http://dx.doi.org/10.18623/rvd.v23.n4.4682

THE "THIRD WAVE" OF COGNITIVE BEHAVIORAL THERAPY IN REHABILITATION PROGRAMS IN CRISIS AND ARMED CONFLICT

A "TERCEIRA ONDA" DA TERAPIA COMPORTAMENTAL COGNITIVA EM PROGRAMAS DE REABILITAÇÃO EM SITUAÇÕES DE CRISE E CONFLITOS ARMADOS

Article received on: 9/2/2025
Article accepted on: 12/1/2025

Olena Serhiieni*
*Higher Private Educational Institution, Dnipro Humanitarian University, Dnipro, Ukraine
Orcid: https://orcid.org/0000-0002-0353-0715
kamekoanna@gmail.com

Serhii Melnychuk**
**Volodymyr Vynnychenko Central Ukrainian State University, Kropyvnytskyi, Ukraine
Orcid: https://orcid.org/0000-0001-6507-3946
sergiyme1nychuk8@gmail.com

Yana Zoska***
***Mariupol State University, Kyiv, Ukraine
Orcid: https://orcid.org/0000-0003-0407-1407
zoskayana@gmail.com

The authors declare that there is no conflict of interest

Abstract
During large scale emergencies such as natural disasters and armed conflicts, mental health needs can increase significantly. The study aims to outline current evidence and peculiarities of third-wave CBTs application in rehabilitation within crisis and armed conflict environments. The study is of qualitative nature. Integrative review method is used as a research tool. Sample of literature sources for analysis contains 54 entries. Third-wave CBT in rehabilitation implemented in the conditions of war or severe crisis, on sample of both military and veterans and civilians, is characterized with evident efficiency (in particular, in comparison with non-CBT interventions) and emphasizes the relationship with thoughts and emotions over changing their content, using approaches like mindfulness, acceptance, and values clarification. By encouraging people to stick to their personal beliefs in the face of PTSD and other symptoms associated with war and crises, third-wave cognitive behavioral therapy (CBT) enhances participation in life-affirming activities. Though third wave CBT can offer a framework for supporting the psychosocial recovery and rehabilitation of populations affected by conflict, more thorough empirical studies with follow-up are required, especially on more diverse samples, as the samples offered in existing studies are typically limited.

Resumo
Durante emergências de grande escala, como catástrofes naturais e conflitos armados, as necessidades de saúde mental podem aumentar significativamente. Este estudo visa delinear as evidências atuais e as peculiaridades da aplicação da Terapia Cognitivo-Comportamental (TCC) de terceira vaga na reabilitação em ambientes de crise e conflito armado. O estudo é de natureza qualitativa. O método de revisão integrativa foi utilizado como ferramenta de investigação. A amostra de fontes bibliográficas para análise contém 54 entradas. A TCC de terceira vaga aplicada na reabilitação em condições de guerra ou crise grave, em amostras compostas por militares, veteranos e civis, caracteriza-se por evidente eficácia (em particular, em comparação com intervenções não baseadas em TCC) e enfatiza a relação com os pensamentos e emoções em vez de modificar o seu conteúdo, utilizando abordagens como mindfulness, aceitação e clarificação de valores. Ao encorajar as pessoas a manterem as suas crenças pessoais face à Perturbação de Stress Pós-Traumático (PSPT) e a outros sintomas associados à guerra e às crises, a TCC de terceira vaga aumenta a participação em atividades que afirmam a vida. Embora a TCC de terceira vaga possa oferecer uma estrutura para apoiar a recuperação psicossocial e a reabilitação de populações afetadas por

Keywords: Mindfulness. Acceptance. Behavior Therapy. PTSD. Veterans. Defusion. Personal Life Values.

conflitos, são necessários estudos empíricos mais aprofundados com seguimento, especialmente em amostras mais diversificadas, dado que as amostras oferecidas nos estudos existentes são normalmente limitadas.

Palavras-chave: *Mindfulness. Aceitação. Terapia Comportamental. PTSD. Veteranos. Desfusão. Valores Pessoais de Vida.*

1 INTRODUCTION

Armed wars cause significant damage to public health, both physically and psychologically. Prolonged exposure to violence and bombardment is usually associated with trauma-related disorders such as post-traumatic stress disorder, anxiety, and depression in conflict-affected populations. Simultaneously, health-care systems are under enormous strain in response to rises in injuries from attacks[1]. In particular, Gaza and Ukraine's eastern regions have recently experienced unparalleled amounts of destruction, particularly within its health-care system and mental health facilities. The continuous violence has seriously harmed medical institutions, reducing access to critical health care and mental health support for the populace. Hospitals have been inundated by casualties, and many clinics have been rendered inoperable as a result of bombs and resource shortages. As resources become scarcer, people are left without proper psychological care, aggravating current mental health problems and creating new ones. Displacement, loss of loved ones, and persistent stress all complicate psychological rehabilitation, making it difficult for people to reestablish a sense of normalcy and well-being. Furthermore, the pervasive climate of fear and uncertainty has the potential to disrupt critical community support structures for rehabilitation.

This psychological cost is worsened by the enormous pressure that conflicts impose on local health systems. Violence frequently causes damage or destruction to infrastructure. Attacks also compel many clinicians and health professionals to depart risky places, drastically restricting treatment access for vulnerable people at critical times[2]. One study found that continuous exposure to conflict during developmentally sensitive stages can physiologically encode stress responses in the body. This likely

explains why those who have experienced more than a decade of instability and hardship are at a higher risk of developing trauma-related diseases[3].

Furthermore, it is observed that service members with mental problems, particularly PTSD, may have a significant sense of stigma, specifically anxieties about how their peers and military leadership will perceive them, which prevents them from obtaining professional medical care[4]. Given that military-related PTSD has a negative impact on the army's combat performance, appropriate measures should be implemented to address this issue.

Mental rehabilitation during crises and armed conflicts entails providing timely and integrated mental health and psychosocial support (MHPSS) to traumatized individuals and communities. Early psychological first aid, community-based self-help, clinical care for priority conditions, and comprehensive support for vulnerable populations, such as veterans and children, are all essential components. Approaches are frequently tailored, including therapeutic techniques, medicine, and other services to improve mental health and well-being.

Studies on the Syrian crisis demonstrate its catastrophic impact on mental health. A systematic analysis discovered that depression among Syrian refugees and internally displaced people ranged from 11 to 49%, while anxiety levels ranged from 49 to 55%[5]. More recent study paints an even grimmer image, with 60% of the Syrian population considered to be suffering from indications of moderate to severe mental problems[6].

A recent quantitative study looked at the incidence of mental health conditions among conflict-affected populations in Ukraine. Among the study population, the researchers discovered concerning prevalences of trauma-related conditions such as anxiety, depression, and post-traumatic stress disorder[7]. Pinchuk et al.[8] found that the number of psychiatric hospitalizations rose two years after the full-scale conflict in Ukraine started, compared to both the pre-war period and six months after the invasion started (433.4 per month in January 2022, 397.5 per month in April 2022, and 552.0 per month in April 2024, respectively). Throughout the study waves, the average percentages of hospitalizations attributable to psychological war trauma were 12.2% in January 2022, 13.5% in April 2022, and 17.3% in April 2024; the differences did not reach statistical significance.

On October 7th, 2023, Israel and Palestinian extremist organizations Hamas and Islamic Jihad clashed[9]. In a surprise attack on a major Jewish holiday, Hamas militants, accompanied by a volley of rockets, swept into neighboring Israeli towns from the blockaded Gaza Strip, killing dozens and kidnapping others. The northern district warmed as a result of the renewed rocket fire from Gaza into Israeli communities in the southern region[10]. The Israeli Air Force retaliated by launching airstrikes against terrorist locations throughout Gaza. Attacks grew more frequent over the course of eight weeks, putting civilian lives on both sides of the border in danger. Approximately 7000 Israelis have been injured and more than 1,500 have been dead by this point[11].

A thorough grasp of the effects on welfare, both immediate and long-term, can be obtained by surveying impacted communities after a conflict.[12,13]

By identifying the groups most in need of trauma-informed medical, psychological, and social support services, data on important public health indicators like conflict-related injuries, the prevalence of mental health conditions like depression and PTSD, access to medical services, and socioeconomic vulnerabilities can help guide a more focused emergency response[14,15]. Disaster planning and response efforts can be greatly improved by learning from healthcare systems that managed to continue operations during conflict[16].

These data underscore the urgent need for tailored interventions and strategies to enhance resilience and rehabilitation landscape. Moreover, social crises derived from both global geoeconomic and geopolitical instability also trigger growth of mental health issues in population of many countries.

Following a crisis or armed conflict, cognitive behavioral therapy (CBT) has been shown to be a successful rehabilitation strategy. It primarily treats symptoms of trauma, such as depression and post-traumatic stress disorder (PTSD). Through methods including anxiety management, cognitive restructuring (altering negative thought patterns), and stress inoculation (preparing for stress reactions), cognitive behavioral therapy (CBT) helps people deal with discomfort by emphasizing the connections between ideas, feelings, and behaviors. Research indicates that CBT can have long-lasting effects on trauma symptoms and is beneficial for both adults and children in high- and middle-income nations. Specifically, Levi et al.'s study[17] examined the efficacy of cognitive-behavioral therapy and psychodynamic psychotherapy (PDT), two

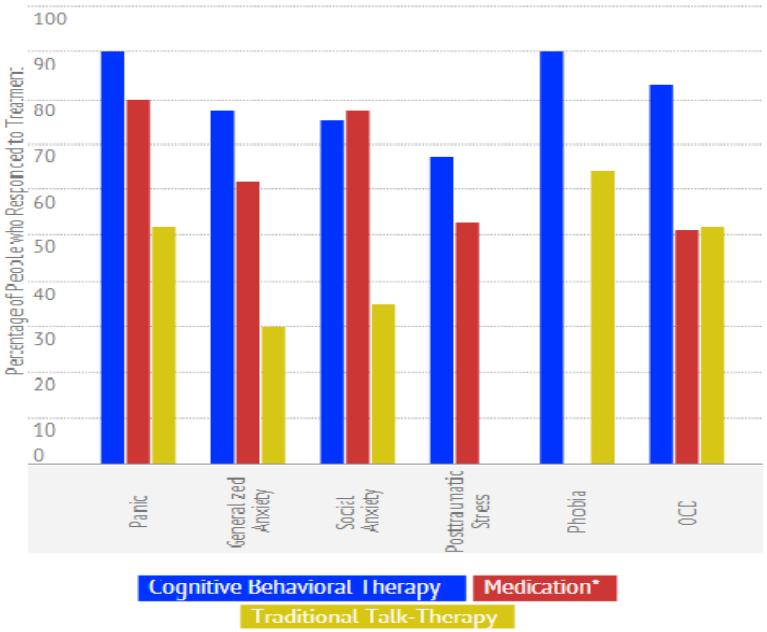
psychotherapy modalities, in treating combat veterans with chronic PTSD. The Israel Defense Forces' (IDF) Unit for Treatment of Combat-Related PTSD often employs these therapies. Based on the kind of complaint and symptoms, IDF soldiers with chronic PTSD were randomized to either CBT (n = 148) or PDT (n = 95). Psychiatric status was assessed at baseline, post-treatment, and 8-12 months follow-up. Both treatment approaches resulted in significant symptom reduction and improved functioning from pre- to post-treatment, which were maintained during follow-up. No differences were found between the two treatments in any of the effectiveness tests. Following treatment, 35% of CBT patients and 45% of PDT patients remitted, with no difference between the groups. At follow-up, the CBT and PDT groups had remission rates of 33% and 36%, respectively.

As psychology has shifted toward evidence-based practice over the past few decades, there has been significant debate regarding the growing popularity of cognitive behavioral therapy (CBT) over alternative treatment modalities. A wealth of new research has emerged to help patients and physicians choose the best therapies for psychological issues as the value of treatments backed by research has grown. CBT has been shown to be the most successful treatment for a wide range of mental health conditions in study after study. Additionally, compared to other therapy approaches, CBT sessions typically last less time and have longer-lasting effects. Due to the shorter treatment length in CBT, therapists educated in more traditional therapies, such as Freudian/psychodynamic therapists, have criticized this approach to therapy, arguing that it oversimplifies issues and seeks a "quick fix".

Figure 1 shows a graph comparing the effectiveness of CBT to medication and other types of talk therapy. Unfortunately, the research is not totally conclusive, as psychotherapy research is still in its infancy and lacks the benefit of big pharma's bottomless coffers. However, the initial study suggests that CBT is the preferred treatment for many psychiatric issues.

Figure 1

What treatment works for anxiety: comparative data[18]



Moreover, a "third wave" of cognitive behavioral therapy was announced twenty years ago. A series of new behavioral and cognitive techniques based on contextual notions that were more concerned with the individual's relationship to thought and emotion than their substance were said to be emerging, and it was claimed that a shift was taking place in the orienting assumptions within CBT. Issues like mindfulness, emotions, acceptance, relationships, values, goals, and metacognition were all highlighted by third wave approaches. Among the novel models and methods of intervention were functional analytic psychotherapy, mindfulness-based cognitive therapy, dialectical behavior therapy, acceptance and commitment therapy, meta-cognitive therapy, and several others[19].

Five key features of "third-wave" therapies are underlined in the literature[20]: a focus on context and function; the belief that new models and procedures should build on other strands of CBT; expanding into more complicated topics, which are traditionally more typical of humanistic, existential, analytical, or system-oriented methods; applying processes to the clinician rather than merely the client; and emphasizing broad and flexible repertoires as opposed to an approach to signs and symptoms.

The “Third Wave” of cognitive behavioral therapy (CBT), which encompasses techniques like Mindfulness-Based Interventions (MBIs) and Acceptance and Commitment Therapy (ACT), is utilized in rehabilitation to enhance psychological adaptability and overall wellbeing. These therapies, which are particularly beneficial for patients with challenging-to-manage conditions like chronic pain or anxiety, focus on altering the connection with thoughts by encouraging acceptance and living in accordance with one’s values, in contrast to earlier cognitive behavioral therapies that concentrate on altering the content of ideas.

With this in mind, the article aims to investigate the current landscape of third-wave CBT application in designing and implementing rehabilitation programs in crisis and armed conflict, and outline existing provisions, experience, and prospects in this field.

2 METHODS

The research applies integrative review method. The fact that an effective integrated review can offer significant insight into the current state of research on a topic and also suggest future research areas led to the method’s selection. Because it can combine a variety of sources, such as theoretical literature, qualitative and quantitative studies, and even non-peer-reviewed publications, to offer a thorough grasp of a subject, an integrative review is more adaptable than a systematic review. Its primary advantage is its capacity to offer a comprehensive perspective and pinpoint knowledge gaps that might influence the development of new theories, policies, or best practices. This method encourages the synthesis of all available evidence to create a thorough grasp of the subject. By synthesizing all available facts, this method encourages the development of a thorough understanding of the subject[21].

Based on the study themes, general library recommendations, and resources pertaining to psychology and education, the following databases were selected: JSTOR, PubMed, American Psychological Association, MDPI, Springer, ScienceDirect, ResearchGate, and JSTOR. 147 resources were discovered after the search. All of these resources were combined to create 84 distinct resources, which were then further screened after duplicate items were eliminated from both within and between databases. During the screening process, the publication’s scope, volume (a minimum of three pages was

established as a special criterion for inclusion), scientific quality, and relevance to the topic were all assessed. 54 entries were ultimately selected to be part of the final sample for the integrative review.

3 RESULTS AND DISCUSSION

Undoubtedly, a number of ideas and techniques that have been essential to third wave interventions - such as acceptance-based procedures, mindfulness techniques, decentering, cognitive defusion, values, and psychological flexibility processes - have become ingrained in the CBT tradition and, in fact, in evidence-based therapy more broadly, largely due to the fact that research indicates they are beneficial. Nowadays, these more recent ideas and approaches mostly coexist alongside more traditional ones, and their dialectic acts as a helpful catalyst for further theoretical and technological research. Packages containing conventional behavioral and cognitive techniques have been supplemented with third wave techniques, producing practical strategies.

According to Hayes and Hoffman[19], these more recent techniques can be taken into account when using an idiographic approach to process-based functional analysis. Cognitive, emotion, attention, self, motivation, and overt behavior are the six categories into which psychological processes of change can be categorized. A number of significant transformation processes integrate two or more of these aspects. A significant advancement in psychiatry and a step toward precision mental health treatment would be to customize therapeutic tactics to target the relevant processes in a particular individual.

Table 1 provides core concepts of third-wave and options of application in rehabilitation.

Table 1

Third-wave CBT: bases and applicability[22]

Core concepts of third-wave therapies	Application in rehabilitation
Acceptance is the ability to recognize and accept challenging ideas, emotions, or sensations without passing judgment on them or attempting to get rid of them. Being mindful is focusing on the here and now without passing judgment	Focus shift: Third-wave therapies assist patients in accepting their internal feelings rather than attempting to alter unpleasant ideas, which can be challenging or impossible for someone with severe mental illness or persistent pain

Psychological flexibility is the capacity to be aware of what is going on and to make decisions based on personal priorities rather than becoming mired in destructive habits. Clarifying one's values involves determining what matters most to a person in order to direct their behavior	Behavioral change: Even in the face of challenging feelings or experiences, this acceptance enables patients to make significant behavioral adjustments that are in line with their own values. For instance, despite accepting their agony, a person with chronic pain may still decide to partake in important activities, such as family time
Defusion: Acknowledging that ideas are merely ideas rather than absolute truths that need to be followed	Enhanced resilience: Patients can become more resilient to stress and other obstacles they encounter during their recovery process by developing psychological flexibility

Almost all of the more recent CBT techniques have concentrated on change principles that address the function and context of psychological events (such as thoughts, feelings, and overt behavior) rather than their content. These many underlying presumptions of "third-wave" cognitive behavioral therapy permeated the clinical techniques they generated and sped up the emergence of new change processes that prioritized the function of emotion and cognition over their form. In contrast to standard CBT, "third-wave" techniques focus on the client's relationship to their own experience, rather than attempting to alter "negative" feelings or thoughts. The "third wave" of CBT introduced various process-oriented models and methods, such as dialectical behavioral therapy (DBT), mindfulness-based cognitive therapy (MBCT), meta-cognitive therapy (MCT), functional analytic psychotherapy (FAP), acceptance and commitment therapy (ACT), and modern forms of behavioral activation[23].

Almost all of the newer CBT procedures require time to apply interventions to both the practitioner and the client. The objective in DBT is to apply the therapy to one another in order to help each therapist adhere to the therapy procedure[24]. Perhaps the most significant guiding concept of MBCT is the instructor's own personal mindfulness practice[25]. In FAP, in order to better attend to the client's experience, therapists must first be aware of their own[26]. In ACT, there is no essential difference between the therapist and the client in terms of the procedures that must be learnt[27].

This is due in part to the fact that the approaches are perhaps more experienced, as well as the concept that "you cannot teach what you cannot do". The other aspect of the picture is that these methods are more focused on how normal psychological processes can occur in ways that cause psychological injury, as well as how these processes might be reorganized to promote greater human flourishing. Evidence suggests that "third-

wave" procedures improve psychological results for practitioners, trainees, and clients alike.

Benfer et al.[28] conducted a meta-analysis to investigate the efficacy of third wave therapy in treating posttraumatic stress disorder (PTSD) symptoms. A secondary goal was to determine whether therapy efficacy was influenced by treatment type, duration, exposure, intent-to-treat samples, and treatment format (individual, group, or both). A literature search yielded 37 studies with a pooled sample of 1268 persons who met the study inclusion criteria. The mean differences between pre- and post-treatment PTS symptoms were calculated using a random effects model (i.e., uncontrolled effect). Furthermore, in a subset of trials that included a control condition, a controlled effect was estimated in which pre- to post-treatment PTS symptom changes compensated for symptom changes in the control group. The overall uncontrolled effect of third-wave therapy on PTS symptoms was moderate to significant (Hedges' g = 0.88 [0.72-1.03]). The uncontrolled impact was attenuated by treatment type, intent-to-treat analysis, exposure, and format, but not by treatment duration. The findings indicate that third wave therapies hold enough potential in treating people with PTS symptoms to merit additional exploration.

It is useful to note that a first wave therapist would introduce the client to the threat stimulus without the feared outcome (e.g., decoupling via PE) in order to minimize the association between a conditioned stimulus (e.g., crowded places) and a conditioned response (e.g., anxious arousal) in the case of a person with PTSD. A cognitive, or second wave, strategy would focus on recognizing and disputing the maladaptive beliefs and ideas linked to the feared stimulus (e.g., presenting objective information that contradicts the belief that "I will panic, have a heart attack, and die if I go to the busy store"). In a third wave treatment, a therapist would try to determine the purpose of a particular problem behavior in a particular setting for a particular client. They would also try to reduce psychological suffering (like PTS symptoms) by using techniques that promote acceptance of psychological phenomena (like thoughts and feelings), mindful awareness of one's experiences, and defusion from one's thoughts.

ACT is arguably the therapy most closely associated with the third wave. The goal of ACT is to lessen psychological suffering and enhance quality of life in general, not necessarily to lessen psychopathology symptoms. ACT is thought of as a transdiagnostic

therapy. ACT modules concentrate on cultivating abilities including mindfulness, cognitive defusion, value definition, valued action, contextualizing oneself, and accepting negative psychological experiences (e.g., mood swings, ruminative thoughts). ACT methods have been improved to more precisely treat issues related to PTSD, despite being transdiagnostic[29].

Mindfulness-Based Stress Reduction (MBSR) served as the foundation for the development of mindfulness-based cognitive therapy. The original goal of MBCT was to help those who were experiencing frequent episodes of depression. Avoidance of trauma-related thoughts and memories may be countered by mindfulness-based practices and therapies, which frequently entail paying nonjudgmental attention to unpleasant feelings. MBCT has attracted some interest as a possible stand-alone treatment for PTSD, while occasionally being employed as an active control in controlled studies of exposure-based therapies for PTSD[30].

Another treatment for depression that has grown in popularity is behavioral activation (BA), which also addresses PTS symptoms. BA features elements that are congruent with “third wave” therapies, even though others may classify it as entirely behavioral and therefore “first wave” (e.g., an emphasis on values-driven action). BA views thoughts and emotions as behaviors that may be addressed through functional analysis, which is the process of determining the contextual causes and effects of problematic behaviors. In primary-care settings, where BA is a frequent treatment option, co-morbid PTSD and depressive symptoms seem to have emerged as the basis for BA as a PTSD treatment[31]. The trauma-specific adaptation known as BA and therapeutic exposure (BA-TE) entails situational and imaginal exposures to trauma reminders, albeit it can be administered without modification for PTSD[32].

By lowering metacognitive beliefs - beliefs about thinking, or second-order cognitions - regarding concern and rumination, MCT was created to treat anxiety disorders. The focus on second-order cognitions and changing one’s connection with thoughts is consistent with the contextual aspect of various third wave therapies, even if it has been disputed whether MCT fits under the second or third wave[33]. The MCT model for treating patients with PTSD posits that second-order positive metacognitive beliefs (e.g., "I must worry in order to be prepared") enhance avoidance and danger monitoring, which exacerbate PTSD symptoms. Wells and Sembi[34] explain an adaption of MCT for

PTSD. Though the examples and prompts are tailored to PTSD, the fundamental framework remains consistent with the original MCT guidebook.

Researchers have used both qualitative and quantitative synthesis to try to summarize the effectiveness of third wave therapy on different psychological outcomes. A meta-analysis of third wave therapies by Öst[35] revealed that ACT and DBT had moderate effect sizes in treating a variety of disorders (such as substance use and depression). However, the methodology of some third wave treatment studies was deemed to be a serious concern (e.g., using waitlists as a control condition). A review of third wave therapies' effectiveness for acute depression was carried out by Hunot et al.[36]. The authors came to the conclusion that third wave therapies are just as beneficial as cognitive behavioral therapy (CBT) in treating acute depression, despite the poor quality of the available evidence.

In a more recent systematic review and meta-analysis, Coventry et al.[37] found that cognitive behavioral therapy (CBT) therapies are useful in treating mental health issues and comorbidities in individuals who have experienced complex trauma. For treating PTSD with complex trauma, multicomponent interventions - which may involve phase-based approaches - were the most successful treatment regimen.

Studies have shown that ACT dramatically reduced PTSD symptoms, enhanced relationship quality, and increased social and recreational participation. Furthermore, ACT participants demonstrated notable gains in avoidance behaviors, mindfulness, and valued living[38]. The development of psychological flexibility is one of the ways that ACT may aid in the treatment of post-traumatic stress disorder. This speaks to the capacity to be in the moment and conscious of one's own feelings. Experts in mental health claim that ACT accomplishes this by enhancing[39]:

- awareness of the present moment and mindfulness
- readiness to be receptive to encounters of all kinds
- relationship to a person's personal values
- determination to behave in a manner consistent with one's own values
- detachment (defusion) from one's own ideas in order to lessen their impact
- examination of life experiences in their entirety

By addressing these several areas, people with PTSD can learn to accept the pain of the past while living their particular life values in the present.

ACT focuses on experiential avoidance, or the avoidance of negative or undesirable emotional states, ideas, and physiological events. Experiential avoidance is regarded as a normal human propensity that both patients and therapists are likely to demonstrate. From an ACT standpoint, experiencing avoidance is problematic for several reasons: (1) It does not eliminate the unwanted thought, emotion, or experience; (2) failed attempts to avoid painful internal experiences can lead to a greater sense of failure and perceived "brokenness", and (3) efforts to remove pain require enormous amounts of energy, which interferes with pursuing valued activities and relationships. As cherished activities decline, veterans' daily lives and sense of identity are increasingly shaped by their trauma. ACT, unlike cognitive behavioral therapies, does not seek to eliminate undesired internal sensations. Instead, the idea is to assist veterans "make room" for their prior traumas. This is known as psychological flexibility. Walser et al.[40] mentioned providing ACT to veterans. The goal is for veterans to be able to accept their unpleasant internal experiences and live a meaningful life despite them. This is performed by the following six core processes:

Mindfulness: Veterans are initially introduced to mindfulness as a technique to reconnect with the present moment. This lays the groundwork for greater exposure to avoided ideas and feelings.

Willingness means being open to one's entire experience, even if it is painful or anxiety-inducing. This does not imply that the veteran enjoys or desires the pain and/or anxiety; rather, they accept its presence and make room for it. Veterans can continue with crucial activities despite discomfort and worry if they take a willing position.

Connection to Personal ideals: Many veterans' lives have become so consumed with avoidance that they have forgotten their own personal ideals. A primary purpose of ACT is to assist veterans in reconnecting with their personal values and establishing a distinction between trauma-driven conduct and value-driven behavior.

Committed Action: Veterans' behavior may still be influenced by trauma even if they are conscious of their own principles. Setting specific objectives to start moving in the direction of one's ideals is the main emphasis of committed action. Veterans who participate in ACT for PTSD use their core values to inform their personal objectives, which serve as the foundation for group-wide in vivo exposure exercises. We call these values-based exposure goals in this handbook.

Defusion: Veterans who practice mindfulness become conscious of unpleasant thoughts that prevent them from achieving their values-based objectives. Veterans can learn to accept their thoughts as just that - thoughts - by using defusion techniques. In contrast to more cognitive tactics, the objective is to recognize when thoughts are unhelpful, disengage from them, and proceed instead of challenging them. Determining whether they are true or not is not required. Veterans can continue to take dedicated action in the face of pain or anxiety by using defusion techniques to remove themselves from unpleasant ideas.

Observing Self: Lastly, over time, veterans learn to apply their abilities to adopt a "big picture" view of their lives. By establishing a connection with the self that is constant throughout time, this aids veterans in the future in placing their unpleasant experiences in the present within the larger framework of life. Greater psychological flexibility and a less threatening feeling of present worry are fostered by this connection to a consistent sense of self.

Wharton et al.[41] showed in 2019 that group ACT treatment for PTSD in veterans reduced PTSD symptoms. In the pilot studies presented, ten veterans with PTSD diagnoses participated in a 12-session group ACT intervention, while nine veterans with PTSD diagnoses participated in a 12-session individual ACT intervention. During the 12-week group treatment period, pilot study veterans were requested to abstain from all other forms of therapy, but they continued to receive case management and medication management through the VA PCT. According to the authors, PTSD symptoms decreased after an individual ACT intervention. Changes were observed in psychological flexibility, mindfulness, and thought suppression[41].

Meyers et al.[42] report on their experience using Dialectical Behavior Therapy (DBT), another third-wave CBT. A brand-new 12-week intense outpatient treatment called DBTPE Journeys treats co-morbid PTSD and Borderline Personality Disorder by combining DBT, Prolonged Exposure (PE), and community integration activities. This program was created to help Veterans who require PTSD treatment but are unable to participate in trauma-focused therapy because they struggle with relationships, stress, and intense emotions. Clinicians are cautious to treat PTSD in this population because they are concerned about increasing suicide ideation, self-harm, or disassociation. Traditionally, therapists believed that it was important to treat these symptoms first with

therapies such as DBT before beginning trauma therapy. However, this rationale impedes access to vitally needed trauma treatment, as DBT alone has not been shown to be beneficial for PTSD.

To address these concerns, as well as to serve patients who live a long distance from DBT and PE providers, scientists developed an intensive outpatient program that includes the full DBT model (all skills covered twice over the course of 12 weeks) and the full PE protocol, which begins in week 2 or after the patients have been self-harm-free for four weeks. If self-harm occurs, PE is discontinued until the situation is under control. Furthermore, twice-weekly community outings were offered to patients to enable them practice using their skills in real-world situations and generalize their application[42]. It was found that about two-thirds of patients were able to successfully complete both therapies when DBT and PE were given concurrently in an intensive setting. There were significant reductions in PTSD symptoms and dysfunctional coping, increases in the use of DBT skills, and a moderate reduction in suicidal ideation. According to this pilot study by Meyers et al., PTSD in this high-risk group can be safely and efficiently treated.

When comparing DBT to other approaches, it is important to note a 2020 randomized controlled trial that examined the cost-effectiveness and effectiveness of an integrated approach that combined DBT and EMDR versus using EMDR alone in adult patients with co-occurring PTSD and (sub)clinical BPD. It has been demonstrated that EMDR-DBT treatment produces better outcomes than EMDR alone[43]. These findings demonstrate the enormous potential of integrated therapy methods for individuals with complex emotional problems, which is highly important for rehabilitation programs in armed conflicts or severe crisis.

Additionally, new chances to employ DBT with children and adolescents have emerged in recent years. Research on therapies that use art therapy and DBT to assist traumatized children control their emotions and control their anger is still ongoing[44]. According to Michałowska and Chęć[45], DBT can lessen PTSD symptoms in a range of age groups.

According to a German study by Priebe et al., understanding dialectical behavior therapy and how to use it effectively in public treatment settings can lower the cost of inpatient care[46]. They showed that among patients hospitalized for PTSD symptoms associated with CSA experience, the average total cost of using psychiatric-

psychotherapeutic care and medication was €18,100 per patient in the previous year and €7,233 in the year following the application of DBT-PTSD. The decrease in costs was due to a reduction in hospital treatment days (an average of 57 days before and 14 days after DBT-PTSD). In our opinion, these findings are valuable for designing and implementing rehabilitations programs in war-affected areas, where access to in-patient mental health services is limited or impossible.

By combining cognitive therapy and mindfulness techniques, Mindfulness-Based Cognitive Therapy (MBCT), another element of third-wave CBT, has shown potential in treating PTSD due to war by lowering symptoms like avoidance, hyperarousal, and negative emotions. According to studies, MBCT can significantly reduce PTSD symptoms in veterans when compared to those receiving standard treatment. In order to assist veterans disengage from trauma-related stimuli and lessen rumination, MBCT promotes present-moment awareness, attentional control, and a nonjudgmental attitude toward thoughts and feelings[47]. Table 2 lists the data supporting MBCT in veterans as well as MBCT approaches for treating TSD symptoms.

Table 2

MBCT in addressing PTSD symptoms in veterans[48]

How MBCT treats symptoms of PTSD
Reduces avoidance: People are more willing to confront fear-inducing situations when a nonjudgmental attitude is used, which lessens avoidance tendencies
Reduces emotional numbness and hyperarousal: Mindfulness exercises like body scans and meditation can assist to soothe the nervous system and control the body's stress reaction
Combats negative thoughts: Veterans can reduce their reactivity to rumination and negative thought patterns that exacerbate feelings of melancholy and helplessness by cultivating a mindful cognitive style
Encourages present-moment focus: Turning attention to the here and now can help people focus less on painful memories of the past or worries about the future
Evidence supporting MBCT in veterans
According to a University of Michigan and VA Ann Arbor Healthcare System study, veterans' PTSD symptoms significantly decreased after an 8-week MBCT group intervention when compared to a control group
MBCT was modified for combat veterans in a pilot research, which revealed that it was a short, acceptable, and perhaps helpful intervention, especially for lowering avoidance symptoms and negative thoughts
According to research, mindfulness-based practices may have neurobiological impacts that could alter the structure and function of the brain, hence enhancing mental health

Two previous pilot trials using veteran samples have demonstrated preliminary indications of MBCT's effectiveness in lowering PTSD symptoms[49.59]. The viability,

acceptability, and therapeutic results of an MBCT group intervention modified to address posttraumatic stress disorder were examined by King et al.[49]. Intent to treat analyses revealed a significant Condition × Time interaction (F[1,35] = 16.4, P <.005) and a substantial improvement in PTSD (CAPS (t(19) = 4.8, P <.001)) in the MBCT condition but not in the TAU conditions. In addition to demonstrating strong and clinically meaningful improvements in PTSD symptom severity on posttreatment assessment in CAPS and PDS (especially in avoidance/numbing symptoms), MBCT completers (n = 15, 75%) also demonstrated decreased PTSD-relevant cognitions in PTCI (self blame).

In addition to citalopram, Jasbi et al.[50] investigated the impact of mindfulness-based cognitive therapy (MBCT) on PTSD symptoms in Iranian veterans of the Iran-Iraq war. In this eight-week intervention research, 48 male veterans with PTSD (mean age: 52.97 years) participated. All patients received citalopram (30–50 mg/day at therapeutic levels) as standard treatment. Patients were randomized to either the control condition or the therapy. MBCT was administered once a week in group sessions as part of the treatment. For socio-therapeutic events, patients in the control condition visited the hospital at the same frequency and for the same amount of time. Patients filled out questionnaires about stress, anxiety, depression, and PTSD symptoms both at baseline and at the end of the trial. At the end of the eight-week trial, the intervention group had higher scores for PTSD (re-experiencing events, avoidance, poor mood and cognition, hyperarousal), sadness, anxiety, and stress than the control group. Research indicates that MBCT is a useful intervention to considerably lessen PTSD, depression, anxiety, and stress symptoms in veterans when used as an adjuvant to conventional SSRI medication. MBCT was given in an 8-week group style by Jasbi et al.[50], with a group size ranging from 7 to 12 participants and weekly sessions lasting 60 to 70 minutes. Table 3 provides specifics about the MBCT sessions' content.

Table 3

MBCT Sessions' Content[50]

Week	Session	Session' content
1	Redirecting automatically	Group formation, member introduction, group rules and boundaries, physical exercise verification, snacking on raisins, handouts, and assignments
2	Overcoming challenges	Breathing techniques, mental and emotional focus, assignment review, and exercise

3	Breathing awareness	Hearing, seeing, and body awareness. Review homework and exercises.
4	Remaining in the moment	Performing exercises, identifying stressors, going over workouts and homework
5	Acceptance of the presence	Three minutes of seated contemplation while paying attention to one's body and breathing
6	Ideas are not facts	Sitting contemplation while being conscious of one's body, emotions, sounds, and thoughts. Reviewing assignments, activities, and termination preparation
7	Taking the best possible care of oneself	Sitting contemplation while being conscious of one's body and respiration. observation of the connection between training for feelings, mood, and action. List of fun and tedious daily tasks, homework, and review exercises
8	Using the knowledge gained from the favorable mood situations going forward	Review activities, assignments, a summary of the course, the exercises completed during the course, and the rationale behind their continuation are all discussed. Completing the course and the final reflection

Even though some MBCT participants had a significant rise in PTSD symptoms at baseline, Videla and Melillo[51] showed in a recent study that there was a significant improvement in PTSD symptoms. While mild trauma symptoms at baseline exhibited somewhat higher symptomatology at the conclusion of treatment, MBSR individuals with moderate to severe trauma symptoms showed a bigger reduction in symptoms. According to the findings, MBCT, MBSR, and their variants appear to address distinct areas of the diagnosis. MBCT helps to link dysfunctional cognitive notions to avoidant actions that sustain the symptomatology, while MBSR is linked to improvements in attentional issues. However, it is unknown which active ingredients in MBSR or MBCT contribute to symptom reduction. Future research will benefit from, among other things, using outcome measures to track changes in the underlying systems linked to mindfulness practice.

PTSD connected to combat can also be effectively treated using metacognitive therapy (MCT). The impact of metacognitive therapy (MCT) and extended exposure therapy (PET) on the quality of life of PTSD-affected soldiers is contrasted by Rahnejat[52]. The findings demonstrate the efficiency of MCT in improving the quality of life in individuals with war-related PTSD at a 3-month follow-up, while simultaneously confirming the usefulness of PET as the gold standard for treating PTSD. Zafarizadeh et al.[53] previously found that metacognitive treatment decreased PTSD symptoms in the experimental group during post-test and two-month follow-up sessions ($p<0.01$). The effectiveness of metacognitive therapy for treating PTSD in young people is investigated by Simons and Kursawe[54]. MCT was linked to notable and substantial decreases in

symptoms of posttraumatic stress disorder at the end of treatment. Following treatment, 95 or 85% of the patients were deemed recovered, depending on the outcome measure.

By employing techniques like mindfulness, acceptance, and values clarification, third-wave cognitive behavioral therapy (CBT) in rehabilitation under war or extreme crisis conditions is therefore distinguished by its obvious effectiveness and prioritizes the relationship with thoughts and emotions over altering their content. By assisting people in accepting challenging internal experiences while engaging in value-driven behaviors, these approaches seek to enhance psychological flexibility and overall well-being rather than just symptom reduction. This is particularly important in situations involving armed conflicts and severe social crises, which are marked by a high degree of uncertainty and ongoing stress.

4 CONCLUSIONS AND PERSPECTIVES

Third wave therapies are gaining popularity, and there is no sign that this trend will slow down. More physicians are able to use third wave therapies as the quantity of treatment manuals and training opportunities increases annually. Active military personnel, veterans of war, and civilians (including children and adolescents) who have experienced various forms of trauma due to war or catastrophic crises have all been safely tested with third-wave cognitive behavioral therapies and their modifications. Meanwhile, since the studied samples are, as a rule, limited, more extensive empirical studies with follow-up are needed, in particular, on more diverse samples.

Simultaneously, the current understanding of post-trauma needs and third-wave cognitive behavioral therapy practices can offer a framework for fostering the psychosocial recovery and rehabilitation of populations affected by conflict. It can also highlight the need for and design of customized interventions and strategies to improve access to mental health services in communities experiencing crisis or in areas affected by war.

REFERENCES

Allais, O., Fagherazzi, G., & Mink, J. (2021). The long-run effects of war on health: Evidence from World War II in France. *Social Science & Medicine, 276*, 113812. https://doi.org/10.1016/j.socscimed.2021.113812

Au, M., Lipschutz, R., Mekawi, Y., et al. (2024). The effect of mindfulness-based cognitive therapy on PTSD and depression symptoms in trauma-exposed Black adults: Pilot randomized controlled trial results. *Journal of Mood and Anxiety Disorders, 8*, 100092. https://doi.org/10.1016/j.xjmad.2024.100092

Benfer, N., Spitzer, E. G., & Bardeen, J. R. (2021). Efficacy of third wave cognitive behavioral therapies in the treatment of posttraumatic stress: A meta-analytic study. *Journal of Anxiety Disorders, 78*, 102360. https://doi.org/10.1016/j.janxdis.2021.102360

Christodoulou, D., Reeves, S., Carvalho, N. P., Stellman, J., & Gould, R. L. (2025). A systematic review of third-wave therapies to reduce distress and improve wellbeing and quality of life in people with Parkinson's disease. *Clinical Gerontologist*, 1–24. https://doi.org/10.1080/07317115.2025.2511957

Clarke, I., & Nicholls, N. (2017). *Third wave CBT integration for individuals and teams*. Routledge.

Cornelisse, S., Biermann, M., Enning, F., Schmahl, C., & Kleindienst, N. (2021). DBT-PTSD-EA: Behandlung der posttraumatischen Belastungsstörung nach interpersoneller Traumatisierung in der Kindheit bei Adoleszenten mit Borderline-Symptomatik. *Der Nervenarzt, 92*(7), 679–685. https://doi.org/10.1007/s00115-021-01151-8

Coventry, P. A., Meader, N., Melton, H., et al. (2020). Psychological and pharmacological interventions for posttraumatic stress disorder and comorbid mental health problems following complex traumatic events: Systematic review and component network meta-analysis. *PLOS Medicine, 17*(8), e1003262. https://doi.org/10.1371/journal.pmed.1003262

Cunha, O., Pereira, B., Sousa, M., & Rodrigues, A. C. (2024). Cognitive behavioural "third wave" therapies in the treatment of justice-involved individuals: A systematic review. *Aggression and Violent Behavior, 76*, 101923. https://doi.org/10.1016/j.avb.2024.101923

Dhollande, S., Taylor, A., Meyer, S., & Scott, M. (2021). Conducting integrative reviews: A guide for novice nursing researchers. *Journal of Research in Nursing, 26*(5), 427–438. https://doi.org/10.1177/1744987121997907

Forbes, C. N. (2020). New directions in behavioral activation: Using findings from basic science and translational neuroscience to inform mechanisms of change. *Clinical Psychology Review, 79*, 101860. https://doi.org/10.1016/j.cpr.2020.101860

Garry, S., & Checchi, F. (2019). Armed conflict and public health: Into the 21st century. *Journal of Public Health, 42*(3). https://doi.org/10.1093/pubmed/fdz095

Haddock, L. R. (2021). Third-wave cognitive behavioral theories with mindfulness-based interventions. In D. Capuzzi & M. D. Stauffer (Eds.), *Counseling and psychotherapy: Theories and interventions* (7th ed., pp. 217–236). American Counseling Association.

Hayes, S. C., & Hofmann, S. G. (2021). "Third-wave" cognitive and behavioral therapies and the emergence of a process-based approach to intervention in psychiatry. *World Psychiatry, 20*(3), 363–375. https://doi.org/10.1002/wps.20884

Hendrickx, M., Woodward, A., Fuhr, D. C., Sondorp, E., & Roberts, B. (2019). The burden of mental disorders and access to mental health and psychosocial support services in Syria and among Syrian refugees. *Journal of Public Health, 42*(3). https://doi.org/10.1093/pubmed/fdz097

Hunot, V., Moore, T. H., Caldwell, D. M., et al. (2013). "Third wave" cognitive and behavioural therapies versus other psychological therapies for depression. *Cochrane Database of Systematic Reviews*. https://doi.org/10.1002/14651858.CD008704.pub2

Kadir, A., Shenoda, S., Goldhagen, J., & Pitterman, S. (2018). The effects of armed conflict on children. *Pediatrics, 142*(6), e20182586. https://doi.org/10.1542/peds.2018-2586

King, A. P., Erickson, T. M., Giardino, N. D., et al. (2013). A pilot study of group mindfulness-based cognitive therapy for combat veterans with PTSD. *Depression and Anxiety, 30*, 638–645. https://doi.org/10.1002/da.22104

Leaning, J., & Guha-Sapir, D. (2013). Natural disasters, armed conflict, and public health. *New England Journal of Medicine, 369*(19), 1836–1842. https://doi.org/10.1056/NEJMra1109877

Linehan, M. M., & Wilks, C. R. (2015). The course and evolution of dialectical behavior therapy. *American Journal of Psychotherapy, 69*(2), 97–110. https://doi.org/10.1176/appi.psychotherapy.2015.69.2.97

Mahase, E. (2023). Israel and Gaza: MSF calls for end to "indiscriminate violence and collective punishment". *BMJ, 383*, p2383. https://doi.org/10.1136/bmj.p2383

Mangabeira, V., Kanter, J., & Del Prette, G. (2012). Functional analytic psychotherapy: A review of publications from 1990 to 2010. *International Journal of Behavioral Consultation and Therapy, 7*(2–3), 78–89. https://doi.org/10.1037/h0100941

Öst, L. G. (2007). Efficacy of the third wave of behavioral therapies: A systematic review and meta-analysis. *Behaviour Research and Therapy, 46*(3), 296–321. https://doi.org/10.1016/j.brat.2007.12.005

Shamir-Stein, N., Feldblum, I., Rotman, E., et al. (2024). Exploring the self-reported physical and psychological effects in a population exposed to a regional conflict. *Journal of Community Health, 49*(4), 674–681. https://doi.org/10.1007/s10900-024-01337-6

Singhal, S. (2019). Early life shocks and mental health: The long-term effect of war in Vietnam. *Journal of Development Economics, 141*, 102244. https://doi.org/10.1016/j.jdeveco.2018.06.002

Zaliska, O., Oleshchuk, O., Forman, R., & Mossialos, E. (2022). Health impacts of the Russian invasion in Ukraine: Need for global health action. *The Lancet, 399*(10334), 1450–1452. https://doi.org/10.1016/S0140-6736(22)00615-8

Authors' Contribution

All authors contributed equally to the development of this article.

Data availability

All datasets relevant to this study's findings are fully available within the article.

How to cite this article (APA)

Serhiieni, O., Melnychuk, S., & Zoska, Y. (2026). THE "THIRD WAVE" OF COGNITIVE BEHAVIORAL THERAPY IN REHABILITATION PROGRAMS IN CRISIS AND ARMED CONFLICT. *Veredas Do Direito*, 23(4), e234682. https://doi.org/10.18623/rvd.v23.n4.4682