



Cognitive Restructuring on the Psychological Wellbeing of Clients with Substance Abuse in the Psychiatric Unit of the Buea Regional Hospital.

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ABSTRACT

This study investigated the effect of cognitive restructuring on the psychological wellbeing of clients with substance abuse in the Psychiatric unit of Buea Regional hospital. It was hypothesized that cognitive restructuring affects the psychological wellbeing of clients with substance abuse. With this, it was argued that cognitive restructuring therapy has capacity to shape client lives entirely: their actions, reactions, decisions, choices, goals, interactions and emotional states in life situations. The social stress model (Rhodes & Jason, 1990); Ellis' (1973) rational emotive behavioural therapy and Bandura's social learning theory formed the theoretical foundation for the study. The quasi-experimental research design specifically the non-equivalent group was adopted for the study but reinforced with qualitative dimension. Ten clients with substance abuse from the psychiatric unit admitted in 2025 made up the sample size, evenly distributed into control and experimental group and five rehabilitation therapists. The purposive sampling technique was used. An experimental guide, Depression, Anxiety and Stress Scale-21 Items (DASS-21), and interview guide were the instruments used for data collection. The validity index of the instrument stood at 0.89, and reliability coefficient value 0.941. Data collected were analysed using Statistical Package for Social Science version 27 and thematically. Results showed that clients with substance abuse after cognitive restructuring intervention significantly improve on their psychological wellbeing with a depression, anxiety and stress mean score of 26.40 ± 2.694 , almost twice lower than participants in the control group without cognitive restructuring 43.60 ± 0.827 , mean difference of 17.20 (T-test value = 6.074, p-value $0.000 < 0.05$). The therapists reported to use techniques such as life event visualization, prompted dialogue, prompted transformation and they proceed via questioning and discussion. Circumstances that led to substance abuse by the clients were death of child, loss of job, husband infidelity, death of parents, broken relationship, and family abandonment due to pregnancy out of wedlock. This study contributes to knowledge by bringing out techniques of cognitive restructuring which constituted individual techniques that significantly affect client psychological wellbeing. Clients are aware of the dangers of substance abuse and what the beginning signs of addiction looks like. Thus, sensitization campaigns, creating awareness through social media, schools, community would help reduce the dangers associated with drug abuse and the ignorance associated with drug consumption. The study concluded that cognitive restructuring should be applied to improve the psychological wellbeing of clients with substance abuse. This could be supported by adequate implementation of policies on drug abuse, counselling and education for parents and communities and stronger social support.

INTRODUCTION

Substance abuse constitutes the self-administration of substances for non-medical reasons in quantities and frequencies which result in severe physical, social, and emotional consequences. It has become an endemic public health concern, affecting the health, family, and professional lives of young people globally (Schulte & Itser, 2013). While motives for abuse range from sociological, psychological, emotional or family background, curiosity, experimentation, personality problems, frustration, drug availability, poverty, peer pressure and the need for stress relief and emotional stability, the consequences are often dire. This is because drugs systematically destroy physical and mental health and relationships (Wall & Kohl, 2007). Not only adults are engaged in substance abuse but adolescents are taking the lead due to the uncontrollable disposition of the substances which has for many times push parents from different parts of the country denouncing substance abuse and calling on

the government to intensify efforts to crack down on drug suppliers.

Substances like tramadol, shisha, and cocaine are commonly consumed and in abusive ways resulting to negative impacts on psychological wellbeing, triggering mental illness symptoms including anxiety, depression, and suicidal ideation. Aside low psychological wellbeing, clients with substance abuse are exposed to high risk of cardiovascular disease, liver damage, and respiratory failure. This study investigated the effects of cognitive restructuring on the psychological wellbeing of clients with substance abuse in the psychiatric unit of the Buea Regional hospital.

Historically, substance abuse has been considered as a critical health-related social and economic problem in most countries. In the last three decades, the world has experienced shocking figures of thirty-five million people expressing substance abuse prevalence in societies, especially among teenagers and the youth, and eleven million people also injected drugs in 2017 (Jahromi et al., 2009).

Substance abuse evolved with opium, which is a mixture of natural alkaloids. The principal active ingredient in opium is morphine, which is indicated for the relief of severe acute and severe chronic pain. More so, cocaine, a crystalline alkaloid derived from the leaves of the cocoa plant, *Erythroxylon Coca*, is endogenous to South America, Mexico, Indonesia and West Indies (Goldstein et al., 2008). Cocaine has been used for centuries by the natives of these countries as a general stimulant, hunger suppressant and an important part of religious rituals.

United Nation Office for Drug Control (2011) considered cocaine as the most problematic drug worldwide in terms of trafficking-related violence. Marijuana is also another commonly abuse substance despite its own positive values used in the fabrication of cosmetics products and many more. Going back as 1980 and 1988, the Anti-Drug Abuse Acts increased funding for treatment and rehabilitation due to the negative sides of the drugs (European Monitoring Centre for Drug Addiction, 2017). Countless state laws specified a variety of punitive measures, including life imprisonment and even death penalty for drug tracking. For example, in USA, we have (Organised Crime Control Act, 1970; Gabay, 2013; Drug Enforcement Administration [DEA], 1973; Department of Justice, 2018). In Africa, United Nations Drug Control Programme had long reported that drug abuse cuts across nearly all categories of people, ranging from youths and adults, rich and poor, rural and urban people intensified by the emergence of West Africa as a transit point in the 1970s and 1980s.

More so, the most used substances in many African countries include alcohol, tobacco, cannabis and khat (Odejide, 2006). khat has been called the archetypal quasi-legal substance because of its recreational and medicinal use and as medicine (Carrier & Klantschnig, 2018). It is an indigenous plant to Eastern and Southern Africa and contains the psychoactive alkaloids cathine and cathinone that have been used as a recreational stimulant in Ethiopia and Yemen since the 12th century (Van, 2015). As a recreational drug, the leaves and stem are chewed by people in East Africa and the Arabian countries to elevate mood. As a medicine, the khat leaf is used for depression, fatigue, obesity, stomach ulcers, and male infertility.

In Cameroon, back as in 1996, an assessment by Wansi et al. (1996) reported that males and females of all age groups were involved in the consumption of recreational substances. Narcotics consumed in Cameroon ranged from cannabis (marijuana) which was the most consumed, to traditional drugs used to diagnose, cure, treat, or prevent disease as well as cocaine and heroin. In 2018, the Cameroon's National Anti-Drug Committee (CNLD) revealed that 21% of the population have already tried hard substances, 10% are frequent consumers aged twenty to twenty-five. Most demanded substance products were cannabis (58.54%) usually associated with tobacco and tramadol (44.62%). Others were cocaine (12.10%), solvents (7.36%) and heroin (5.7%).

In 2023, reports from addiction treatment centres revealed that 17.2% of addiction cases were

adolescents aged under 19, while 34% were young adults aged between 20 and 24. Based on data on drug consumption, the prevalence rates of drug-related disorders have risen from 18.83% to 31.82% (psychosis), 10.38% to 14.99% (depression) and 6.88% to 8.83% (drug use and consequences) between 2021 and 2024, with even greater increases in some regions, such as Centre, North-West, South-West, East and Littoral over the same period (Minister of public health, 2025).

In support of this scenario, Lo-oh and Afumbom (2017) opined that in Cameroon despite legislative efforts and collaboration with international bodies to curb drug trafficking, the prevalence of substance abuse among youths remains alarmingly high. Evidence-based observations reveal an increase in fear by parents, staff, clergy, civil society, young people/individuals themselves and local administrators who have jointly engaged in continuous efforts to curb the spread of substance abuse. Substances like tramadol, shisha, and cocaine are commonly consumed and in abusive ways resulting to negative impacts on psychological wellbeing, triggering symptoms of mental illness such as anxiety, depression, and suicidal ideation. Aside low psychological wellbeing, clients with substance abuse are exposed to high risks of cardiovascular disease, liver damage, and respiratory failure. This study investigated the effects of cognitive restructuring on the psychological wellbeing of clients with substance abuse in the Psychiatric Unit of the Buea Regional Hospital.

Objective of the study

The main objective of this study was to investigate the effects of cognitive restructuring on the psychological wellbeing of clients with substance abuse.

This objective was substantiated by the following hypothesis:

Cognitive restructuring does not significantly affect the psychological wellbeing of clients with substance abuse in the Psychiatric Unit of the Buea Regional hospital.

Statement of Problem

Young people are expected to enjoy a state of positive psychological wellbeing, characterized by emotional stability, self-acceptance, and the ability to cope with daily stressors without reliance on psychoactive substances. They are expected to possess a sense of belonging and engage in productive activities that contribute to their personal growth and societal development. However, there is a marked escalation in substance abuse, with drugs such as tramadol, marijuana, shisha, cocaine, and alcohol becoming freely available and increasingly consumed by young people for curiosity or mood modification. This abuse has resulted in severe deterioration of the mental health of youth, manifesting as anxiety, depression, social maladjustment, and a loss of purpose. Beyond

the individual psychological toll, this scourge propagated school-related problems, such as violence, truancy, and academic failure, effectively “washing away” the potential of the youthful population.

Despite government measures, media sensitization, and existing health warnings to curb this menace, the rate of substance abuse remains alarmingly high and destructive. This suggests that current general interventions may be insufficient and that there is a critical need for structured, evidence-based psychotherapeutic approaches that address the root cognitive and behavioural patterns of addiction. This study seeks to find out the effects of utilizing cognitive restructuring on the psychological wellbeing of clients with substance abuse in the Psychiatric Unit of the Buea Regional Hospital.

REVIEW OF RELATED LITERATURE

Substance abuse

According to the American Psychiatric Association (1994) and classified in the Diagnostic and Statistical Manual IV (DSM-IV), substance abuse is substance-related disorders and substance induced disorders. These disorders include the active use and/or dependency on any mood-altering substance. The process of substance dependence is a complex one, involving an interaction of biogenetic, neurochemical, and psychological factors. Therefore, it's hard to predict that someone will eventually engage in substance abuse unless it happens.

Hingson et al. (2009) reported that more than ninety-seven thousand youths aged eighteen to twenty-four are substance related victims of sexual assault and date rapes. As a result, there is a higher chance of mishaps, injuries, poor academic performance, criminal activity, strained social relationships, sexual assault, depression, mental illness, and hazardous sexual conduct (Zufferey et al., 2007). According to Piehler et al. (2012), exposure to any stressors elevates negative emotional states (or internalizing symptoms) which result in negative feelings and in turn lead to high substance use and more risk for substance-use disorders. Bano et al. (2019) stipulated that substance abuse is not only health problem but also a social problem for family and society that affects people's psychological wellbeing which is the interest of the study examined in terms of depression, anxiety, and stress.

Low levels of psychological wellbeing include disturbed relationships with others, lack of autonomy, decrease environmental mastery, lack of purpose in life, and personal growth make individuals vulnerable towards escape from unwanted situations and this escape lead them towards drug abuse. Low psychological wellbeing has also been strongly linked to disturb physiological patterns and triggering changes that are inimical to organs functioning and triggers some noncommunicable diseases like heart dysfunction, erectile problems, hypertension, increased risk of stroke, and capillary haemorrhages. They are myriads of substances abuse by persons

ranging from liquid form to solid form for various motives. For example, long term habitual use of alcohol increases tolerance but eventually causes damage to the brain (Craig & Baucum, 2001) while its short-term abuse may affect the cognitive performance (Rice & Dolgin, 2008).

Another substance abuse on a rise is tramadol, a prescription opioid painkiller known for moderate pain relieve. Mbanga et al. (2018) reported that tramadol and cannabis are the most consumed recreational substances among medical nursing students in Cameroon. Tramadol is a drug that is abuse heavily in urban and rural areas mostly by youths in Cameroon. Exacerbated by the armed conflict in the country, the rate of tramadol abuse among youths has surge that mothers have protest countless times on the street reiterating for enforced government actions. As reported by Nakhaee et al. (2021), tramadol slows down lung and heart function and WHO (2020) reported that taking tramadol in combination with other substances as many youths do, also increases the risk of serious and sometimes fatal side effects, withdrawal symptoms and manifestation of symptoms of irritability and depression.

Looking at the petrified trends of substance abuse in Cameroon, notably among youths, at the Government Bilingual High School, Nkoi-Eton in Yaoundé, a school inspection revealed young people carrying cannabis and weapons, underscoring the link between substance use and school violence (Kingsley et al., 2022). Asoh and Bruno (2022), exclaimed that this issue prompted a consultative workshop in Buea, where educators and regional delegates discussed tailored preventive strategies. More recent studies also confirm substance use among both high school youths (Nkouonlack et al., 2023) and university youths (Edzamba et al., 2024) in Cameroon. A previous study among 399 street children aged 12 to 19 years in Cameroon revealed that they were actively using psychoactive substances (Mabouopda et al., 2022). Atabong et al. (2022) stipulated that in the South West region where there is an ongoing armed conflict, some of the highest rates of substance use have been reported in recent years: alcohol (62.5%), cigarette smoking (23.8%), tramadol (12.1%), marijuana (9.6%), and hard drugs (>3%). Thus, if this trend continues, the health system in Cameroon would be strained, the nation manpower productive capacity would be stagnant, societal ills would escalate, and family burdens increases.

Cognitive restructuring

Cognitive restructuring is a therapeutic process that helps client discover and challenge irrational thoughts (Clark, 2013) and it is used to treat a wide variety of conditions including depression, addictions, anxiety, social phobias, relationship issues and stress. Cognitive restructuring is classified as the main cognitive behavioural therapy in treating clients with substance abuse. It is a structured and collaborative therapeutic approach in which distressed individuals are taught how to identify, evaluate, and modify the faulty thoughts, self-evaluations, and beliefs that are

considered responsible for their psychological disturbance (Dozois, 2010). A key goal of cognitive restructuring is to reverse this maladaptive schema-congruent processing bias. This means replacing stress-producing thoughts (cognitive distortions) with more balanced thoughts that do not produce stress. This is done by questioning the automatic acceptance of negative schema-congruent information and encouraging assimilation of more adaptive schema-incongruent data.

Cognitive restructuring is used for people whose personality is pessimistic, shows doubt and pressure under certain circumstances, or is carried away by ordinary life problems using drastic measures. By discriminating between the considerations that trigger the sensation of tension, children can find ways to challenge their own self-defeating contemplations with coping thoughts (Velting et al., 2006). Cognitive restructuring equally lowers stress, replacing stress-producing thoughts (cognitive distortions) with more balanced thoughts that do not produce stress, alleviate anxiety, strengthen communication skills and build healthier relationships. It replaces unhealthy coping mechanisms like substance use and rebuilds self-confidence and self-esteem. According to Ellis (1973), its techniques give clients who abuse substances the opportunity to talk about themselves, reasons for abusing substances, risk involved in substance abuse, how to stop abusing substances and the development of rational thinking.

Furthermore, cognitive restructuring techniques have great success in identifying challenges and replacing faulty ways of thinking with more accurate, helpful, and positive ways of thinking. According to Becks (2011), some of these techniques include Socratic questioning, guided imagery, life event visualization, reinstatement of a dream or daytime image, feeling focusing, summary and reframing, directed dialogue, prompted dialogue, directed transformation, prompted transformation, and thoughts records which are beneficial for substance abuse clients thus, helping them reshaped their thoughts and behaviour.

Cognitive restructuring has three critical components which are necessary to achieve schematic change and each component consists of various intervention strategies. With cognitive restructuring intervention, therapist encourages the client to use Socratic questioning approach to long-held beliefs and attitudes, guided imagery, life event visualization, and reinstatement of a dream or daytime image. The therapist uses Socratic questioning of the client's past personal experiences to evaluate the validity of maladaptive beliefs and to introduce the possibility of a more adaptive alternative perspective. The client is encouraged to test his/her experience. According to Muhamad and Setiawati (2020), cognitive restructuring is the most common way to find and assess an individual's insight. Beck (2011) adds that cognitive restructuring techniques have great success in identifying and replacing faulty ways of thinking with more accurate, helpful, and positive ways of thinking.

A theoretical perspective on which cognitive restructuring is driven from is the modified social stress

model which posits that substance use is initiated as a coping mechanism for stressors arising from the family, school, or community. The risk of abuse is determined by the balance between risk factors (stress, victimization) and protective factors (social competencies, positive attachments, resources). Thus, cognitive behavioural therapy acts as a resource to build the protective skills necessary to offset environmental stressor, thereby restructuring the mindset of substance abuse clients.

Psychological wellbeing

Huppert (2009) defined wellbeing as the combination of feeling good and functioning well, the experience of positive emotions such as happiness and commitments as well as the development of one's potential, having some control over one's life, having a sense of purpose and experiencing positive relationships. Psychological wellbeing state depends on the mental wellbeing of individuals. On this note, World Health Organisation (WHO, 2021) defines mental wellbeing as a state of mind in which a person is able to develop their potential, work productively and creatively, and is able to cope with the normal stresses of life.

Therefore, maintaining low levels of negative emotions is critical for psychological wellbeing since it enables clients to sustain pleasant feelings and prevents adverse effects on mental health (Keyes & Lopez, 2002). Positive relations with others signify a warm, satisfying, trusting relationships with others; concern for the welfare of others; capacity for strong empathy, affection, and intimacy; and understanding of the give-and-take of relationships. Clients exhibiting a positive relation with others would describe themselves as a giving type, willing to share their time with others and willing to help and share positive ideas with others. However, when substance enters in the scene, relational life becomes problematic. Stewart and Harkness (2017) opined that poor interpersonal social relationship experienced by clients with substance abuse play an important role in generating negative emotions such as depression and anxiety.

Another key component of psychological wellbeing is autonomy which is the ability to make decisions and act in a self-determined way. When an individual abuses substances either due to stress or depression, it impairs autonomy and it prevents them from sufficiently integrating their agency over time. An essential component of wellbeing is having a feeling of purpose in life, or a reason to live as it gives individuals a sense of direction and meaning. People are more likely to feel content and happy if they have a clear sense of purpose (Sheldon & King, 2001).

Depending on the relative balance of the equation, young people may either turn to early drug abuse as a means of coping with stress or choose to avoid the pressures to engage in substance abuse and other high-risk behaviours. Some young people may engage in drug abuse to reduce stress arising from a lack of support and pride in one's family, difficulties with peers or at school, or lack of family and community resources. According to this model, the likelihood of

people engaging in drug abuse is a function of the stress level. For instance, regular and helpful parents and teachers may lead to the acquisition of appropriate social competencies and may facilitate the development of hardy, resilient individuals. The social stress model highlights that substance use is a coping mechanism for environmental stress, which aligns with cognitive behavioural therapy's goal of building skills to manage stressors without drugs.

Rhodes and Jason (1990) model propose that substance abuse results from deficiencies in coping skills, social networks, and community resources. The social stress model emphasizes that Urban youth often turn to drugs due to lack of social resources, such as supportive mentors. This theory fits well in the study because cognitive restructuring could act as a social resource to clients with substance abuse by helping them to rethink of their actions, wrong thought, and wrong beliefs, and see reasons to deviate from substance abuse. Cognitive restructuring therapy can be used as a social resource support that could be given by therapy, friends, and family relatives.

METHODS

Research design: The quasi-experimental research design especially the non-equivalent group was used because assignment of participants into the control and experimental group was not done using randomisation as in the case with randomized control trials. In addition, the quasi-experimental design, a qualitative dimension was added for robust results.

Population of the study: The population of this study constituted clients (young people) with substance abuse at the Psychiatric Unit of the Buea Regional hospital and five rehabilitation therapists. Statistics from 2022 to 2025 showed that there were 126 substance abusers (The Psychiatric Unit of Buea Regional Hospital, 2026).

Sample size: The sample consisted of ten (10) clients (young people) with substance abuse. They were equally distributed to the control and experimental groups. They were recruited with the collaboration of the Chief of Centre at the Psychiatric Unit of the Buea Regional Hospital.

Table 1: Distribution of Participants by Demographic Information

Demographic characteristics		Frequency	Percentage
Age range (n=10)	15-16 years	1	10.0
	17-18 years	4	40.0
	19 years and above	5	50.0
Gender (n=10)	Female	5	50.0
	Male	5	50.0
Neighbourhood (n=10)	Muea	3	30.0
	Malingo	2	20.0
	Bomaka	1	10.0
	Dirty South	1	10.0
	MILE 16	1	10.0
	Mile 18	1	10.0
	Sosoliso	1	10.0
Parents living (n=10)	Alive	8	80.0
	Death	2	20.0
Marital status (n=10)	Married	4	40.0
	Single	6	60.0

Among the ten participants who took part in the experiment, age range, 50% (5) of them were 19 years and above to 25 years, 40% (4) were within 17-18 years, and 10% (1) 15-16 years. Gender wise, an equal number of males 50% (5) and females 50% (5) were sample for the study. The gender balance was good to rule any effect of intervening variable gender wise and to solidify outcome of the study. In terms of neighbourhood the ten participants span across seven neighbourhoods in Buea. More so, among the ten participants, majority of them 80% (8) parents were alive and 20% (2) parents were death. Finally, based on marital status, 60% (6) were single and 40% (4) were married.

Instruments for Data Collection: This study made use of two data collection instruments; a questionnaire on psychological wellbeing for clients with substance

abuse and an interview guide for rehabilitation therapists. The instrument used to collect data was the Depression, Anxiety and Stress Scale-21 Items (DASS-21) developed by Lovibond and Lovibond (1995). Each of the three DASS-21 scales contains 7 items. The depression scale assesses dysphoria, hopelessness, devaluation of life, self-deprecation, lack of interest or involvement, anhedonia and inertia. The anxiety scale assesses autonomic arousal, skeletal muscle effects, situational anxiety, and subjective experience of anxious affect. The stress scale is sensitive to levels of chronic non-specific arousal. It assesses difficulty relaxing, nervous arousal, and being easily upset or agitated, irritable or over-reactive and impatient. Scores for depression, anxiety and stress are calculated by summing the scores for the relevant items.

Reliability of Instrument: To ensure that the instruments are reliable for the study, a pilot study was carried out on five persons. Quantitative data collected

from the participants were tested using the Cronbach Alpha test and the coefficient value was 0.941, above 0.7.

Table 2: Test of Normality

Variables		Group	Kolmogorov-Smirnov ^a			Shapiro-Wilk		
			Statistic	df	Sig.	Statistic	df	Sig.
Cognitive restructuring	Depression score	Control	.144	10	.200*	.964	10	.834
		Experimental	.169	10	.200*	.866	10	.090
	Anxiety score	Control	.227	10	.155	.942	10	.579
		Experimental	.192	10	.200*	.966	10	.852
	Stress score	Control	.216	10	.200*	.923	10	.380
		Experimental	.225	10	.165	.905	10	.250
	Total psychological wellbeing score	Control	.169	10	.200*	.926	10	.411
		Experimental	.150	10	.200*	.968	10	.871
		Experimental	.272	10	.034	.887	10	.158

*. This is a lower bound of the true significance.

a. Lilliefors Significance Correction

Data from the test of normality revealed that for sub-scale components and at all levels and group, the data did not significantly deviate from the normal distribution curve (p -value > 0.05). Therefore, the use of a parametric T-test was preferred the Mann Whitney U-test which is non-parametric and applicable when data is significantly skewed from the normal distribution. On

the other, the qualitative data from some substance abuse persons and therapists were analysed using the thematic analysis approach with the aid of themes and quotations. Finally, the results were presented using tables, figures, and inferential statistics set at 95% confidence interval.

Table 3: Clients' Psychological Wellbeing at Pretest

Group	Test level (Pretest)	Depression score	Anxiety score	Stress score	Total psychological wellbeing score
Control	N	5	5	5	5
	Mean	16.20	15.20	16.00	47.40
	Median	17.00	15.00	16.00	50.00
	Minimum	11	11	11	38
	Maximum	20	20	19	59
	Std. Error of Mean	1.463	1.715	1.483	3.957
	Std. Deviation	3.271	3.834	3.317	8.849
Experimental	N	5	5	5	5
	Mean	14.00	11.80	13.00	38.80
	Median	15.00	13.00	11.00	39.00
	Minimum	12	7	10	29
	Maximum	15	17	18	50
	Std. Error of Mean	.632	1.881	1.517	3.569
	Std. Deviation	1.414	4.207	3.391	7.981

At pretest level when the substance abuse clients did not receive cognitive restructuring intervention, in the control group, the depression mean score was 16.20 ± 1.46 , median score 17, minimum score 11 and maximum 20. The high standard deviation of 3.271 confirmed great variation in depression score among the five clients. However, in the experimental group, depression mean score was 14.00 ± 0.632 , median score was 15, minimum score 12 and maximum 15. The low standard deviation of 1.414 also confirmed low variation in the experimental group.

For anxiety, control group mean score was 15.20 ± 1.72 , median score 15, minimum score 11 and maximum 20.0 The high standard deviation of 3.834 confirmed great variation in anxiety score among the

five clients. In the experimental group, anxiety mean score was 11.80 ± 1.88 , median score 13, minimum score 7 and maximum score 17. The high standard deviation of 4.207 confirmed high variation in the experimental group. For stress, control group mean score was 16.00 ± 1.48 , median score 16, minimum score 11 and maximum 19. The high standard deviation of 3.317 confirmed great variation in stress score among the five clients. In the experimental group, stress mean score was 13.00 ± 1.517 , median score 11, minimum score 10 and maximum score 18. The high standard deviation of 3.391 confirmed high variation in the experimental group as well.

In total, the overall mean score for the control group was 47.40 ± 3.957 and 38.80 ± 3.569 in the

experimental group which were both high, indicating that psychological wellbeing was low among clients with substance abuse. Although the mean scores were not exactly same in both group at pretest level, we must be cognizant that clients with substance abuse differ in

their characteristics and will not be affected exactly in the same level. Despite this variation, the high mean both groups at pretest test level revealed low psychological wellbeing.

Table 4: Clients' Psychological Wellbeing at Post Test

Group	Test level (Post test)	Depression score	Anxiety score	Stress score	Total psychological wellbeing score
Control	N	5	5	5	5
	Mean	13.40	15.20	15.00	43.60
	Median	13.00	15.00	15.00	43.00
	Minimum	12	13	14	41
	Maximum	15	19	16	46
	Std. Error of Mean	.510	1.020	.447	.872
Experimental	Std. Deviation	1.140	2.280	1.000	1.949
	N	5	5	5	5
	Mean	9.00	8.00	9.40	26.40
	Median	10.00	9.00	10.00	26.00
	Minimum	6	4	7	20
	Maximum	13	11	12	36
	Std. Error of Mean	1.342	1.183	.872	2.694
	Std. Deviation	3.000	2.646	1.949	6.025

At post-test level after the substance abuse clients in the experimental group had cognitive restructuring intervention while those in the control did not, the mean score for depression was 9.00 ± 1.342 , anxiety 8.00 ± 1.183 , and stress 9.40 ± 0.872 , with an overall mean of 26.40 ± 2.694 , all very low when compared to the mean scores at the pretest level. However, for the control group, the post-test mean score remain almost

same (high) as seen at the pretest level, indicating a slight drop in the mean score from 47.40 ± 3.957 observed at pretest level to 43.60 ± 0.872 observed at post-test level. This slight drop in mean score was attributed more to the drop in depression score from 16.20 at pretest to 13.40 at post-test in the control group whereas anxiety and stress stay almost same.

Table 5: Therapists Opinion of Cognitive Restructuring

Question	Themes	Quotations
Use cognitive restructuring therapy in treating substance abuse persons	Yes	"Yes."
		"Yes."
		"Yes"
		"Yes"
		"Yes"
Use techniques such as life event visualization, prompted dialogue, prompted transformation?	Yes	"Yes"
		"Yes."
		"Yes"
		"Yes."
How do you proceed?	No	"No"
		"Discussions and questioning."
		"Discussions and seminars."
		"Engage in meaningful discussions and clients' responds positively."
How effective is cognitive restructuring	Effective	"Effective."
		"Effective."
		"Effective."
	Ineffective	"Not effective."

Moreover, from the interview with therapists on the use of cognitive restructuring, all of them agreed using cognitive restructuring in treating substance abuse persons. In addition, most of them said they make use of techniques such as life event visualization, prompted dialogue, and prompted transformation while one does not. For those who accepted to use techniques such as

life event visualization, prompted dialogue, and prompted transformation, they proceed more by discussions and seminars as explained in the statements "*Discussions and seminars.*", "*Engage in meaningful discussions and clients' responds positively.*" Finally, almost all the therapists indicated

that cognitive restructuring techniques are effective on clients with substance abuse.

In conclusion, regarding the effect on cognitive restructuring on clients with substance abuse, findings

from the experimental group, testimonies shared, and opinion of the therapists aligned regarding the effectiveness of cognitive restructuring.

Table 6: Effect of Cognitive Restructuring on the Psychological Wellbeing of Clients

Group Statistics		Group	N	Mean	Std. Deviation	Std. Error Mean	T-test value
Test level							
Post test	Depression score	Control	5	13.40	1.140	.510	T-value=3.066
		Experimental	5	9.00	3.000	1.342	p-value =0.015
	Anxiety score	Control	5	15.20	2.280	1.020	T-value=4.609
		Experimental	5	8.00	2.646	1.183	p-value =0.002
	Stress score	Control	5	15.00	1.000	.447	T-value=5.715
		Experimental	5	9.40	1.949	.872	p-value =0.000
	Total psychological wellbeing score	Control	5	43.60	1.949	.872	T-value=6.074
		Experimental	5	26.40	6.025	2.694	p-value =0.000

Df= 8, Confidence interval 95%, Levene Test for Equality of Variance (Depression: $F=5.418$, p-value 0.048, Anxiety: $F= 0.267$, p-value = 0.619, Stress: $F=2.331$, p-value =0.165, Overall: $F=1.998$, p-value =0.195)

Statistically, results showed that clients with substance abuse in the experimental group at post-test level after cognitive restructuring intervention significantly improve on their psychological wellbeing with a depression, anxiety and stress mean score of 26.40 ± 2.694 , almost twice lower than participants in the control group without cognitive restructuring 43.60 ± 0.827 , mean difference of 17.20 (T-test value = 6.074, p-value $0.000 < 0.05$). In fact, a cross comparison with the pretest total mean score of 38.80 ± 3.569 revealed that participants in the experimental group drop in their total depression, anxiety, and stress score by 12.4. This showed that cognitive restructuring reduces participants in the experimental group depression, anxiety, and stress by almost half, confirming it significant effect. Depression, anxiety, and stress were all significantly lower for experimental group when compared to control group (p-values < 0.05). Thus, the null hypothesis was rejected and the alternative hypothesis that states there is a significant effect of cognitive restructuring on the psychological wellbeing of clients with substance abuse was accepted.

DISCUSSIONS

The results showed that cognitive restructuring has a strong and positive effect on the psychological wellbeing of clients with substance abuse. Elaborately, clients with substance abuse in the experimental group at post-test level after cognitive restructuring intervention significantly improve on their psychological wellbeing with a depression, anxiety and stress mean score significantly lower than persons in the control group who never had any cognitive restructuring. In fact, the psychological wellbeing of the substance abuse clients after cognitive restructuring improve to almost twenty percent. Specifically, cognitive restructuring was reported to boast determination,

positivity, and see past mistakes as learning process to do better in the future. Some therapists confirmed that they use techniques such as life event visualization, prompted dialogue, and prompted transformation which they all reported as effective and affordable in treating clients with substance abuse.

Our findings tied with that of Bela et al. (2022) who carried out a study on cognitive restructuring techniques for controlling the self-control of victims of drugs abuse and the results indicated that the effect of self-control on victims of drug abuse after group counselling with cognitive restructuring techniques is categorized as moderate because the average value is 6.72 and after the average value is 8.25. The moderate increase in self-control depicted in the study of Bela et al. (2022) aligned with the twenty percent increase (moderate) in the psychological wellbeing of the substance abuse persons after cognitive restructuring.

Furthermore, our findings corroborate with that of Ali et al. (2021) who conducted a study on the effectiveness of the cognitive restructuring approach on irrational beliefs and hopelessness in individuals with substance abuse disorder and the results showed that the cognitive restructuring approach was effective in reducing the irrational beliefs and hopelessness of the subjects in the experimental group. In the same alignment, study by Zahiri et al. (2016) on the effect of cognitive restructuring therapy on anxiety in substance abuse persons' results showed that cognitive restructuring therapy significantly reduces the state and trait anxiety of the substance-dependent individuals. Thus, our findings and that of previous studies all confirmed how significant cognitive restructuring is to the psychological wellbeing of substance abuse persons.

According to social stress theory by Rodes and Jones (1990), drug abuse is viewed as the long-term outcome of multiple experiences with significant others and social systems from birth through adolescence. According to the social stress model, people initiate

substance use and abuse as a means of coping with a variety of stressors and influences that may arise from within the family, the school, the peer group, or the community. This perfectly aligned with the findings of our study where myriads of reasons were noted for causing substance abuse among the study participants. The reasons were child death, husband infidelity, stress, peer pressure, curiosity, low self-esteem, and zeal to enhance performance. The motive for using drugs varied among the substance abuse persons.

The social stress theory also stated that individuals would be more resilient and less likely to engage in problematic early usage as a means of coping with these stressors if there are members of prosocial and supportive social networks. Thus, the risk for abuse would be reduced if individuals have developed adequate social competencies to offset the stressors of adolescence and pressures to abuse drugs and if they have sufficient community resources, role models, and opportunities. Cognitive restructuring is a counselling therapy that even non-professional therapists can use to help substance abuse persons.

As reiterated by social stress model, its emphasis people and family systemic support to help substance abuse persons. Helping persons who abuse drugs to stop is a collective effort that must be supported with professional guide from therapists. For example, Dobson and Dozois (2010) opined that cognitive restructuring is a structured, collaborative therapeutic approach in which distressed clients are taught how to identify, evaluate, and modify the faulty thoughts, evaluations, and beliefs that are considered responsible for their psychological disturbance.

From this description, it's vital that even when family can't afford the services of professionals, family members or loved ones should be ready to help their loved ones trapped in substance abuse due to some ugly past experiences or curiosity motives. Our findings proved that the substance abuse persons feel defeated and worthless. In fact, why some of them do abuse drugs to console themselves, it is clear that with systematic supports from loved ones and family, their psychological wellbeing will be more improve. We argued on the fact that cognitive restructuring even had stronger effect on substance abuse persons who got some family support from their parents than those whose parents were death. Therefore, clients with substance abuse without any intervention wallow in their drugs addiction and will eventually continue to get worst. Family relatives and loved ones can use simply questioning and discussion approach to help their loved ones trapped in substance abuse rethink of their actions.

CONCLUSION

In conclusion, with evidence from our study and that of previous researchers in other countries, cognitive restructuring was proven to have profound positive effects on the psychological wellbeing of clients with substance abuse. In fact, it was proven to significantly reduce depression, anxiety, and stress level but

significant social supports are needed to strengthen the effectiveness of cognitive restructuring. In addition to the social support, significant collaboration is expected of the substance abuse persons. This implies that even with refined therapists, if clients with substance abuse reject collaboration, their situation will not improve and they will continue to wallow in their psychological distress that could even result to suicide, complete self-destruction, harming of loved ones, and strained family resources. In addition, uncollaborative nature of the substance abuse persons to treatment can even have a ripple mental effect on family members that are close to the substance abuse person.

The causes that led to substance abuse were death of parents, death of child, broken relationship, marital problems such as husband infidelity, loss of job, and family abandonment for getting pregnant out of wedlock. These causes were found to have substantial negative effects on the persons. Thus, from these causes, it is lucid that some clients with substance abuse would have been completely avoided if their family accepted their mistake such as getting pregnant out of wedlock and still show them love instead of neglecting them to suffer from their mistakes.

REFERENCES

- Ali, M.A., Ullah, R., & Khalid, S. (2021). Effectiveness of cognitive restructuring on reducing craving and relapse among individuals with substance use disorder. *Journal of the Pakistan Psychiatric Society*, 18(4), 16-20.
- American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders*. (4th ed.).
- Asoh CP, Bruno BB. (2022). Social media and substance abuse: Implication for preventive strategies among adolescent students in Urban schools in Cameroon. *Int J Trend Sci Res Dev.*, Sep-Oct; 6(6):615-27.
- Atabong, E.N., Fombo, E.J., Nyuydzedze, S. S., & Kemndah, D. (2022). Prevalence and predictors of recreational drug use in a conflict affected area in the Southwest region of Cameroon: A cross-sectional study. *Journal of Public Health and Epidemiology*, 14(2), 107-115.
- Bano Z, Naz I, Leghari N, Ahmed I. (2019). Psychological wellbeing of substance use patients: Role of religious therapy as the treatment. *Pak J Med Sci.*;35(5): 1376-1381
- Beck, A. T., Weishaar, M. E. (2011). *Cognitive therapy*. In Current Psychotherapies, ed. RJ Corsini, D Wedding, pp. 276–309. Brooks/Cole.
- Bele, G.K., Girei, B.I., & Gana, H.Y. (2022). Effectiveness of cognitive restructuring and rational emotive behaviour therapy on relapse prevention among drug abusers in Taraba State, Nigeria. *Lafia Journal of Education*, 6(1), 1-8.
- Cameroon's National Anti-Drug Committee (CNLD) (2018).

- Carrier, N., & Klantschnig, G. (2018). Quasilegality: Khat, cannabis, and Africa's drug laws. *Third World Quarterly*, 39(9584), 1-16.
- Clark, D. A. (2013). Cognitive restructuring. In S. G. Hoffman, D. J. A. Dozois, W. Rief, & J. Smiths (Eds.), *The Wiley handbook of cognitive behavioral therapy* (pp. 1-22). John Wiley & Sons.
- Craig, G. J. & Baucum, D. (2001). *Human development*. (9th ed.). London: Prentice Hall
- Dobson, K. S., & Dozois, D. J. A. (2010). Historical and philosophical bases of the cognitive-behavioural therapies. In K. S. Dodson (ED.), *Handbook of cognitive-behavioural therapies* (3rd ed., pp. 3-38). New York, NY: Guilford Press.
- Durdle, H., Lundahl, L. H., Johanson, C. E., & Tancer, M. (2008). Major depression: The relative contribution of gender, MDMA, and cannabis use. *Depression and Anxiety*, 25(3), 241-247.
- Edzamba, M. F., Cheuyem, F. Z. L., Amani, A. & Mossus. T. (2024). Prevalence of substance use and related behaviours among tertiary students: Across-sectional survey in Yaoundé, Cameroon. *AJBSR*.21(2),120-137.
- Goldstein, LB., Amarenco, P., Szarek, M., Callahan, A 3rd, Hennerici, M., Silleisen, H., Zivin, J.A., & Welch, K.M. (2008). Hemorrhagic stroke in the stroke prevention by aggressive reduction in cholesterol levels study. *Neurology*, 70(24Pt2), 2364-70.
- Goldstein, R. A, Deslauriers C, Burda AM. (2009). Cocaine: history, social implications, and toxicity-a review. 55: 6-38.
- Hingson, R.W., Zha, W., & Weirzman, E.R. (2009). Magnitude of and trends in alcohol-related mortality and morbidity among US college students ages 18-24: Changes from 1998 to 2005. *Journal of Studies on Alcohol and Drugs*, 70 (2), 270-279.
- Huppert F.A. (2009). Psychological wellbeing: Evidence regarding its causes and consequence. *Applied Psychology, Health and Well-Being*, 1, 137-164.
- Jahromi, B. L., Kasari .C.L., McCracken, J.T., Lee, L.S., Aman, M.G., McDouggle, C.J., Scahill, L., Tierney, E., Arnold, L.E., Vitiello, B., Ritz, L., Witwer, A., Kustan, E., Ghuman, J., & Posey, D.J., (2009). Positive effects of methylphenidate on social communication and self-regulation in children with pervasive developmental disorders and hyperactivity. *J Autism Dev Disord*, 39(3), 395-404.
- Keyes, C. L. M., & Lopez, S. J. (2002). The dimensionality of mental health: Symptoms, functional impairment, and positive wellbeing. *Journal of Health and Wellbeing*, 1, 196-205.
- Kingsley TA, Asangbeng TE, Acha AE. (2022). Factors influencing psychoactive substance use among students, why juvenile violence and delinquency within schools in Cameroon. Scope of the Evidence. *Ann. Public Health Epidemiol*. 2(1): 527.
- Lo-oh, J. L. & Afumbom, D. A. (2017). Aspects of youth culture and the emergence of discipline problems: Implications for university neighbourhoods in Cameroon. *African Journal of Social Sciences*, 8, 2, 35-45.
- Mabouopda, V., Toguem, MG., Noche, CD. (2022). Substance use and substance abuse among street children in Yaoundé, Cameroon. (Pre-Print) <https://www.researchsquare.com/article/rs-1180441v1>.
- Minister of public health Cameroon (2025). *Establishing, organizing, and operationalizing the National Supply Coordination Platform*. CRTV web.
- Nakhaee, S., Hoyte, C., Dart, R.C. et al. (2021). A review on tramadol toxicity: mechanism of action, clinical presentation, and treatment. *Forensic Toxicol* 39, 293-310.
- Nkouonlack, C., Shifu, I. N., Atchou, J. G. B., Eyoun, C., Dinayen, D. Y., Nsagha, D. S., et. al., (2023). Prevalence and associated factors of non-medical use of prescription drugs among adolescents in Secondary schools in Buea, Cameroon: a cross-sectional study. *BMC Psychiatry*. 23(1), 695-712.
- Odejide, A. O. (2006). Status of drug use/abuse in Africa: A review. *Int J Mental Health Addict*, (2):87-102. DOI:10.1007/s11469-006-9015
- Pedersen, W. (2008). *Does cannabis use lead to depression and suicidal behaviours? A population-based longitudinal study*. *Acta Psychiatrica Scandinavica*, 118(5), 395-403. World Health Organization.
- Piehlér, F. T., Veronneau, H. M., & Dishion, J. T. (2012). Substance use progression from adolescence to early adulthood: Effortful control in the context of friendship influence and early onset use. *Journal of Abnormal Child Psychology*
- Rhodes, J.E., & Jason, L.A. (1990). A social stress model of substance abuse. *Journal of Consulting and Clinical Psychology*, 58 (4), 395-401.
- Schulte, M. T., & Itser, Y. (2013). Substance use and associated health conditions throughout the lifespan. *Public Health Rev*. 35(2).
- Shildon, K.M., & Kings, L. (2001). Why positive psychology is necessary. *American Psychologist*, 56, 216-217.
- Stewart, J. G., & Harkness, K. L. (2017). Testing a revised interpersonal theory of depression using a laboratory measure of excessive reassurance seeking. *J Clin Psychol*. 73(3): 331-48. doi:10.1002/jclp.22338.
- UNODC. (2011). *World Drug Report*. United Nations Publication; p.272.
- Van Leeuwen, T. (2015). Multimodality in education: Some directions and some questions. *TESOL Quarterly*, 49, 582-589.
- Wall, A. E., & Kohl, P.L. (2007). Substance Use in Maltreated Youth: Findings from the National Survey of Child and Adolescents Well-Being. *Child Maltreatment*.
- Wansi, J.D., Tchouankeu, J.VC., Gadjibeka, N., & Ngadjuui, B.T. (1996). Three new xanthenes

- from *Garcinia lucida*. *Phytochemistry*, 43(6), 1363-1365.
- WHO (2020). *International Standard for the Treatment of Drug Use Disorders*.
- WHO (2021). *Mental Health and Well-Being Report*.
- Zahiri, S., Karimi, F., & Zadeh, M. A.K. (2016). The effectiveness of cognitive-behavioural therapy on self-efficacy and craving in patients with substance abuse. *International Journal of High-Risk Behaviours & Addiction*, 5(3), e30230.
- Zufferey, A., Michaud, P. A., Jeannin, A., Berchtold, A., Chossis, I., van Melle, G., & Carles Suris, J. (2007). Cumulative risk factors for adolescent alcohol misuse and its perceived consequences among 16- to 20-year-old adolescents in Switzerland. *Preventive Medicine*, 45 (2–3), 233–239. doi: 10.1016/j.ypmed.2007.04.015.

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