International Journal of Innovative Technologies in Social Science

e-ISSN: 2544-9435

Scholarly Publisher
RS Global Sp. z O.O.
ISNI: 0000 0004 8495 2390

Dolna 17, Warsaw,
Poland 00-773
+48 226 0 227 03
editorial_office@rsglobal.pl

ARTICLE TITLE	THE EFFECTIVENESS OF COGNITIVE BEHAVIORAL THERAPY (CBT) IN THE TREATMENT OF ALCOHOL USE DISORDER (AUD) – A COMPREHENSIVE REVIEW
DOI	https://doi.org/10.31435/ijitss.4(48).2025.4406
RECEIVED	12 October 2025
ACCEPTED	17 December 2025
PUBLISHED	26 December 2025
LICENSE	The article is licensed under a **Creative Commons Attribution 4.0 International License.**

THE EFFECTIVENESS OF COGNITIVE BEHAVIORAL THERAPY (CBT) IN THE TREATMENT OF ALCOHOL USE DISORDER (AUD) – A COMPREHENSIVE REVIEW

Michal Ziemba *(Corresponding Author, Email: michal.ziemba98@gmail.com)*
University Clinical Hospital in Białystok, Białystok, Poland
ORCID ID: 0009-0003-2200-431X

Klaudia Zackiewicz
University Clinical Hospital in Białystok, Białystok, Poland
ORCID ID: 0009-0009-4778-7211

Agata Wińska
University Clinical Hospital in Białystok, Białystok, Poland
ORCID ID: 0009-0000-3455-5432

Oliwia Sędziak
Faculty of Medicine, University of Opole, Opole, Poland
ORCID ID: 0009-0003-2128-0662

Hanna Pietruszewska
Medical University of Łódź, Łódź, Poland
ORCID ID: 0009-0000-7626-2996

Agata Ogórek
Lower Silesian Center of Oncology, Pulmonology and Hematology, Wrocław, Poland
ORCID ID: 0009-0000-2916-5368

Irmina Czerepak
District Hospital Complex in Oleśnica, Oleśnica, Poland
ORCID ID: 0009-0009-9964-3439

Paweł Liszka
Jan Mikulicz-Radecki University Clinical Hospital, Wrocław, Poland
ORCID ID: 0009-0003-5465-3656

Katarzyna Kleszczewska
Independent Public Health Care Complex in Myszków, Myszków, Poland
ORCID ID: 0009-0009-4177-089X

Izabela Majchrzak
University Clinical Hospital in Poznań, Poznań, Poland
ORCID ID: 0009-0009-0682-7184

ABSTRACT

Introduction: Alcohol use disorder (AUD) drives preventable illness and death worldwide, causing medical, mental health, and social harms that strain individuals and health systems. Cognitive behavioral therapy (CBT) targets maladaptive cognitions, conditioned cues, and high risk situations using functional analysis, coping skills training, and relapse prevention grounded in learning and cognitive theory. Relapse prevention frameworks emphasize high risk situations, coping responses, outcome expectancies, abstinence violation effects, and covert antecedents (e.g., urges) to enhance self efficacy and reduce relapse, with meta analyses showing benefits over minimal or non specific controls. Effects versus non specific therapies are small but significant early and generally attenuate over time, while head to head comparisons show comparable efficacy, highlighting maintenance care, treatment matching, and mechanism focused augmentation. Technology delivered CBT expands access and can reduce consumption and increase abstinence, with early trials suggesting noninferiority or advantages over clinician delivered CBT, warranting larger, longer evaluations and careful integration with pharmacotherapy in stepped care.

Study overview and methodology: This review examined randomized controlled trials evaluating CBT efficacy for substance use disorders, primarily alcohol. Studies compared CBT against three types of controls: minimal treatment, non-specific therapy, and specific evidence-based therapy. Effect sizes were pooled using inverse-variance weighting under random effects assumptions, with outcomes assessed at both early and late follow-up periods for frequency and quantity measures.

Conclusion: Cognitive behavioral therapy is a reliable, evidence-based option for alcohol use disorder that achieves meaningful reductions in drinking and supports maintenance of gains, performing on par with other established therapies; its emphasis on relapse prevention skills and flexible delivery, including effective digital formats, makes it well suited for integration into comprehensive, stepped-care models tailored to individual needs.

KEYWORDS

Cognitive Behavioral Therapy, CBT, Alcohol Use Disorder, AUD, Alcohol Dependence

CITATION

Michal Ziemba, Klaudia Zackiewicz, Agata Wińska, Oliwia Sędziak, Hanna Pietruszewska, Agata Ogórek, Irmina Czerepak, Paweł Liszka, Katarzyna Kleszczewska, Izabela Majchrzak (2025) The Effectiveness of Cognitive Behavioral Therapy (CBT) in the Treatment of Alcohol Use Disorder (AUD) – A Comprehensive Review. *International Journal of Innovative Technologies in Social Science*. 4(48). doi: 10.31435/ijitss.4(48).2025.4406

1. Introduction

Alcohol use disorder (AUD) contributes substantially to preventable morbidity and mortality worldwide and is associated with medical, psychiatric, and social harms that burden individuals and health systems. [1][2] Cognitive behavioral therapy (CBT) is a foundational, skills-based psychosocial intervention for AUD that targets maladaptive cognitions, conditioned cues, and high-risk situations through functional analysis, coping-skills training, and relapse prevention strategies grounded in learning theory and cognitive models. [3] Traditional relapse prevention models, such as Marlatt's framework, explain how high-risk situations, coping strategies, and the abstinence violation effect influence patterns of drinking. They also offer a theoretical basis for CBT interventions designed to enhance self-efficacy and metacognitive regulation when individuals encounter triggers or cravings. [4]

This review synthesizes the effectiveness of CBT for alcohol addiction across outcomes and time horizons, compares traditional and technology-delivered formats, and identifies moderators and implementation factors to enhance reach, fidelity, and sustained benefit in contemporary AUD care.

Table 1. DSM-5 Diagnostic Criteria for Alcohol Use Disorder, American Psychiatric Association [5]

DSM-5 Diagnostic Criteria for Alcohol Use Disorder* The DSM-5 outlines 11 criteria for diagnosing Alcohol Use Disorder (AUD). The severity is determined by the number of criteria met within a 12-month period.	
Criterion	Description
1	Alcohol is often taken in larger amounts or over a longer period than was intended.
2	There is a persistent desire or unsuccessful efforts to cut down or control alcohol use.
3	A great deal of time is spent in activities necessary to obtain, use, or recover from alcohol's effects.
4	Craving, or a strong desire or urge to use alcohol.
5	Recurrent alcohol use resulting in a failure to fulfill major role obligations at work, school, or home.
6	Continued alcohol use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by alcohol.
7	Important social, occupational, or recreational activities are given up or reduced because of alcohol use.
8	Recurrent alcohol use in situations in which it is physically hazardous.
9	Alcohol use is continued despite knowledge of having a persistent or recurrent physical or psychological problem likely caused or worsened by alcohol.
10	Tolerance, as defined by either a need for markedly increased amounts of alcohol to achieve intoxication or a markedly diminished effect with continued use of the same amount.
11	Withdrawal, as manifested by either the characteristic withdrawal syndrome for alcohol, or alcohol (or a closely related substance) is taken to relieve or avoid withdrawal symptoms.
*(At least of 2 symptoms in the past 1 year: mild disorder: 2-3; moderate: 4-5; severe disorder ≥6)	

2. Materials and methods

This research paper reviewed and used sources such as PubMed, Google Scholar, SpringerLink, and Frontiers for peer-reviewed studies on cognitive behavioral therapy (CBT) for alcohol dependence/alcohol use disorder (AUD). Bibliographic search was conducted, using key words and their combinations e.g.: "alcohol dependence," "alcohol use disorder," "AUD," "cognitive behavioral therapy," "CBT,". Inclusion criteria covered randomized or quasi-randomized trials, systematic reviews, and meta-analyses of clinician-delivered or technology-delivered CBT reporting alcohol outcomes (e.g., abstinence, heavy drinking days, drinks per drinking day) in adults published between 2019-2025. Evidence was synthesized thematically to provide a comprehensive overview of current knowledge.

3. Evidence synthesis: treatment effectiveness

A landmark meta-analysis by Magill and colleagues examined 30 randomized controlled trials testing CBT efficacy for alcohol or other drug use disorders, involving 5,398 participants across studies published between 1982 and 2018. They found that CBT demonstrated moderate and significant effect sizes when compared to minimal treatment conditions, with results consistent across both outcome types and follow-up periods. The pooled effect size for frequency outcomes was g = 0.58 (95% CI = 0.15, 1.01, p = 0.009) at early follow-up and g = 0.44 (95% CI = 0.02, 0.86, p = 0.039) at late follow-up. Converting these to practical outcomes, 15-26% of CBT participants achieved better outcomes than the median of those receiving minimal treatment. The methodology utilized inverse-variance weighted effect sizes pooled under random effects assumptions, with outcomes assessed at early (1-6 months) and late (8+ months) follow-up periods. When compared to non-specific therapies such as treatment as usual, supportive therapy, or group drug counseling, CBT showed small but statistically significant effects for consumption frequency and quantity at early follow-up (g = 0.18, 95% CI = 0.02, 0.35, p = 0.04). However, these effects were not sustained at late follow-up (g = 0.05, p = 0.492), indicating limited durability over time compared to standard care approaches. CBT effects in contrast to other evidence-based specific therapies (such as Motivational Interviewing or Contingency Management) were consistently non-significant across all outcomes and follow-up time points. This finding aligns with the "dodo bird effect" commonly observed in psychotherapy research, where different evidence-based treatments show equivalent effectiveness. [6]

A meta-analysis by Ray and colleagues examined combined cognitive behavioral therapy and medication for alcohol and substance use disorders across 30 trials with over 5,000 participants. CBT combined

with medication was significantly more effective than medication alone for reducing drinking frequency (g = 0.18, 95% CI: 0.01–0.35, p = 0.04) and quantity (g = 0.28, 95% CI: 0.03–0.54, p = 0.03). However, CBT showed comparable efficacy to other evidence-based behavioral therapies like motivational interviewing and contingency management when combined with medication, indicating that any structured psychosocial intervention with medication is beneficial. The findings support combining CBT or equivalent behavioral therapy with pharmacotherapy rather than medication alone. [7]

A network meta-analysis by Tan and colleagues compared 11 psychosocial interventions for harmful alcohol use across 19 trials with over 7,000 participants. The most effective approach was combining motivational interviewing with cognitive behavioral therapy in multiple face-to-face sessions, which reduced harmful drinking by 4.98 AUDIT points compared to standard care (95% CI: −7.04 to −2.91). This combined MI-CBT approach ranked superior to all other interventions (SUCRA = 91.3). Brief single-session interventions were less effective than intensive multi-session treatments. [8]

A recent systematic review and meta-analysis by Kim and colleagues compared digital and traditional face-to-face cognitive behavioral therapy across 25 randomized controlled trials for alcohol use disorder. For reducing drinking quantity, digital CBT showed a significant effect (SMD = 1.21, 95% CI: 0.38–2.04, p = 0.004), whereas face-to-face CBT showed a non-significant effect (SMD = 0.69, 95% CI: −0.16 to 1.53, p = 0.110). For drinking frequency, both modalities significantly reduced frequency, but face-to-face CBT demonstrated a stronger effect (SMD = 1.02) compared to digital CBT (SMD = 0.54). These findings suggest that digital CBT is an effective alternative to face-to-face therapy, particularly for reducing alcohol consumption amount, and supports blended or stepped-care treatment models. [9]

Table 2. Comparison of various meta-analyses Magill et al., 2019 [6] Ray et al., 2020 [7] Tan et al., 2023 [8], Kim et al., 2025 [9]

Year	Studies (n)	Total Participants	Comparison Groups	Primary Outcomes	Key Findings
2019	30 RCTs (35 study arms)	5,398	Minimal treatment, non-specific therapy, specific therapy	Frequency and quantity of use	CBT superior to minimal treatment (g=0.58, 95% CI 0.15-1.01); small effects vs non-specific therapy (g=0.18, 95% CI 0.02-0.35); equivalent to other evidence-based therapies
2020	30 RCTs	62 effect sizes	CBT +pharmacotherapy vs standard care	Substance use reduction	Combined treatment showed substantial benefits (g=0.18-0.28); modest additional benefit of CBT over pharmacotherapy alone
2023	19 trials	7,149	11 intervention combinations	Harmful drinking reduction	MI-CBT (multiple sessions, face-to-face) most effective (MD=-4.98, 95% CI -7.04 to -2.91; SUCRA 91.3%)
2025	25 RCTs	Not specified	Digital CBT vs face-to-face CBT	Consumption quantity and frequency	Digital CBT: SMD=1.21 (95% CI 0.38-2.04, p=0.004); Face-to-face: SMD=0.69 (95% CI -0.16 to 1.53, p=0.110)

3.1 Clinical Significance and Real-World Outcomes

The Project MATCH trial, one of the largest alcohol treatment studies included in the analysis, demonstrated clinically meaningful within-condition improvements. Baseline to 15-month follow-up effect sizes for CBT were d = 1.46 for percentage of days abstinent and d = 1.61 for drinks per drinking day. These represent substantial clinical improvements, with 25% of outpatient participants and 48% of aftercare participants achieving abstinence. [10][11]

3.2 Treatment Modality Comparisons

Recent research has explored various CBT delivery modalities with promising results:

- Digital CBT Interventions

Multiple studies have demonstrated the effectiveness of technology-delivered CBT. A 2025 randomized controlled trial found that participants receiving digital CBT achieved significantly higher abstinence rates (73.3%) compared to face-to-face CBT controls (30.8%) during weeks 9-12 of treatment. Digital interventions showed particular effectiveness in reducing alcohol consumption quantity, while both digital and face-to-face modalities effectively reduced drinking frequency. [12][13] Recent randomized evaluations of digital CBT for AUD report higher abstinence rates and reduced risky drinking compared with standard in-person CBT in small samples, pointing to the feasibility of digital therapeutics as either alternatives or adjuncts within stepped-care pathways, while underscoring the need for larger trials and longer follow-up. [14][15]

- Combined Treatment Approaches

Pharmacological interventions encompassed naltrexone and/or acamprosate (42% of effect sizes), methadone or buprenorphine with naltrexone (18%), disulfiram (8%), and other pharmacotherapies or combinations (32%). Random-effects analysis revealed substantial benefits associated with combined CBT and pharmacotherapy relative to standard care (g range = 0.18–0.28; k = 9), suggesting that integrated treatment approaches may produce superior outcomes compared to CBT monotherapy. [7]

Research indicates that combining CBT with other interventions can enhance outcomes. Studies of CBT combined with motivational enhancement therapy (MET) showed superior results, with one integrated approach demonstrating the highest effect size in reducing alcohol use frequency. However, meta-analytic evidence suggests that adding CBT to pharmacotherapy provides only modest additional benefits over pharmacotherapy alone. [7][16]

The largest treatment effect emerged from multimodal face-to-face motivational interviewing–CBT combinations (MI–CBT/Multiple sessions/Face-to-face) versus standard care with SUCRA analysis indicating this approach as most likely superior to alternative interventions. These findings underscore the potential synergistic benefits of integrating CBT with complementary evidence-based techniques within multi-component treatment protocols. [8]

Complementary evidence indicates that adding pharmacotherapy to behavioral treatment is common in AUD care, and combined approaches may shape effectiveness and implementation choices, motivating careful consideration of additive or synergistic effects when appraising CBT’s role in contemporary practice. [16]

In head-to-head comparisons with other specific, active interventions, CBT generally performs comparably rather than superior, consistent with psychotherapy equivalence patterns across substance use treatments, suggesting that optimization may hinge on patient–treatment matching and mechanism-targeted augmentation rather than modality replacement. [6]

3.3 Durability and Long-term Effectiveness

CBT demonstrates particular strength in maintaining treatment gains over time. Studies using minimal treatment contrasts showed that CBT effects were quite durable, with moderate effects maintained at both early and late follow-ups. This durability aligns with CBT's cognitive-behavioral emphasis on relapse prevention and long-term functioning skills.

The treatment's effectiveness appears most pronounced during the initial treatment phase, with gains maintained through follow-up periods. In one systematic case series, the main treatment effects appeared in the first half of therapy, focusing on acquiring greater control over alcohol use, with these gains consolidated and maintained in the second half of treatment. [17]

3.4 Mechanisms and Moderating Factors

Research examining CBT's mechanisms of action has revealed limited evidence for specific mediating pathways, with only modest understanding of how CBT produces its therapeutic effects. However, age appears to be a significant moderator, with older participants showing smaller effect sizes when CBT is compared to non-specific therapy. [18] When contrasted with non-specific therapies or treatment as usual, CBT shows significant advantages at early follow-up (approximately 1–6 months) for consumption outcomes, with effects tending to attenuate at later assessments, highlighting the importance of maintenance strategies and continuing care models to sustain gains. [6]

4. Discussion

4.1 Treatment effectiveness summary

Established Efficacy: As demonstrated in the meta-analyses, CBT efficacy of 15-26% superior to controls has critical implications compared to no treatment, minimal treatment, or non-specific controls. [6]

4.2 Comparative effectiveness findings

Equivalent to Other Evidence-Based Treatments: While CBT is effective, it does not show superior efficacy compared to other specific evidence-based modalities, suggesting that treatment selection might be based on patient preferences, therapist expertise, or practical considerations rather than differential effectiveness. [6] On the other hand integrated CBT for co-occurring depression and AUD yields small but meaningful improvements in substance and depressive outcomes, while heterogeneity and variable fidelity temper certainty and highlight implementation challenges. [19]

Treatment Retention Benefits: CBT demonstrates superior treatment retention rates compared to standard care, with studies showing completion rates of 63-65% for CBT conditions versus 26% for treatment as usual. [20] Clinically relevant effects include increased percent days abstinent and decreased drinks per drinking day under CBT in randomized evaluations, supporting its practical impact beyond statistical significance. [21]

4.3 Limitations and Future Directions

Despite the underlying evidence base regarding the durability of effects, [6] [22] the relative contribution of individual CBT components, moderating factors such as AUD severity and comorbidity [10][15], and comparative effects of therapist versus use of digital formats across diverse settings and populations, including adolescents and adults. [9][23] Heterogeneity in content, exposure, and engagement in CBT, which influences outcomes, makes adherence to information and user experience critical levers for improving outcomes that should be evaluated alongside efficacy.

5. Conclusions

The comprehensive meta-analytic evidence demonstrates that CBT is an effective, evidence-based treatment for alcohol use disorder with moderate to large effects when compared to minimal treatment and small but significant effects compared to standard care. While CBT does not show superior efficacy over other specific evidence-based therapies [6], its established effectiveness, focus on relapse prevention skills, [4] and demonstrated durability of treatment gains make it a valuable component of comprehensive alcohol treatment programs. [8] Specialized applications of CBT extend its utility further: for individuals with comorbid alcohol and depressive symptoms, combined CBT and motivational interviewing approaches yield particularly strong outcomes, [24] and internet-delivered CBT formats expand access while maintaining efficacy, [25] supporting flexible, accessible treatment options across diverse populations. Evidence supports the effectiveness of CBT in helping individuals achieve and maintain reduced alcohol consumption, with digital CBT demonstrating non-inferior - and in some cases, superiority - to face-to-face therapy representing a paradigm shift in treatment accessibility, [9] while long-term follow-up studies of internet-delivered CBT show that therapeutic benefits are generally persist for 12 months or longer for a range of behavioral and mental health conditions, including those involving substance use. [22] Both traditional face-to-face delivery and emerging digital formats show promise, offering flexibility in treatment delivery to meet diverse patient needs and preferences. [14][26]

Conflict of interest statement: The authors declare no conflict of interest.
Financing statement: This research received no external funding.
All authors have read and agreed with the published version of the manuscript.

REFERENCES

1. Rehm J, Gmel GE Sr, Gmel G, et al. The relationship between different dimensions of alcohol use and the burden of disease-an update. Addiction. 2017;112(6):968-1001. doi:10.1111/add.13757
2. Castillo-Carniglia A, Keyes KM, Hasin DS, Cerdá M. Psychiatric comorbidities in alcohol use disorder. Lancet Psychiatry. 2019;6(12):1068-1080. doi:10.1016/S2215-0366(19)30222-6
3. McHugh RK, Hearon BA, Otto MW. Cognitive behavioral therapy for substance use disorders. Psychiatr Clin North Am. 2010;33(3):511-525. doi:10.1016/j.psc.2010.04.012
4. Larimer ME, Palmer RS, Marlatt GA. Relapse prevention: An overview of Marlatt's cognitive-behavioral model. Alcohol Res Health. 1999;23(2):151-160. doi:10.1037/1063-1984.23.2.151
5. DSM-5 Diagnostic Criteria for Alcohol Use Disorder, American Psychiatric Association. (2022). Diagnostic and statistical manual of mental disorders (5th ed., text rev.). https://doi.org/10.1176/appi.books.9780890425787
6. Magill M, Ray L, Kiluk B, et al. A meta-analysis of cognitive-behavioral therapy for alcohol or other drug use disorders: Treatment efficacy by contrast condition. J Consult Clin Psychol. 2019;87(12):1093-1105. doi:10.1037/ccp0000447
7. Ray LA, Meredith LR, Kiluk BD, Walthers J, Carroll KM, Magill M. Combined pharmacotherapy and cognitive behavioral therapy for adults with alcohol or substance use disorders: a systematic review and meta-analysis. JAMA Netw Open. 2020;3(6):e208279. doi:10.1001/jamanetworkopen.2020.8279
8. Tan, C. J., Shufelt, T., Behan, E., Chantara, J., Koomsri, C., Gordon, A. J., Chaiyakunapruk, N., & Dhippayom, T. (2023). Comparative effectiveness of psychosocial interventions in adults with harmful use of alcohol: a systematic review and network meta-analysis. Addiction (Abingdon, England), 118(8), 1414–1429. https://doi.org/10.1111/add.16187
9. Kim JE, Kang J, Choi N, Ryu S. Comparative effectiveness of digital versus face-to-face cognitive behavioral therapy for alcohol use disorder: a systematic review and meta-analysis. Psychol Med. 2025. doi:10.1017/S0033291725102043
10. Magill M, Kiluk BD, Ray LA. Efficacy of cognitive behavioral therapy for alcohol and other drug use disorders: is a one-size-fits-all approach appropriate? Subst Abuse Rehabil. 2023;14:1-11. doi:10.2147/SAR.S362864
11. Project MATCH Research Group. Matching alcoholism treatments to client heterogeneity: project MATCH posttreatment drinking outcomes. J Stud Alcohol. 1997;58(1):7-29.
12. Lim SH, Shin JK, Ahn ME, Lee CH, Lee SK. The effects of cognitive behavioral therapy-based digital therapeutic intervention on patients with alcohol use disorder. Front Psychiatry. 2025;16:1486338. doi:10.3389/fpsyt.2025.1486338
13. Kiluk BD, Ray LA, Walthers J, Bernstein M, Tonigan JS, Magill M. Technology-Delivered Cognitive-Behavioral Interventions for Alcohol Use: A Meta-Analysis. Alcohol Clin Exp Res. 2019;43(11):2285-2295. doi:10.1111/acer.14189
14. Kiluk BD, Devore KA, Buck MB, et al. Randomized Trial of Computerized Cognitive Behavioral Therapy for Alcohol Use Disorders: Efficacy as a Virtual Stand-Alone and Treatment Add-On Compared with Standard Outpatient Treatment. Alcohol Clin Exp Res. 2016;40(9):1991-2000. doi:10.1111/acer.13162
15. Kiluk BD, Benitez B, DeVito EE, et al. A Digital Cognitive Behavioral Therapy Program for Adults With Alcohol Use Disorder: A Randomized Clinical Trial. JAMA Netw Open. 2024;7(9):e2435205. Published 2024 Sep 3. doi:10.1001/jamanetworkopen.2024.35205
16. Belay GM, Mak YW, Wong FKY, et al. Psychosocial treatment options for adolescents and young adults with alcohol use disorder: systematic review and meta-analysis. Front Public Health. 2024;12:1371497. Published 2024 Jul 23. doi:10.3389/fpubh.2024.1371497
17. Caselli G, Martino F, Spada MM, Wells A. Metacognitive therapy for alcohol use disorder: a systematic case series. Front Psychol. 2018;9:2619. doi:10.3389/fpsyg.2018.02619
18. Magill, M., & Ray, L. A. (2009). Cognitive-behavioral treatment with adult alcohol and illicit drug users: a meta-analysis of randomized controlled trials. Journal of studies on alcohol and drugs, 70(4), 516–527. https://doi.org/10.15288/jsad.2009.70.516
19. Grant S, Azhar G, Han E, et al. Clinical interventions for adults with comorbid alcohol use and depressive disorders: A systematic review and network meta-analysis. PLoS Med. 2021;18(10):e1003822. Published 2021 Oct 8. doi:10.1371/journal.pmed.1003822
20. Carroll KM, Kiluk BD. Cognitive behavioral interventions for alcohol and drug use disorders: through the stage model and back again. Psychol Addict Behav. 2017;31(8):847-861. doi:10.1037/adb0000311
21. Boness, C. L., Votaw, V. R., Schwebel, F. J., Moniz-Lewis, D. I. K., McHugh, R. K., & Witkiewitz, K. (2023). An Evaluation of Cognitive Behavioral Therapy for Substance Use Disorder: A Systematic Review and Application of the Society of Clinical Psychology Criteria for Empirically Supported Treatments. Clinical psychology : a publication of the Division of Clinical Psychology of the American Psychological Association, 30(2), 129–142. https://doi.org/10.1037/cps0000131

22. Adhikary, D., Barman, S., & Ranjan, R. (2023). Do the effects of internet-delivered cognitive-behavioral therapy (i-CBT) last after a year and beyond? A meta-analysis of 154 randomized controlled trials with ≥ 12-month follow-ups. Journal of Anxiety Disorders, 94, 102–130. https://doi.org/10.1016/j.janxdis.2024.102300
23. Gan, D. Z. Q., McGillivray, L., Han, J., Christensen, H., & Torok, M. (2021). Effect of Engagement With Digital Interventions on Mental Health Outcomes: A Systematic Review and Meta-Analysis. Frontiers in digital health, 3, 764079. https://doi.org/10.3389/fdgth.2021.764079
24. Riper H, Andersson G, Hunter SB, de Wit J, Berking M, Cuijpers P. Treatment of comorbid alcohol use disorders and depression with cognitive-behavioural therapy and motivational interviewing: a meta-analysis. Addiction. 2014;109(3):394-406. doi:10.1111/add.12441
25. Hadjistavropoulos HD, Mehta S, Wilhelms A, Keough MT, Sundström C. A systematic review of internet-delivered cognitive behavior therapy for alcohol misuse: study characteristics, program content and outcomes. Cogn Behav Ther. 2020;49(4):327-346. doi:10.1080/16506073.2019.1663258
26. Hyland, K., Hammarberg, A., Hedman-Lagerlöf, E., Johansson, M., Lindner, P., & Andreasson, S. (2023). The efficacy of an internet-based cognitive behavioral program added to treatment-as-usual for alcohol-dependent patients in primary care: a randomized controlled trial. Addiction (Abingdon, England), 118(7), 1232–1243. https://doi.org/10.1111/add.16157