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BRIEF COGNITIVE BEHAVIORAL THERAPY (CBT) INTERVENTION IN PRIMARY CARE FOR AN ADOLESCENT WITH SOMATIC SYMPTOM DISORDER EXTRAPOLATED FROM PAST BULLYING TRAUMA: A CASE REPORT

ABSTRACT

Background: Somatic Symptom Disorder (SSD) in adolescents is frequently associated with Adverse Childhood Experiences (ACEs), such as bullying. In primary care settings with limited access to specialist resources, structured brief interventions are urgently required. **Case Presentation:** A 16-year-old male presented with recurrent syncope, dyspnea, and diaphoresis over the past six months. These symptoms were triggered by traumatic memories of physical bullying experienced during elementary school. **Methods:** The patient underwent a Brief CBT intervention consisting of six sessions (30 minutes per session). The protocol included ABC model psychoeducation, the "Worry Time" technique, cognitive restructuring, and behavioral activation. **Results:** The frequency of anxiety attacks and somatic symptoms decreased significantly, from daily occurrences to once per month. The patient demonstrated marked improvement in emotional regulation and coping mechanisms. **Conclusion:** Brief CBT is an effective and safe modality in primary care for managing trauma-related somatic symptoms in adolescents.

Keywords: Brief CBT, Somatic Symptom Disorder, Bullying, Adolescent Psychiatry, Primary Care.

I. INTRODUCTION

Adolescent mental health has emerged as an urgent global concern.^{1,2} Recent data from the 2022 Indonesia National Adolescent Mental Health Survey (I-NAMHS) indicates that approximately 1 in 20 Indonesian adolescents (5.5%) were diagnosed with a mental disorder within the past 12 months, with anxiety disorders being the most prevalent.³ Despite this high disease burden, Indonesia continues to face significant challenges regarding a wide treatment gap. This disparity is driven by pervasive social stigma and limited accessibility to specialist mental health services, which are often concentrated in urban areas.⁴

In first-level health facilities or primary care settings, Somatic Symptom Disorder (SSD) is a frequently encountered clinical manifestation that often goes undiagnosed or is misdiagnosed.^{5,6} Persistent physical symptoms without adequate organic pathological basis frequently leads patients to undergo unnecessary medical over-investigation, which ultimately increases the burden of healthcare costs and heightens patient anxiety.^{7,8} Recent meta-analyses and literature reinforce the strong correlation between Adverse Childhood Experiences (ACEs)—specifically bullying—and the emergence of medically unexplained chronic physical complaints.^{9,10,11,12}

Bullying trauma experienced during critical developmental stages triggers chronic dysregulation of the Hypothalamic-Pituitary-Adrenal (HPA) axis and the autonomic nervous system.¹³ This condition manifests as somatization, which, if not adequately addressed, can permanently impair academic function, social interaction, and psychosocial development in adolescents.^{14,15,16} In Indonesia, government policy via Minister of Health Regulation (PMK) No. 43 of 2019 has emphasized the importance of integrating mental health services into Community Health Center (Puskesmas).^{17,18} However, the uneven distribution of clinical

psychologists and psychiatrists necessitates that primary care physicians possess the competency to perform basic psychological interventions. Brief Cognitive Behavioral Therapy (Brief CBT) has emerged as an evidence-based intervention modality that is efficient and practical for implementation in primary care settings with limited time and resources.^{19,20,21}

II. CASE REPORT

2.1 Identity and Chief Complaint

The patient is a 16-year-old male, an 11th-grade high school student, who presented to the Community Health Center (Puskesmas) with a chief complaint of recurrent episodes of generalized weakness and fainting (syncope) over the last six months.

2.2 History of Present Illness

The reported somatic symptoms included lightheadedness, palpitations, dyspnea (hyperventilation), and diaphoresis of the palms. These complaints occurred paroxysmally, particularly within the school environment, specifically preceding or during physical education classes. The patient reported experiencing "racing thoughts" in the form of flashbacks of past memories that interfered with his academic concentration. Over the last two months, the frequency of syncope increased to nearly every time a stressor was triggered at school. There was no history of seizures, tongue-biting, or urinary incontinence during the syncopal episodes, suggesting a suspicion of psychogenic syncope.

2.3 Psychosocial History (HEADSSS Approach)

- Home: The patient lives with his parents and two older sisters. The socioeconomic status is lower-middle class. There is a history of psychological issues in the second older sister, indicating family system vulnerability.^{11,13}
- Education: Academic performance is good; however, the patient experiences learned helplessness, where he feels forced to allow others to cheat due to a fear of bullying, despite the current high school environment being supportive.
- Eating: Appetite is good, and there are no weight-related issues.
- Activities: The patient enjoys listening to music and occasionally plays with friends.
- Drugs: There is no reported history of substance abuse.
- Sexuality: No issues related to sexuality were identified.
- Suicide: There is a history of self-harming behavior, specifically repetitive head immersion in water, and passive suicidal ideation without a specific plan within the last month.
- Safety: There is a significant history of physical bullying in the 4th and 5th grades of elementary school, involving routine physical assault on the legs, arms, and jaw by peers during physical education hours.

2.4 Physical and Diagnostic Examinations

Physical examination during an episode revealed tachycardia (Heart Rate: 108 bpm); however, vital signs were within normal limits during stable conditions. Neurological examination showed no focal deficits. Electrocardiogram (ECG) results were within normal limits (sinus tachycardia), and routine blood laboratory tests ruled out anemia or hypoglycemia as the cause of syncope.

2.5 Mental Status Examination

The patient maintained fair eye contact, with an anxious mood and restricted affect. Thought processes were coherent, with cognitive rumination related to past trauma. No delusions or hallucinations were identified. Orientation and memory remained intact.

III. METHODS

This study is a case report with a longitudinal approach that evaluates the effectiveness of a brief psychological intervention for an adolescent patient in a primary health care facility. The case management procedure was divided into three main stages:

3.1 Assessment Procedure (HEADSSS Approach)

The assessment was conducted during the first visit using the HEADSSS framework, which is the gold standard for adolescent psychosocial evaluation.¹⁵ A semi-structured clinical interview technique was employed to explore past trauma history, current coping mechanisms, and environmental risk factors. A mental status examination was performed to identify perceptual disturbances, thought content disorders (rumination), and autonomic manifestations of anxiety.²²

3.2 Intervention Design (Brief Cognitive Behavioral Therapy)

The chosen intervention was Brief CBT, a modified form of standard CBT adapted for the constraints of primary care settings.²⁰ The intervention was designed in 6 sessions, occurring once every two weeks, with each session lasting between 30 to 45 minutes. The intervention protocol was developed based on guidelines from Cully & Teten²⁰ and Beck²³, which included:

- ABC Model Psychoeducation: Linking Autonomic (physical symptoms), Behaviour, and Cognition (thoughts or feelings).²⁴
- Worry Time Technique: A stimulus control strategy to limit the duration of cognitive rumination.^{20,25}
- Cognitive Restructuring: Identifying cognitive distortions through the use of Thought Records and analysis of supporting and opposing facts.^{23,26,27}
- Behavioral Activation: Activity scheduling to enhance mastery and pleasure.²⁸
- Relaxation Training and Lifestyle: Diaphragmatic breathing techniques and the 90-second rule.^{21,29,30}

3.3 Outcome Measurement and Evaluation

To evaluate the effectiveness of the intervention, the study utilized Patient-Reported Outcome Measures (PROMs). At the beginning of the program, the patient explicitly defined his therapeutic goal: *"To reduce panic attacks or bodily discomfort from a daily occurrence to at most once a week."* The achievement of this self-defined goal was systematically monitored across all sessions to evaluate the intervention's efficacy.

IV. RESULTS

4.1 Progression of Brief CBT Intervention

The outcomes over the six-session intervention demonstrated significant and gradual clinical improvement. The frequency of somatic attacks decreased markedly from 14 episodes per two-week period at the commencement of therapy to 0–1 episode per month by the conclusion of the sixth session.

Table 1. Summary of Clinical Progression During the 6-Session Intervention

Session	Intervention Focus	Panic Intensity (0-100%)	Somatic Attack Frequency (per 2 weeks)	Outcomes & Evaluation
1	Clinical Assessment, Safety Planning, & Psychoeducation	100%	14 times	Mental Status: Presence of severe autonomic symptoms and cognitive rumination. History of non-suicidal self-injury (self-harm) and low-intensity suicidal ideation identified. Interventions: 1. Safety Contract: Patient and family committed to maintaining a safe environment. 2. Psychoeducation on the ABC Cycle. 3. Pharmacotherapy: Diazepam 2mg (PRN) and Amitriptyline 12.5mg (nocte) for sleep regulation and autonomic anxiety management. Risk Mitigation: Family education regarding strict monitoring of side effects and supervised medication.
2	Worry Time Technique	90%	12 times	Evaluation: Pharmacotherapy was discontinued due to excessive sedation. Intervention: Established a designated "Worry Time" (17:00–17:30). The patient learned to distinguish between productive (solvable) and non-productive (unsolvable) worries (e.g., identifying intrusive thoughts like "what if there are two earths" as thoughts that do

				not require cognitive processing).
3	Cognitive Restructuring	40%	4 times	Evaluation: Anxiety attacks decreased from daily occurrences to twice per week. Intervention: Utilized evidence-based tables (supporting vs. opposing facts). The patient recognized that current high school peers are supportive; thus, the thought "I will be hit again" was identified as a cognitive distortion.
4	Behavioral Activation	55%	6 times	Evaluation: Anxiety showed fluctuant increases due to the examination period. Intervention: Implemented Daily Activity Scheduling (DAS). The patient incorporated positive activities, such as vocal lessons and listening to music, to enhance positive affirmations and self-efficacy.
5	Relaxation Training & Lifestyle	30%	2 times	Evaluation: Anxiety attacks further reduced to once per week. Intervention: Education on sleep hygiene and diaphragmatic breathing techniques to manage somatic symptoms during acute episodes of dyspnea.
6	Termination & Relapse Prevention	10%	0-1 time	Final Evaluation: Complaints of syncope and dyspnea decreased drastically (occurring only once per month). The patient demonstrated the ability to independently manage negative thoughts. The sessions concluded with a scheduled periodic monitoring plan.

4.2 Cognitive Restructuring Outcomes

The implementation of cognitive restructuring during the third session yielded a significant shift in the patient's belief system. As illustrated in **Table 2**, the patient was able to systematically challenge his core automatic thought—specifically the fear of recurring physical assault during physical education classes. By identifying contradictory evidence from his

current supportive peer environment, the patient developed a more balanced cognitive appraisal. This intervention resulted in a marked reduction in panic intensity, decreasing from a self-reported 100% to 25%, which directly corresponded with the clinical cessation of syncopal episodes.^{25,26}

Notably, in the patient's Thought Record (**Table 2**), the column for "Evidence Supporting the Thought" remained vacant. This absence of supportive evidence served as a powerful clinical realization for the patient, highlighting that his fear was a cognitive distortion (catastrophizing) rooted in past trauma rather than current reality.^{23,27} The identification of supportive peers acted as a "corrective emotional experience," weakening the neural circuits that reinforced his fear and replacing them with more adaptive cognitive appraisals.²⁶

Table 2. Patient's Thought Record (Session 3): Cognitive Restructuring Process

Situation	Emotions & Intensity (0-100%)	Automatic Thoughts (Belief 0-100%)	Evidence Supporting the Thought	Evidence Against the Thought (Contradictory Facts)	Cognitive Revision (Alternative Thought)	New Emotions & Intensity (0-100%)
Physical Education (PE) class at the school sports field	Sad (50%) Panic (100%)	"I am terrified that I will be bullied or physically assaulted again" (75%)	— (None identified)	1. Current peers are consistently helpful 2. Friends actively invited me to join the game 3. Friends provided support during the physical assessment 4. Peers offered assistance during my panic attacks 5. No incidents of mocking or violence	"The environment is different now; I am surrounded by supportive peers and I am safe." (60%)	Sad (25%) Panic (25%)

V. DISCUSSION

5.1 Neurobiological Analysis of Trauma and Pathophysiology of Somatization

The clinical manifestations in this patient represent the complexity of the relationship between childhood psychological trauma and adolescent somatic responses. The repetitive bullying experienced occurred during a critical period of brain development, which is associated with

Adverse Childhood Experiences (ACEs).^{11,12} Neurobiologically, this chronic trauma triggers sensitization and dysregulation of the Hypothalamic-Pituitary-Adrenal (HPA) axis and the autonomic nervous system.¹³ This condition places the patient in a state of persistent hypervigilance. When exposed to triggers, such as physical education classes, the amygdala overactivates the fight-or-flight response, while the prefrontal cortex fails to perform top-down emotional regulation. The syncope experienced is analyzed as a dissociative defense mechanism or a "freeze response" when the patient's ego capacity can no longer manage the flooding of anxiety.^{5,14,15,31}

5.2 Cognitive Perspective: Maladaptive Schemas and Restructuring

According to Beck's theory, trauma forms Early Maladaptive Schemas, particularly in the Disconnection and Rejection domain.^{23,27} The patient's "catastrophizing" triggers "racing thoughts" during physical education. As demonstrated in **Table 2**, the absence of evidence supporting his fears was a crucial turning point. Cognitive restructuring aimed to weaken neural circuits reinforcing fear by identifying "Contradictory Facts" in his current peer environment.²⁶

5.3 Patient-Reported Outcome Measures (PROMs) and Functional Recovery

The success of this intervention was validated through Patient-Reported Outcome Measures (PROMs). By allowing the patient to define his own functional goal (*"reducing attacks from daily to once a week"*), the therapy shifted from mere symptom reduction to regaining agency over his life. This approach aligns with the principle of Goal Attainment Scaling (GAS). The patient surpassed his initial PROM target, reaching near-zero episodes, which facilitated his return to the sports field—a setting that previously served as a trauma-triggering environment.



Figure 1. Correlation between Symptom Severity and Patient-Reported Outcome. The primary axis (left) displays the downward trajectory of panic intensity, while the secondary axis (right) shows the upward progression of the PROM score (0-6). The clinical breakthrough at Session 3 underscores the impact of the 'Worry Time' technique, while the slight deviation in Session 4 reflects the impact of an external academic stressor (school exams).

5.4 The Concept of "The Body Keeps the Score" and Biopsychosocial Interaction

This somatization phenomenon illustrates the concept that "the body keeps the score" of past trauma.³² Bullying trauma is not only stored as a cognitive memory but is imprinted within the body's physiological circuits, where the patient's sensorimotor system remains in a high-alert status even when external threats are no longer present.^{31,32,33} Broadly, the patient's condition is viewed through the lens of biopsychosocial interaction.³⁴ Biological factors (autonomic hypersensitivity), psychological factors (maladaptive schemas), and social factors (history of bullying and family dynamics) interact reciprocally in maintaining this disorder.^{8,34,35}

5.5 Adolescent Psychopathology and Identity Development

At age 16, the primary developmental task is the formation of self-identity. Unresolved trauma hinders this process, leading the patient to have low self-esteem. Somatic symptoms often become a "language" for adolescents experiencing alexithymia, where unexpressed psychological conflicts are converted into physical complaints to be more socially acceptable.^{14,15,36,37}

5.6 Pharmacotherapy Management in Primary Care

Therapy selection at the Puskesmas faces logistical challenges. Although SSRIs are the first-line treatment, limited availability leaves Amitriptyline (TCA) as an alternative.^{15,19} The emergence of sedative effects and the risk of a "Black Box Warning" regarding increased suicidal ideation in individuals under the age of 25 required rapid discontinuation of the medication.^{15,22} The decision to transition entirely to non-pharmacological interventions aligns with the principles of personalized medicine.^{18,21}

5.7 The Role of Therapeutic Alliance and Clinical Perseverance

A fundamental element of this case was the evolving dynamic of the therapeutic relationship.^{13,15} During the initial phase, particularly by the second session, the clinical process was met with a period of stagnation as the patient's anxiety showed no measurable decrease, momentarily leading to clinical pessimism. This challenge was further compounded in the third and fourth sessions by the patient's limited adherence to home-based exercises or "homework".^{23,26}

Despite these obstacles, the intervention was sustained by a robust therapeutic alliance^{17,20}; the patient's consistent punctuality and unwavering commitment to attending sessions suggested a deep-seated trust in the clinical process. Even with the counselor being in the early stages of psychotherapeutic proficiency, the ability to maintain a consistent therapeutic presence and a safe, compassionate environment proved instrumental.^{23,35} This dedication to fostering a supportive atmosphere to alleviate the patient's complex distress became a pivotal catalyst for recovery. Ultimately, this highlights that in primary care settings, the quality of the therapeutic bond and the counselor's empathy can significantly bridge the gap between technical protocol and meaningful clinical outcomes, particularly for an adolescent patient with a profound history of interpersonal betrayal.³⁴

5.8 Family Dynamics and the Strategic Role of Primary Care

The success of the intervention is inseparable from the role of the family as the patient's micro-environment. The family functions as an "external ego" that assists in emotional regulation.^{13,15} However, one must be cautious of transgenerational psychological burdens and a "high expressed emotion" environment that may reinforce the somatization response.^{11,14} Strengthening basic psychotherapy competencies for primary care physicians is a crucial step in bridging the mental health treatment gap in Indonesia.^{3,4,6}

VI. CONCLUSION AND RECOMMENDATIONS

6.1 Conclusion

This case report demonstrates that Brief Cognitive Behavioral Therapy (Brief CBT) is an effective and safe modality for reducing somatic symptoms and anxiety in adolescents with a history of bullying trauma. The integration of neurobiological and psychosocial approaches is vital to prevent misdiagnosis and prolonged treatment. Primary care physicians hold a strategic role as the front line in early detection and management of adolescent mental health disorders to mitigate the long-term impacts of ACEs.

6.2 Recommendations

- For Clinicians: Increase vigilance regarding chronic physical complaints through HEADSSS screening to explore trauma history. The application of brief techniques such as "Worry Time" is highly recommended due to time efficiency and significant clinical impact.
- For Puskesmas Management: Ensure the provision of SSRI class medications (such as Fluoxetine) as a safer first-line option for adolescents and strengthen integrated referral systems.
- For Families & Schools: Cross-sectoral synergy is required for bullying prevention programs and education explaining that the patient's somatic complaints are neurobiologically real. Family support as a supportive "gatekeeper" is key to long-term recovery success.

DAFTAR PUSTAKA

1. Malhi GS, Mann JJ. Depression. *Lancet*. 2018;392(10161):2299-312.
2. Wittchen HU, et al. The size and burden of mental disorders and other disorders of the brain in Europe 2010. *Eur Neuropsychopharmacol*. 2011;21(9):655-79.
3. Indonesia National Adolescent Mental Health Survey (I-NAMHS). Laporan Nasional I-NAMHS: Projek Kesehatan Mental Remaja Nasional Indonesia. Jakarta: Pusat Kedokteran Tropis UGM; 2022.
4. Patel V, Saxena S, Lund C, et al. The Lancet Commission on global mental health and sustainable development. *Lancet*. 2018;392(10157):1553-98.
5. Dimsdale JE, Levenson JL. Somatic symptom disorder: an important change in DSM-5. *Psychosom Med*. 2013;75(3):223-28.
6. Goldberg D, Gask L, Razanza T. The Assessment and Management of Common Mental Disorders at the Primary Care Level. London: Royal College of Psychiatrists; 2008.
7. Sharp D, Lipsky MS. Somatization: How to care for patients with unexplained physical symptoms. *Fam Pract Manag*. 2002;9(5):45-8.

8. Kirmayer LJ, Looper KJ. Abnormal illness behaviour: physiological, psychological and social dimensions of medical complements. *Curr Opin Psychiatry*. 2006;19(1):54-9.
9. Gini G, Pozzoli T, Lenzi M, Vieno A. Peer victimization and somatic complaints: A genetic-informed study. *Child Dev*. 2022;93(6):1812-24.
10. Arseneault L. Annual Research Review: The lifelong health and well-being consequences of childhood bullying victimization. *J Child Psychol Psychiatry*. 2018;59(4):373-97.
11. Felitti VJ, Anda RF, Nordenberg D, et al. Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study. *Am J Prev Med*. 1998;14(4):245-58.
12. Wolke D, Lereya ST. Long-term effects of bullying. *Arch Dis Child*. 2015;100(9):879-85.
13. Sadock BJ, Sadock VA, Ruiz P. Kaplan & Sadock's Synopsis of Psychiatry. 12th ed. Philadelphia: Wolters Kluwer; 2021.
14. Kroenke K. Somatic symptom disorder: an update. *Focus (Am Psychiatr Publ)*. 2019;17(4):344-53.
15. Brent DA, McMakin DL, Kennard BD, et al. Practice parameter for the assessment and treatment of children and adolescents with depressive disorders. *J Am Acad Child Adolesc Psychiatry*. 2007;46(11):1503-26.
16. Graham-Bermann SA, Seng J. Violence exposure and Health Risk in Adolescents. *J Adolesc Health*. 2005;36(1):10-7.
17. Cully JA, Teten AL. A Therapist's Guide to Brief Cognitive Behavioral Therapy. Houston: Department of Veterans Affairs South Central MIRECC; 2008.
18. Kementerian Kesehatan RI. Keputusan Menteri Kesehatan No. HK.01.07/MENKES/495/2020 tentang Pedoman Nasional Pelayanan Kedokteran Tata Laksana Depresi. Jakarta: Kemenkes RI; 2020.
19. National Institute for Health and Care Excellence (NICE). Generalized anxiety disorder and panic disorder in adults: management. London: NICE; 2019 (Updated 2023).
20. Cully JA, Teten AL. A Therapist's Guide to Brief Cognitive Behavioral Therapy. Houston: Department of Veterans Affairs South Central MIRECC; 2008.
21. Henningsen P. Management of somatic symptom disorder. *Med Clin North Am*. 2018;102(4):611-26.
22. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders. 5th ed. Washington, DC: APA; 2013.
23. Beck JS. Cognitive Behavior Therapy: Basics and Beyond. 3rd ed. New York: Guilford Press; 2020.
24. Hertfordshire Partnership University NHS Foundation Trust. Cognitive Behavioural Therapy (CBT) Skills Workbook. Hertfordshire: Hertfordshire Wellbeing Services; 2016.
25. McEvoy PM, Erceg-Hurn DM, Saulsman LM, Nathan PR. Effectiveness of repetitive thinking-focused cognitive behavioral therapy for mixed anxiety and depression in a real-world setting. *J Affect Disord*. 2015;175:223-32.
26. Wright JH, Brown GK, Thase ME, Basco MR. Learning Cognitive-Behavior Therapy: An Illustrated Guide. 2nd ed. Washington, DC: American Psychiatric Association Publishing; 2017.
27. Young JE, Klosko JS, Weishaar ME. Schema Therapy: A Practitioner's Guide. New York: Guilford Press; 2003.
28. Martell CR, Addis ME, Jacobson NS. Behavioral Activation for Depression: A Clinician's Guide. New York: Guilford Press; 2010.
29. Linehan MM. DBT Skills Training Manual. 2nd ed. New York: Guilford Press; 2014.

30. Meuret AE, et al. Respiratory and cognitive mediators of treatment change in panic disorder. *J Consult Clin Psychol*. 2010;78(2):258-66.
31. Moore DJ, Keogh E, Eccleston C. The effects of threat on attention to pain. *Pain*. 2012;153(11):2184-91.
32. Van der Kolk B. *The Body Keeps the Score: Brain, Mind, and Body in the Healing of Trauma*. New York: Viking; 2014.
33. Rief W, Broadbent E. Explaining medical symptoms-post-modern skin and traditional mind. *J Psychosom Res*. 2007;62(5):487-90.
34. Sarafino EP, Smith TW. *Health Psychology: Biopsychosocial Interactions*. 9th ed. Wiley; 2016.
35. Fritzsche K, et al. *Psychosomatic Medicine: An International Primer for the Primary Care Setting*. Springer; 2014.
36. Takazawa AT, et al. Psychosomatic complaints in children and adolescents. *Pediatr Int*. 2017;59(5):515-22.
37. Creed F, et al. The epidemiology of multiple somatic symptoms. *J Psychosom Res*. 2011;71(3):138-43.