presented illustrating the application of CBT with a Ukrainian university student struggling with alcohol dependence amid wartime. The case highlights the role of identifying cognitive distortions/irrational beliefs, developing robust coping strategies, and strengthening social support to sustain recovery. The paper concludes with recommendations for culturally adapting and scaling CBT interventions in Ukraine, emphasizing workforce development, the integration of motivational interviewing, digital delivery of therapy, and systemic support to ensure sustainability and accessibility for students affected by war-related stressors. The review concludes with recommendations for culturally adapting and scaling CBT interventions in Ukraine, emphasizing the need for workforce development, integrating motivational interviewing strategies, and providing systemic support for the sustainable implementation of interventions and accessibility for students affected by war-related stressors.

Keywords: *cognitive behavior therapy, cognitive reappraisal, cognitive restructuring, motivational enhancement, motivational intervention, skills training, relapse prevention, students.*

INTRODUCTION

Armed conflict disrupts daily routines and health systems, escalating the risk for hazardous alcohol and other drug (AOD) use while disrupting continuity of care. In such contexts, the need for scalable, skills-based psychosocial treatments expands precisely as access to services contracts. Cognitive behavior therapy (CBT), an evidence-based modality studied for AOD, targets learned associations, cognitive appraisals, and reinforcement contingencies, with demonstrable and durable

benefits across diverse settings (Carroll & Kiluk, 2017; Magill et al., 2023). However, the feasibility and clinical impact of CBT in ongoing conflict-related conditions, such as in the case of Ukraine, where displacement and intermittent service access pose persistent challenges, remain underdescribed (Pfeiffer et al., 2025; Kurapov et al., 2025).

CBT is established on the premise that maladaptive behaviors, such as substance use, are learned responses to internal and external triggers, which can be unlearned through structured interventions that teach individuals to identify distorted thoughts, develop coping skills, and replace maladaptive behaviors with adaptive behaviors (Beck et al., 1979). This makes CBT a highly suitable modality for addressing substance use and addiction during wartime, when civilians, armed personnel, and veterans experience increased stress, trauma, and disrupted social networks. CBT is considered one of the highest levels of evidence-based treatment for drug and alcohol use disorders (Carroll & Kiluk, 2017; U.S. Department of Health and Human Services, 2016), lending itself to the Ukrainian context.

Since 2014, the protracted Russian-Ukrainian war, which has intensified in recent years, has been associated with heightened mental health concerns (such as anxiety, depression, and trauma-related disorders) and constrained service access, including gaps in coverage of evidence-based treatments (Goto et al., 2024; Martsenkovskyi et al., 2024; Seleznova et al., 2023). Internally displaced persons and conflict-affected populations in Ukraine face increased risk of hazardous alcohol use and substance misuse due to trauma, displacement, and disrupted health services, despite critical gaps in treatment access during the war (Bogdanov et al., 2025; Pinchuk et al., 2022; WHO Ukraine, 2024). These conditions strengthened the case for modular, skills-focused approaches, such as cognitive behavior therapy, particularly among internally displaced populations (Carroll & Kiluk, 2017; Magill et al., 2023).

Global indicators reveal a sustained rise in drug use over the past decade, underscoring the importance of evidence-based responses (World Drug Report, [UNODC], 2021, 2023). In Ukraine specifically, recent national data likewise show high lifetime and past-year drug use rates, with cannabis, MDMA/ecstasy, hallucinogens, amphetamines, and cocaine being most common explained by motives such as experimentation, stress reduction, and recreation amidst instability (Institute of Psychiatry, Forensic Psychiatric Examination and Drug Monitoring of the Ministry of Health of Ukraine, 2023). Meta-analytic evidence indicates elevated alcohol-use-disorder risk among deployed veterans' relative to non-deployed comparison groups (Kelsall et al., 2015). Alcohol-attributable harm remains a considerable contributing factor to the national health burden, with trends of episodic drinking persisting, despite some decline in overall consumption (World Health Organization [WHO], 2018, 2024).

Despite the increased risk and consumption of AOD, many shy away from seeking treatment due to stigma (Quirke et al., 2021). O. Morozova et al. (2023) report that traditional treatment options, such as medication-assisted therapy for AOD, have faced significant challenges due to the disruption of infrastructure and manufacturing facilities, leading to increased relapse and withdrawal issues. Consequently, there is a critical need for effective psychosocial interventions like CBT that can be delivered flexibly and at scale, supplementing or replacing medication management when supplies are interrupted. CBT offers practical advantages in different settings due to its structured, time-limited, and goal-oriented nature, making it adaptable to resource-constrained environments. CBT interventions are modular (including motivational enhancement, coping skills training, relapse prevention, cognitive restructuring, and contingency management), enabling clinicians to sequence assessment, treatment components, and client engagement tailored to individual client needs while integrating culturally responsive practices (McHugh et al., 2010; Magill et al., 2023). K. Carroll and B. Kiluk (2017) noted in their study that CBT is not stagnant, but a constantly evolving intervention with the capacity to refine itself until it produces an optimal, powerful intervention that addresses addictions.

Historically, CBT has evolved through three waves of development. The first wave highlights classical and operant conditioning principles, emphasizing behavioral modification (Hayes, 2004; Hayes & Hofmann, 2017). The second wave involved integrating social-cognitive principles, as outlined in the

works of A. Bandura (1969), A. Ellis (1990), and A. Beck (1993), who emphasized the role of thoughts and beliefs in maintaining addictive behaviors. The third wave involved the extended integration of relational and humanistic, as well as spiritual and meditation practices, including but not limited to Acceptance and Commitment Therapy (ACT), Dialectical Behavior Therapy (DBT), and Mindfulness-Based Relapse Prevention (MBRP) (Hayes, 2004; Hayes et al., 2006; Witkiewitz et al., 2005). CBT has emerged with a distinctive feature of having relative durability, marked by significant treatment outcomes through follow-ups and notable improvement after treatment (Carroll & Kiluk, 2017). In an armed conflict setting like Ukraine, with intermittent service interruptions, modules can be delivered in brief formats to continue skill rehearsal even during displacement and service interruptions, using tele-CBT or phone-based approaches to enhance coping strategies (Carroll & Kiluk, 2017; Magill et al., 2023).

Various studies have focused on providing statistical information on the impact of war exposure and substance use, and perhaps medication management. However, little is known about effective modalities that counselors can use to manage substance use concerns, particularly in wartime. These patterns, combined with conflict-related service disruptions, highlight a persistent treatment-access gap and a sustained need for scalable psychosocial care (Martsenkovskyi et al., 2024; Seleznova et al., 2023; WHO/Europe, 2024, 2025). In a wartime zone, such as Ukraine, utilizing an effective, scalable, skills-based psychosocial treatment, like CBT interventions, is crucial since it can be delivered in a brief, interrupted, and resumed format, despite displacement, transportation barriers, and intermittent, disruptive access to service provision. Telehealth adaptations, including video or phone-based sessions, facilitate continuity of care even during periods of active conflict. For displaced populations, CBT's emphasis on skills acquisition, such as craving management, refusal skills, and mood regulation, helps clients regain a sense of control and resilience in the face of chaos. These features make CBT not only effective for reducing substance use but also for addressing co-occurring mental health challenges such as post-traumatic stress and depression, which frequently intersect with addiction in war-affected populations (Stotts & Northrup, 2015).

Building upon a robust evidence base, CBT can play a key role in Ukraine's public health response to substance use disorders, especially in wartime. This narrative review synthesizes key components of CBT for AOD treatment and examines how these interventions can be culturally adapted and scaled for the Ukrainian context. It further highlights flexible strategies that can be delivered in intermittent service access and ongoing displacement, aiming for a culturally adaptive modality for addressing the dual challenges of addiction and trauma during wartime.

Purpose and Aim. This narrative review supports the implementation of CBT for alcohol and other drugs in Ukraine by synthesizing relevant empirical evidence and translating it into context-specific guidance. CBT implementation in Ukraine is constrained by limited mental health infrastructure, workforce shortages, stigma, and low public awareness (Quirke et al., 2021). We summarized CBT components with the strongest empirical support for AOD, mapped key Ukrainian implementation barriers to practical delivery adaptations (e.g., brief modular formats, tele-CBT, supervision, and fidelity support), and identified research and service gaps to inform scale-up.

METHOD AND MATERIALS

Design and scope. This paper provides an overview of evidence-based support for implementing cognitive behavior therapy. We conducted a narrative review focused on CBT for alcohol and other drugs, specifically in unstable or resource-limited contexts. Sources were identified through an iterative database search (including PsycINFO, PubMed, and Google Scholar), as well as backward citation tracking of key reviews published between 1989 and 2025. Combined CBT-related keywords (e.g., "cognitive behavior therapy", "coping skills," "relapse prevention") paired with AOD terms (e.g., "alcohol," "substance use" and context terms (e.g., "conflict," "war," "wartime Ukraine") were used to

identify the literature. The inclusion criteria emphasized peer-reviewed studies, meta-analyses, manuals, and implementation reports that addressed CBT components and outcomes for AOD.

Extraction and synthesis. We summarize the intervention components (functional analysis, coping skills, relapse prevention, outcome (abstinence, use frequency, craving), and effect sizes where available, noting heterogeneity and follow-up durability. Where conflict-setting data were limited or non-existent, we derived practice inferences from feasibility reports to guide implementation.

The narrative review did not employ a formal risk-of-bias rating or meta-analytic pooling, given the scope and heterogeneity of the study. The search approach, eligibility criteria, and synthesis procedures are described to support transparency and reproducibility.

RESEARCH RESULTS

Cognitive behavior therapy interventions. Cognitive behavior therapy (CBT) is a well-established evidence-based intervention for alcohol and other drug (AOD) use, with its modular structure offering flexibility for adaptation to individual needs and treatment context (McHugh et al., 2010; Magill et al., 2023). There are various forms of CBT treatments, including motivational interventions, contingency management, and relapse prevention (Magill et al., 2023). CBT is a well-established, evidence-based intervention for psychotic and substance use disorders. However, its effective implementation is often impeded by limited access to high-quality training, adequate supervision, and formal certification systems in many clinical settings (Carroll & Kiluk, 2017).

Table 1

Techniques Used in CBT for Alcohol and Other Drug Treatment Phase

Technique	Description
Assessment and Engagement	
Treatment Rationale	Provide psychoeducation on the cognitive-behavioral approach, explaining the relationship between thoughts, feelings, and behaviors, as well as modalities for treatment (e.g., the use of experiential exercises and extra-session activities).
Motivational Enhancement	Build rapport, explore presenting problems, and assess the client's readiness for treatment.
Goal Setting/Contracting	Collaborate with the client to identify treatment goals that align with cognitive behavior therapy, based on the client's goals. Mutually develop a structured treatment plan based on the goals.
Functional Analysis/Analysis of High-Risk Situations	Conduct a personalized assessment of substance use context, exploring thoughts, feelings, behaviors associated with the use or non-use, and the consequences of such behaviors.
Coping Skills Training	
Goal Setting/Contracting	Collaborate with the client to identify goals that align with the cognitive behavior therapy based on the presenting problems. Mutually develop a structured treatment plan based on the goals.
Self-Monitoring	Ensure ongoing application of the situation-thought-behavior framework to facilitate self-awareness on triggers and risks linked to substance use behaviors through self-monitoring. A comparable CBT model can be used.
Coping with	Educate and guide the client to recognize situations or triggers that lead to cravings or urges. Guide the client to explore and practice

Craving/Urges/Thoughts about Use	various coping strategies to replace the cravings/urges. Reinforce implementation of the coping strategies outside of therapy.
Substance Refusal Skills/ Communication Skills	Guide the client to explore situations where he or she can refuse alcohol or other drugs, including communication and assertive skills against interpersonal triggers.
Mood Management	Guide the client in determining personally relevant emotional states that can act as intrapersonal triggers for alcohol and other drug use. Assist the client in practicing evidence-based coping strategies such as thought-stopping, cognitive restructuring, and physical exercises.
Positive Lifestyle Enhancement	Explore a variety of rewarding activities that can compensate for substance use behaviors. Intentionally plan the activities between sessions. Review their effectiveness, highlighting positive outcomes and potential for ongoing use.
Planning and Maintenance	
Relapse Prevention	Establish goal maintenance and relapse prevention when the client achieves their goal(s). Provide psychoeducation on relapse and lapse. Equip the client on how to respond and recover when a relapse or lapse occurs.
Social Supports	Explore and identify the client's support network that can be included in the relapse prevention plan.

Source: Adopted from M. Magill et al., 2023.

Contingency intervention. The administration of non-drug reinforcers has its roots in operant learning theory. It sometimes uses stable or escalating reinforcement schedules with a positive relationship whereby the value of the reinforcer increases as the duration of abstinence increases. Though contingency management produces better results as treatment progresses, it has a higher potential for abstinence when combined with CBT during the follow-up period (Petitjean et al., 2014).

Relapse Prevention. This is a CBT treatment that targets the identification and prevention of high-risk environments that are likely to entice an individual to re-engage in substance use. CBT variants such as Dialectical Behavior Therapy (Linehan, 1993), Acceptance and Commitment Therapy (Hayes et al., 2006), and Mindfulness-Based Relapse Prevention (Bowen et al., 2009) are useful for treating mental and substance use disorders by applying the processes of mindfulness, acceptance, and values. In reducing or eliminating addictive behaviors, acceptance, and emotional regulation equip individuals to live with distressed situations, thereby decreasing overwhelming emotions. In contrast, mindfulness increases awareness of triggers and consequences of drug use and gives a reason to value and live a meaningful life (Stotts & Northrup, 2015).

Cognitive restructuring. The term "cognitive restructuring" encapsulates the structured therapeutic process within Cognitive Therapy (CT). It involves a collaborative approach wherein individuals experiencing distress are taught to identify, assess, and modify their faulty thoughts, evaluations, and beliefs, which are seen as contributors to their psychological disturbances (Burns & Beck, 1978; Dobson & Dozois, 2010; Hollon & Dimidjian, 2009).

A. T. Beck et al. (1979) in their pioneering treatment manual, outlined several key interventions integral to inducing cognitive change, including thought self-monitoring, reality testing, external reattribution, gathering evidence, assessing consequences, conducting cost-benefit analyses, generating alternatives, and implementing behavioral assignments. These techniques collectively facilitate the process of identifying and challenging maladaptive thinking patterns, leading to cognitive restructuring and more adaptive beliefs and behaviors (Harvey & Gumport, 2015; Olmstead et al., 2012).

Table 2

Verbal Intervention Strategies Employed in Cognitive Restructuring

Intervention strategy	Description
Evidence gathering	Obtaining schema-congruent and incongruent evidence from the client's past and current experience that enables a more balanced evaluation of schematic content.
Consequential analysis	Examining the immediate and long-term costs and benefits of continued acceptance of the maladaptive belief.
Cognitive identification	Training clients in greater awareness of the cognitive biases that operate when processing schema-relevant information (e.g., dichotomous thinking, catastrophizing, mind reading, magnification/minimization, etc.).
Generate alternative	Formulating a more adaptive conceptualization of the self or some aspect of personal experience that more accurately represents external contingencies and enhances the client's functional adaptation.
Normalization	Reconceptualizing unwanted thoughts, feelings, and behavior as deviations from normal human experience in order to encourage greater acceptance and confidence in dealing with schema-related subjective experience.
Decatastrophizing	Developing a hypothetical account of a worst-case scenario, evaluating its realistic and probable effects on quality of life, and formulating a coping plan to deal with the catastrophe.
Problem-solving	Specifying a real-life problem, delineating the pros and cons of various responses to the problem, selecting a course of action, and evaluating the outcome.
Imaginal exposure	Guiding the client in repeatedly and systematically generating a schema-related unwanted intrusive thought, image, or emotion in order to enhance client self-efficacy in dealing with unacceptable emotions.
Distancing	Teaching clients to take a "third party" or observer stance to their unwanted thoughts and emotions; to react to their subjective experience as if it belonged to another person.
Reframing or perspective-taking	Focusing on current experience as a moment in time and situating it within a longer lifespan time frame or the totality of one's life experience.
Reattribution	Identifying the external or situational causes of the client's difficulties in order to address exaggerated internal attributions and self-blame.
Positive reorientation	Refocusing the client on positive, adaptive personal coping experiences that provide schema-incongruent information.

Source: Adopted from D. A. Clark, 2013.

Cognitive reappraisal. Cognitive reappraisal is a psychological strategy used to manage emotional responses by reinterpreting the meaning of a situation. It involves reframing one's thoughts about an event or experience in a way that alters its emotional impact. Rather than changing the situation itself, cognitive reappraisal focuses on changing the interpretation or perspective of the situation.

Skills training. B. Kiluk et al. (2010) found that computerized CBT's effect on abstinence from drugs was based on increased coping skills. Drink refusal training, an offshoot of CBT, was found to increase self-efficacy (Witkiewitz et al., 2012). The use of homework is effective in addiction treatment (Carroll et al., 2008; Gonzalez et al., 2006). D. Martignoni and T. Keil (2021) note that behaviors learned can be unlearned as the individual continues to try. CBT can help individuals unlearn maladaptive behaviors and learn adaptive ones.

Despite CBT's effectiveness in addiction treatment, moving it into all-embracing clinical practice has been a challenge (Emmelkamp et al., 2014; Harvey & Gumport, 2015), explained by the lack of training and certification, high training cost, differing viewpoint on standard protocols among researchers and practitioners, lack of evaluative tools, high turnover of clinicians in facilities (Harvey & Gumport, 2015; Hoffman et al., 2013; Olmstead et al., 2012). The underlying cases make a case for the effectiveness of CBT in the treatment of alcohol and other drug addiction presenting issues.

Effectiveness of Cognitive Behavior Therapy. K. Mehta et al. (2021) conducted a comprehensive meta-analysis reviewing 15 clinical trials across 18 study sites or arms. Their focus was on evaluating the effectiveness of integrated Cognitive-Behavioral Intervention (CBI) among individuals dealing with alcohol and other drug use alongside a co-occurring mental health disorder. This study aimed to assess the impact of CBI, when integrated into treatment plans, on this specific population. The analysis delved into various aspects, such as the efficacy of CBI in reducing substance use, improving mental health outcomes, or enhancing overall treatment effectiveness for this dual-diagnosis group. They found "a small but significant effect size (g = 0.0188 and 0.274, respectively) for integrated CBI versus a single-disorder intervention, but not for the addition of integrated CBI to usual community services." However, their research findings suggest that approximately 57–60% of individuals in integrated CBT had better outcomes compared to the mean outcomes observed in participants with single-disorder conditions. This contrasts with previous studies that could not find sufficient evidence supporting the superiority of integrated treatments over non-integrated treatments for psychiatric and substance use outcomes in co-occurring disorders (Torchalla et al., 2012). Their finding provides a nuanced advancement in favor of CBIs, especially in co-occurring disorders. The researcher's outcome of small but significant effect size, together with remarkable higher percentage of positive outcomes in integrated CBT, provides evidence-based support to the ongoing argument that integrated treatments may offer a slight edge over single-disorder approaches, challenging the previous study by I. Torchalla et al. (2012) that cast doubt on their efficacy.

K. Mehta et al. (2021) found that the efficacy appeared to plateau when integrated services were combined with existing community-based care. This suggests that while integrated treatments may be more effective than single-disorder approaches, there may be limitations to the additional benefit that can be gained by incorporating integrated services into established community-based care (Mehta et al., 2021). In line with substance use outcomes, the study noted nonsignificant treatment effects immediately after treatment but found significant effects at 3 to 6-month follow-ups for AOD outcomes using Hedges' g. The intervention showed a small effect on alcohol and other drug outcomes with Hedges' g values from -0.121 to 0.280, suggesting minimal to moderate changes in substance use, with some indicators exhibiting a slight decrease and other minimal improvement. Comparatively, mental health disorder outcomes were relatively stable during the study, with consistent effect sizes of 0.100 to 0.119, indicating little to no clinical significance in change.

There was an increase in effect size over time for substance use outcomes, suggesting that skills learned during treatment might continue to influence behavior post-treatment, known as a 'sleeper effect.' In contrast to substance use outcomes, the effects on MHD outcomes remained relatively stable over time. While the study did not observe the same 'sleeper effect' as seen in substance use outcomes, there was an indication of the need for targeted interventions to ensure the durability and maintenance of integrated CBI effects on MHD outcomes. The divergence in outcomes between substance use and mental health suggests the possibility that the skills learned during treatment might be more directly applicable or easier to sustain for maintaining abstinence and preventing relapse in substance use compared to managing mental health symptoms. However, the reasons behind this difference are unclear and require further investigation. The study's findings underscore the evolving definition of optimal outcomes for addiction treatment trials. It suggests the importance of continued research to better understand the dynamics of treatment effects over time and how they specifically impact different aspects of substance use and mental health.

A meta-analysis of 30 clinical trials examined in 2019 revealed similar results, except that the effect size for the active comparator studies was non-significant, with Kes = 17. The challenge lies in determining a clinically meaningful measure of CBT's effect due to the limited number of waitlist-controlled trials. These trials are essential as they help gauge the true impact of an intervention by comparing it against a period of no treatment or delayed treatment. The rarity of such trials complicates the assessment of CBT's effectiveness compared to other forms of treatment. Therefore, while there is robust evidence supporting CBT's efficacy compared to no treatment, attention-placebo, and usual care, accurately quantifying the strength of its effect and identifying the specific outcomes it most significantly impacts remains a complex task. The nuances of how much change can be expected relative to baseline and the precise domains or conditions where CBT exerts its most potent effects require further investigation and possibly more controlled studies to establish more definitive conclusions (Magill et al., 2019). In Project MATCH, a notable patient-to-treatment matching trial for alcohol use disorder in the US, the Cognitive behavior therapy (CBT) condition demonstrated substantial improvements in various outcome measures from baseline to the 15-month follow-up: Percentage of days abstinent showed the effect size for CBT as d = 1.46 (r = 0.59), indicating a significant and clinically meaningful improvement in the percentage of days abstinent from alcohol. This suggests that individuals undergoing CBT experienced a substantial increase in the number of days they abstained from drinking. Regarding the number of drinks per day, CBT also showed a significant effect with an effect size of d = 1.61 (r = 0.62) for reducing the number of drinks per drinking day. This indicates a clinically important reduction in the amount of alcohol consumed on drinking days for participants receiving CBT.

Additionally, the outcomes were categorized into abstinence rate, indicating that approximately 25% of participants in the outpatient arm and 48% of participants in the aftercare arm achieved abstinence from alcohol. Conversely, continued use without consequences revealed a smaller percentage of about 7% of participants in the outpatient settings and 14% of participants in the aftercare setting who continued to use alcohol without associated negative consequences (Magill et al., 2023). These findings suggest that CBT, as implemented in Project MATCH, was associated with significant improvements in alcohol-related outcomes. The high effect sizes and clinically meaningful changes in both abstinence rates and reduced alcohol consumption on drinking days underscore the efficacy of CBT in addressing alcohol use disorder over a longer duration (Project MATCH Research Group, 1997). The findings from the above research provide compelling evidence in support of the robust efficacy of CBT in treating alcohol use disorder. The observed large effect sizes in abstinence (d = 1.46) and a decrease in drinking quantity (d = 1.61) emphasize CBT's capacity to yield clinically significant behavioral change over time. It also affirms CBT's capability in promoting reliable abstinence and harm reduction. Additionally, CBT is adaptable to various treatment contexts, as evidenced by its use in outpatient and aftercare settings. This reveals CBT's ability as a tested, evidence-based treatment in assisting individuals with alcohol dependence.

Motivational interventions. Motivational interviewing (MI) is a therapeutic approach primarily used as a precursor or adjunct to Cognitive behavior therapy (CBT), rather than as a core CBT technique itself. At the initial stage of treatment, an individual's motivation for treatment ought to be considered. Motivational interviewing can enhance early engagement and readiness and then transition to CBT coping-skills work; combined approaches improve retention and may augment outcomes in some AOD populations (Carroll & Kiluk, 2017; McKee et al., 2007). Motivational interviewing is a strategy that targets ambivalent behavioral change toward drug and alcohol use (Miller & Rollnick, 2013), resulting in its application to varied disorders and behaviors that include increasing adherence to CBT for anxiety disorders (Merlo et al., 2009). Studies have revealed an effective combination of CBT and MI for varied drug abuses, marijuana (Babor, 2004), Amphetamines (Baker et al., 2005), methamphetamines (Bux & Irwin, 2006), and cocaine (McKee et al., 2007; Rohsenow et al., 2004).

MI seeks to enhance an individual's motivation to change behavior by exploring and resolving ambivalence. MI, in essence, concentrates on exploring and resolving ambivalence to initiate behavior change. It involves empathetic listening, reflective questioning, and guiding individuals toward resolving their ambivalence about change. CBT, on the other hand, focuses on identifying and modifying dysfunctional thoughts, beliefs, and behaviors that contribute to psychological distress. It includes techniques like cognitive restructuring, behavioral experiments, and problem-solving to bring about change. It is worth noting that sometimes aspects of MI, such as motivational enhancement, can be incorporated into CBT interventions. For instance, therapists might use MI techniques at the initial stages of therapy to increase a client's motivation to engage in and benefit from subsequent CBT interventions. This hybrid approach can help address resistance or ambivalence towards change before transitioning to CBT techniques for addressing specific cognitive or behavioral patterns. While motivational interventions are not core CBT techniques, they can complement CBT by facilitating a client's readiness and motivation to engage in the therapeutic process and make changes in their thoughts and behaviors.

CASE STUDY

Iryna is a 26-year-old lady living in Odessa, Ukraine. Iryna was born into a middle-class family. Iryna reports that her childhood was intact and supportive, and she enjoyed much love from her parents and siblings, who showed her much love. Despite that, Iryna experienced internal struggles with feelings of anxiety and low self-esteem growing up. At the age of 13, Iryna began experimenting with alcohol and marijuana to cope with the feelings and challenges of stress and social anxiety. Iryna is currently in college at one of the national universities in Odessa. Odessa has been heavily bombed due to the ongoing Russia-Ukraine war, which has affected the supply of basic utilities such as electricity and water. Iryna's boyfriend is currently serving on the warfront as a drafted soldier, and she is concerned about his safety. The Impact of the war, such as fear of the unknown, the safety of her boyfriend, and the challenges associated with college life during wartime, has increased Iryna's substance intake to cope with life issues. It was not long before Iryna was introduced to college party culture and recreational drug use. Iryna experienced heightened anxiety and feelings of inadequacy due to the high demands of classwork and presentations, coupled with the challenge of meeting new people. Iryna increased the use of alcohol, marijuana, cocaine, and prescription medication to manage her emotional pain and feelings of inadequacy. As a result, Iryna's daily consumption increased to 40g nearly every day, or under compulsive drinking with a high tolerance level. She has made constant efforts to cut down, but continues to experience relapse. She reports daily cannabis consumption, where she smokes 2–3 joints per day, with peaks during the evenings and weekends. She also uses MDMA about 2–3 times per month, mostly in social settings.

Despite noting academic decline, she self-reported making 3-4 serious attempts to decrease her cannabis use over the past six months, but, to no avail, explained by the influence of peers, difficulty sleeping without cannabis, and the need to reduce stress. She did not see concern for MDMA, but was quick to point out that its combined use with alcohol and cannabis increases her risk of dehydration and impaired judgment. The alcohol and drug use interfered with Iryna's personal, social, academic, and professional life, evidenced by poor academic performance, fractured relationships with her family and friends, explained by increasing isolation, frequent conflicts, and a lack of emotional support. She currently finds it challenging to maintain a job due to irregular attendance, decreased motivation, and difficulty managing tasks due to substance use. Iryna struggles to stay sober because of psychological and environmental triggers. Her friendship group is made up of peers who abuse substances. Occasionally, Iryna has made some attempts at breaking free from addiction. However, her attempt at staying sober had been short-lived for about 3 days due to constant exposure to environmental triggers. Iryna thinks that she cannot do without substances, as she is devastated and overwhelmed with emotional distress. Recently, she has shown markedly increased craving for alcohol and drugs when she is going

through stress and at social gatherings. The addictive behavior has impacted Iryna's physical and mental health, as she looks pale and often exhibits mood swings and cognitive impairment. Iryna has also experienced blackouts on multiple occasions. Recently, Iryna has expressed concern about the severity of her alcohol and drug addiction. Iryna came to see a psychotherapist to seek professional help in controlling her substance intake with a long-term goal of being sober.

The use of CBT

Identify Irrational Thoughts: Iryna may have irrational beliefs such as "I need alcohol and drugs to cope with stress and anxiety" or "I do not feel loved and respected without substance". These beliefs stimulate Iryna's addictive behavior and feelings of low self-esteem and inadequacy.

Iryna: I need alcohol and drugs to cope with stress and anxiety.

Therapist (Validate and normalize feeling): What I am hearing is that you feel like you need alcohol and drugs to cope with stress and anxiety. Given the many challenging lived experiences, it is understandable that you feel this way. You are not alone; other people resort to substances to numb or escape from overwhelming emotions temporarily. Indeed, your feelings are valid. Let us explore other healthier coping strategies together.

Guide Iryna to challenge negative beliefs: The therapist can work with Iryna to identify and challenge these negative beliefs by examining the evidence supporting them. For example, Iryna can reflect on instances where she was able to cope with stress and anxiety without using substances. Iryna can also think of times when she received love and support from others despite her struggles.

Therapist: I am wondering if there have been instances where you were able to cope with stress and anxiety without substances.

Iryna: Hmm! The last time I was going to meet my boyfriend on our first date, I was anxious, but I needed to be sober, so I refrained from taking drugs. Though I was initially anxious, I later overcame it when I realized he was receptive.

Therapist: Thank you for sharing that. From your statement, it seems that you can overcome anxiety and stress when your boyfriend shows you love.

Iryna: I did

Therapist: This means you can overcome anxiety and stress when you feel loved and supported. That is a reality. The thought of "I need alcohol and drugs to cope with stress and anxiety" is irrational. We are going to work to challenge this irrational thought that only alcohol and drugs can help you overcome anxiety and stress.

Replace with Realistic Beliefs: Guide Iryna to develop more realistic and adaptive beliefs to replace her irrational thoughts. For instance, Iryna can adopt the belief, "I have the strength and resilience to cope with stress and anxiety without substances".

Therapist: Since you could overcome anxiety and stress in the past without substances, you can replace the irrational statement "I need alcohol and drugs to cope with stress and anxiety" with "I am capable of dealing with stress and anxiety without substances". Iryna can repeat this statement.

Further practice: Have Iryna identify irrational thoughts and replace them with realistic beliefs. For example: "I do not feel loved and respected without substance".

Iryna: I am worthy of love and respect, despite my struggles.

Therapist:

Coping Statements: Guide Iryna in creating effective coping statements to use when faced with cravings or negative emotions. For example, Iryna can practice by repeating positive statements, such as "I am in control of my actions and choices" or "I deserve a healthy and fulfilling life".

Therapist: Iryna, I like your openness. I heard you say you feel overwhelmed with the thoughts of your boyfriend being at the warfront. Tell me more about what's going through your mind.

Iryna: I panic whenever I hear a bomb or read the news. I struggle with the thought of 'What if he's already dead and I just don't know yet? We have been texting with intermittent calls, but lately, he has been unable to answer my text messages for about a week. I find it challenging to concentrate, and I drink to calm myself down.

Therapist: That must be hard and sounds very distressing. In CBT, we refer to this type of thought as a catastrophic thought – your mind jumps to the worst-case scenario without any evidence to support it. Can we try to identify the thought, the feeling, and the behavior that follows?

Iryna: I am thinking, *he's probably dead or hurt.* I have been experiencing feelings of fear, anxiety, and *helplessness.* When this happens, I resort to *drinking or zoning out instead of studying.*

Therapist: Great insight. I would like for us to challenge that thought. Is there any evidence for and against the idea that he's already dead?

Iryna: For: I haven't heard from him in two days. **Against:** He mentioned to me that communication is hard in war zones, and it is likely to happen.

Therapist: Great! What might be a more balanced and realistic thought?

Iryna: I am unsure of his exact status, but no news doesn't mean bad news. It's possible he's okay, but has not had the opportunity to reach out to me. It may even be that he is not getting the reception to call.

Therapist: Excellent. We can write this down so you can use it as a coping statement. When anxiety rises, you say to yourself: *"No news doesn't mean bad news. He's trained, and there are communication delays."* How do you feel about saying that?

Iryna: That makes me panic less. It feels more manageable. I will commit to repeating this whenever those thoughts arise. I believe it will help calm down my anxiety.

Therapist: That is great. I like that you are committed to practicing this outside of therapy.

Challenge Distorted Thinking: Iryna may engage in cognitive distortions such as black-and-white thinking («I am either perfect or a failure»), catastrophizing («If I don't use drugs, my life will fall apart»), or personalization («My addiction is solely my fault»). By challenging these distortions and replacing them with balanced and rational thoughts, Iryna can reduce her emotional distress and improve her coping abilities.

Positive Self-Talk: Iryna can practice positive self-talk to counteract negative self-perceptions and build self-esteem. She can affirm herself with statements like "I am strong and capable of overcoming challenges" or "I deserve love and support".

Dealing with the craving
Therapist: You mentioned experiencing increased cravings when stressed or in a social gathering.

Iryna: Yes

Therapist: How would you describe that experience, helpful or unhelpful

Iryna: Unhelpful

Therapist: We are going to learn and practice a technique called thought-stopping.

Iryna: Okay

Therapist: Thought-stopping is a CBT technique that helps to interrupt and change negative or distressing thought patterns. The goal is to help individuals manage intrusive or harmful thoughts, most especially those associated with anxiety, depression, or other mental health concerns. We often use the words "Stop!" or "Cancel!" loudly or silently to ourselves when a negative thought comes to mind. Other times, we also employ visualizing or imagining a "stop sign" or "red light signal" to stop intrusive thoughts. We can also utilize distracting activities to redirect negative thoughts. The thoughts can then be replaced with positive affirmations or positive self-talk.

Therapist: Iryna, I would like you to think of a craving. As the urge or craving begins, tell yourself aloud or silently in your mind, using "Stop!" or "Cancel."

Iryna: Practice

Therapist: Guide Iryna with the word(s) used, process the feeling, and praise Iryna for practicing. Now, I want you to replace the thought with the flavor of your favorite food.

Therapist: I want you to practice the same activity again, but this time by visualizing the "Stop sign" or "Red light signal".

Iryna: Practice.

Therapist: The therapist encourages Iryna to continue to practice this outside of therapy, any time she is experiencing cravings or negative thoughts.

The case highlights the complex interplay of nearly daily alcohol and cannabis use with intermittent MDMA, emotional dysregulation, and social impairment in a young adult college student. The substance dependence appears to have maladaptive coping strategies used to manage stress, insomnia, and relational difficulties. Her fractured relationships, declining academic performance, and difficulty sustaining employment reflect the broader psychosocial impact of substance use during a critical stage of identity formation and independence. The case also presents the challenge of working with clients who may normalize or minimize the use of socially accepted drugs. The case demonstration highlights a robust and solid therapeutic alliance between the therapist and the client, evident in the client's ability to engage in honest discussion and reflection in a non-judgmental space that enabled the client to explore the emotional roots of her substance use. Through motivational interviewing and cognitive behavior strategies, the therapist was able to enhance the client's readiness for change, identify emotional triggers, challenge irrational thinking related to substance use, and set preliminary goals for decreasing the substance use. The client has committed to rebuilding trust with a family member and sustaining the relationship. Future treatment goals will focus on developing healthy coping strategies, increasing insight into emotional avoidance patterns, exploring unresolved emotional issues, and supporting vocational planning. The therapist will continue to assist the client in developing robust coping skills for relapse prevention, enhancing a positive social network, and setting vocational goals that promote functional recovery and long-term wellness.

CONCLUSION

The evidence supports that CBT is not just a treatment modality for treating substance use disorders but a lifeline for individuals navigating the emotional ruins of war. Its flexibility allows for the simultaneous management of addiction, anxiety, hopelessness, and trauma-related distress. Training and equipping mental health professionals to adapt culturally sensitive CBT that encompasses pain regulation, adjustment support, and relapse prevention will uncover a robust strategic intervention for individual and national healing. Future direction should prioritize the development of community-based CBT hubs, clinical training sites, and policy development, implementation, and evaluation that favors scalable, trauma-informed care. As Ukraine continues its path through adversity, the integration of CBT into public mental health strategy stands as both a scientific and moral imperative.

RECOMMENDATIONS

The protracted Russian invasion of Ukraine has remarkably impacted the psychosocial impairment of substance use in Ukraine. As indicated by national data, there has been a marked increase in drug and alcohol use, particularly among youth, internally displaced persons, and individuals facing war-induced trauma (Institute of Psychiatry, 2023; Morozova et al., 2023). The rise in psychoactive substances indicates maladaptive coping strategies and a public health emergency that requires trauma-informed, evidence-based interventions. Cognitive behavior therapy (CBT), when combined with motivation enhancement and relapse prevention, has been empirically successful in addressing complex cases of psychological, behavioral, and environmental factors that sustain addiction (Carroll & Kiluk, 2017; Mehta et al., 2021)

Given the effectiveness of CBT in treating mental health challenges, including alcohol and other drug addictions, the researchers hope that its implementation in Ukraine will enhance the provision of mental health services, particularly among higher education students. Considering growing rates of relapse, anxiety, hopelessness, and psychological pain during wartime, CBT intervention can help address critical domains such as academic stress, pain management, anxiety regulation, emotional adjustment, and resilience-building.

The prolonged war has increased mental health crises among single parents burdened by separation, caregiving responsibilities, and economic instability. Culturally adapted CBT interventions can help individuals experiencing emotional distress and hopelessness by fostering emotional regulation skills, problem-solving, and resilience strategies. Therapists can employ techniques such as mindfulness-based relapse prevention, cognitive restructuring, and personalized coping strategies to restore a sense of agency and hope (Stotts & Northrup, 2015; Hayes et al., 2006). Tailoring these interventions to the Ukrainian context can mitigate war-related trauma and prevent its intergenerational transmission.

CBT provides a robust coping strategy for relapse prevention by addressing psychological and environmental triggers, especially in high-risk areas with non-existent or limited social support. These interventions should include thought-stopping techniques, cognitive reframing, coping skills development, and trauma-informed psychoeducation. Training mental health practitioners in CBT ensures the effective and high-quality implementation of this approach. Addressing substance use in Ukraine requires a comprehensive approach by mental health professionals that also targets co-occurring problems, such as anxiety, adjustment difficulties, and existential concerns, alongside traditional CBT. Cultural adaptation of CBT examined through mixed-methods research can align with Ukrainian values, language, and lived experiences. Findings from the study can inform culturally sensitive modifications and enhance cultural competence among mental health practitioners and researchers.

Future research can use focus groups in training mental health professionals on how to use CBT as a treatment technique in assisting clients to deal with substance use disorders, particularly during wartime. A recommendation is made for future research to consider conducting a longitudinal study to assess the effectiveness of CBT in treating substance use disorders during and after the war. Future research may explore the integration of brief, digital CBT modules to increase accessibility in remote or conflict-ridden areas. Again, researchers can also explore the development and evaluation of brief, digitally delivered CBT modules, which will improve accessibility, especially in remote and high-conflict zone areas. Together, these recommendations align with Ukraine's growing need for scalable, evidence-based mental health services that are responsive to individual suffering and national trauma.

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ЕФЕКТИВНІСТЬ КОГНІТИВНО-ПОВЕДІНКОВОЇ ТЕРАПІЇ В ЛІКУВАННІ ЗАЛЕЖНОСТЕЙ У СТУДЕНТІВ: ЗАСТОСУВАННЯ В УКРАЇНІ ПІД ЧАС ВІЙНИ

Френсіс Кобіна Нкрума
https://orcid.org/0009-0007-6790-023X
магістр у галузі клінічного консультування з питань психічного здоров'я,
аспірант за програмою консультаційної освіти та супервізії,
Школа психології і консультування, Ріджент університет,
вул. Ріджент університету, 1000,
23464 Вірджинія-Біч, Вірджинія, США,
frannkr@mail.regent.edu

Оля Запорожець
https://orcid.org/0000-0003-3206-7464
PhD в галузі консультаційної освіти та супервізії, доцент,
Школа психології і консультування, Ріджент університет,
вул. Ріджент університету, 1000,
23464 Вірджинія-Біч, Вірджинія, США,
ozaporozhets@regent.edu

Розлади, пов'язані зі вживанням психоактивних речовин, залишаються актуальною глобальною проблемою громадського здоров'я, оскільки студенти є особливо вразливою групою через академічний стрес, соціальний вплив та обмежений доступ до послуг психічного здоров'я. В Україні ці проблеми посилилися через триваючу війну, яка порушила роботу інфраструктури охорони здоров'я, призвела до переміщення населення та посилила психологічний дистрес. У статті представлено сучасні дані про ефективність когнітивно-поведінкової терапії для лікування розладів, пов'язаних зі вживанням алкоголю та інших наркотиків, серед студентів закладів вищої освіти в умовах обмежених ресурсів та нестабільності, як-то воєнний період в Україні. Втручання когнітивно-поведінкової терапії, зокрема підвищення мотивації, управління непередбачуваними ситуаціями, профілактику рецидивів, когнітивну реструктуризацію та тренінг навичок, постійно демонструють позитивні результати у сприянні утриманню, зменшенні тяги та покращенні психосоціального функціонування. Однак впровадження в Україні гальмується такими бар'єрами, як обмежена інфраструктура, нестача кваліфікованих

фахівців та постійна стигма навколо залежності та психіатричної допомоги. Наведено приклад застосування когнітивно-поведінкової терапії з українською студенткою університету, яка бореться з алкогольною залежністю під час війни. У цьому випадку підкреслюється роль виявлення когнітивних спотворень/ірраціональних переконань, розроблення надійних стратегій подолання труднощів та посилення соціальної підтримки для одужання. Стаття завершується рекомендаціями щодо культурної адаптації та масштабування застосування когнітивно-поведінкової терапії в Україні, з акцентом на розвитку робочої сили, інтеграції мотиваційного інтерв'ювання, цифровому наданні терапії та системній підтримці для забезпечення сталості та доступності для студентів, які постраждали від стресових факторів, пов'язаних з війною.

Ключові слова: *когнітивно-поведінкова терапія, когнітивна переоцінка, когнітивна реструктуризація, мотиваційне втручання, мотиваційне підсилення, профілактика рецидиву, студенти, тренінг навичок.*